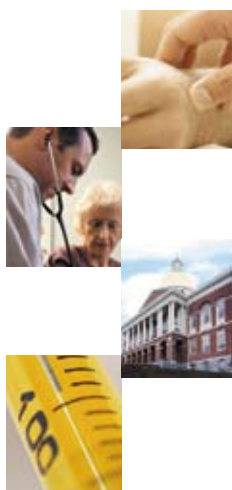




# VITAL SIGNS



- 2 PRESIDENT'S MESSAGE**  
Performance-Measurement Legislation
- 3 YOUR PRACTICE**  
CIGNA Care Network  
Helpful Health Plan Websites  
Malpractice Credits for EHRs
- 4 THE PUBLIC'S HEALTH**  
Hep C among Young People  
DPH Limits Free Flu Vaccine  
Balancing Privacy & Public Health
- 5 GOVERNMENT AFFAIRS**  
State: Coalitions Boost Health Access  
Federal: New Congress Keys on  
Health Care

- 6 PROFESSIONAL MATTERS**  
Landmark PHS Study Published  
Reality Medicine for Minorities  
Michigan's Approach to Malpractice  
Women's Lecture Series: Obesity
- 7 INSIDE MMS**  
Medem Member Discounts  
AMA Disparities Commission  
Poster Symposium  
Across the Commonwealth
- 8 MMS EDUCATION PROGRAMS**  
What's on the Web?

## GIC Ratings May Change, but Copay Differentials Won't

BY TOM WALSH

Massachusetts doctors whose patients are among the state government's 267,000 employees, retirees, and their families may be getting new performance ratings this spring from the Group Insurance Commission (GIC), the state agency that oversees health benefits for this population.

Also, during the second year of what the GIC calls its "Select and Save" program, it's likely that more health plans will use individual performance ratings rather than ratings based on physician groups. Only one plan, Unicare, is fully utilizing individual physician tiering in 2006–2007 (see *Vital Signs*, August 2006, page 1).

"[Individual rating] was always the plan," said Delores L. Mitchell, GIC

executive director. "I believe we will make some substantial steps forward in that regard."

Under Select and Save, patients are subject to lower co-payments when they chose a tier 1 doctor rather than one who is rated tier 2. The GIC maintains that this strategy will improve the quality of care and control costs.

### Newer Data Still Not Good Enough

The MMS supports the overall objective of enhancing quality of care while at the same time controlling costs. However, the Society has questioned the GIC's



Illustration by Chris Twichell

program, which places doctors in different tiers based on evaluations of health plan claims data. Claims data has not yet proven accurate for this purpose, and using it as the raw material for physician ratings — especially ratings of individual doctors —

could lead to patients being misled about the cost-effectiveness and quality of their physicians.

The Society's contention about data accuracy was reinforced by a review of the GIC's methodology by Focused Medical Analytics of Rochester, N.Y. Among its 34 recommendations for change, the study

suggested that physicians be tiered only by groups "until data accuracy is improved and validated."

To establish initial physician tiers for 2006–2007, the GIC used claims data from 2002 through 2004. One year later, the data being used is from 2003 through 2005. The fresher data could result in changes to doctors' ratings for 2007–2008. Kenneth R. Peelle, M.D., MMS president, called the use of more recent physician data "a step in the right direction," but he reiterated that individual ratings based on claims data will still be prone to inaccuracies.

### No Stampede to Switch Doctors

When asked whether the GIC's first year of physician tiering prompted substantial numbers of GIC-covered patients to

*continued on page 2*

## No Increase in ProMutual Premiums for 2007

ProMutual Group, the state's largest commercial medical malpractice insurer, recently announced its intention *not* to increase professional liability premiums for Massachusetts physicians and surgeons for 2007. Some specialties — such as obstetrics, orthopedics, and anesthesiology — will see rate reductions up to 10 percent, the company said.

While calling the rate freeze and reductions "good news that will give needed relief to our physicians," MMS President Kenneth R. Peelle, M.D., cautioned that the current liability system remains fundamentally broken and in need of major reform.

"Our premium costs are still among the highest in the nation and are a significant reason why health care costs in Massachusetts are high," Dr. Peelle said. Noting further that the current system breeds mistrust and impedes patient safety efforts, Dr. Peelle said, "The costs of this system, in both financial and emotional terms, are enormous."

The Society has filed six professional-liability reform bills with the current session of the state Legislature. These include a comprehensive package that addresses, among other things, board certification of expert witnesses and the elimination of joint and several liability, and a bill that would make statements of regret and apology inadmissible as evidence in judicial and administrative proceedings. **VS**

## Tiering Possible in Upcoming Batch of Connector Health Plans

BY TOM WALSH

A few months ago, the Commonwealth Health Insurance Connector Authority sent out a Request for Responses (RFR) to recruit health insurers to cover what may be as many as 200,000 Massachusetts residents who presumably can afford to pay for health insurance but nevertheless remain uninsured.

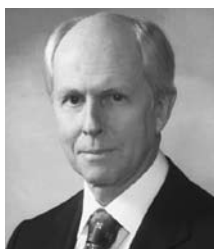
The RFR is a formidable document — all 49 pages of it. And it would be easy to read right past the information on page 13, where the Connector Authority suggests that plans might employ tiered physician networks in the effort to fashion affordable packages for this portion of the Massachusetts populace.

"The Connector strongly encourages carriers to offer a health benefit plan with a provider network that rewards members for using cost-efficient, quality providers," the document says. It goes on to specifically mention "select or tiered networks."

The practice of rating physician performance in this way has been controversial among the state's doctors, particularly those who see patients covered by a plan under the Group Insurance Commission (GIC), the agency that oversees health benefits for the state's 267,000 workers, retirees, and their families. The GIC began using tiered physician

*continued on page 2*

## PRESIDENT'S MESSAGE



### Performance-Measurement Legislation Would Protect Patients

The two page-one articles on tiering underscore the importance of implementing “transparency” correctly. It is worthwhile to repeat that physicians welcome good performance evaluation programs. We look forward to working with insurers, state agencies, and legislators to improve clinical quality and educate ourselves and our patients with accurate, actionable, and trustworthy measures of quality care.

We strongly oppose, however, poor methodology and inaccurate data, which can have unintended but potentially far-reaching consequences. For example, publication of inaccurate data could lead patients to switch physicians without reasonable cause. The consequent disruptions in care could result in duplication of effort and delays in treatment, both of which add unnecessary cost to the health care system.

An independent and comprehensive review of the Group Insurance Commission's physician profiling and tiering system outlined 34 recommendations for improvement. From those ideas we crafted legislation aimed at improving the accuracy and usefulness of performance measures to protect physician-patient relationships.

The legislation sets forth several standards for developing performance- and quality-measurement programs. Among them are:

- Public disclosure of methods and criteria to be used

- Input from physicians to ensure the measures are clinically relevant, understandable, and fair
- A feedback mechanism for correcting erroneous data
- Sample sizes large enough to yield valid information
- Appropriate risk adjustment

Not surprisingly, some in the purchaser and insurer communities were displeased to hear of our legislation. Having learned from our more reactive legislative response to the untenable managed care situation in prior years (which nonetheless resulted in landmark reforms), we decided to be more legislatively proactive this time to protect the interests of patients and physicians alike.

The measurement-standards legislation is especially timely considering that the health plans developing products for the Commonwealth Connector may also utilize performance and efficiency measures (see article on page 1). In addition, if enacted, the legislation will help ensure fairness and accuracy in any further reporting of physician performance by the state's Division of Health Care Finance and Policy.

We have addressed these transparency efforts at every level of our organization. We will continue to do so with any practice or proposal that could impact the physician-patient relationship.

*Kenneth R. Peelle*  
— Kenneth R. Peelle, M.D.

#### GIC Tiering

*continued from page 1*

switch from tier 2 to tier 1 doctors to avoid higher copayments, Mitchell was emphatic that this had not occurred in great numbers.

“There's absolutely no reason why that would happen,” she said. “Our goal is to provide both physicians and patients with more information on a broader range of data on doctors' cost effectiveness. We are not encouraging anyone to switch their doctors. It's up to the patients to decide whether and how to use the data.”

The copayment differential between tier 1 and tier 2 in 2006–2007 is \$10, and Mitchell said that will not change for 2007–2008, emphasizing again that the objective is not to encourage patients to switch doctors, but rather to “get the attention of the medical community to look at this data.”

Mitchell said she hoped doctors rated tier 2 in the first year will have used the data to make practice changes to bring them up to tier 1. But many physicians have complained that the performance information they receive from Select and Save plans is neither complete nor practical enough to use in performance-improvement efforts. The Rochester evaluation recommended that physicians receive reports of “specific behaviors (action items) by which they can improve their results.”

In theory, a wider copayment differential between the tiers could result in more patients switching doctors for financial reasons. Mitchell acknowledged that possibility, but emphasized that the GIC has no plans to increase the differential.

New physician ratings for GIC health plans are expected to be announced in March. **VS**

#### Connector Health Plans

*continued from page 1*

networks last year and will continue the program this year (see related article on page 1).

#### Tiered Plans Possible

Until health plan responses are made public, it will remain a matter of conjecture whether tiered networks will be used. However, it seems that tiering may be part of at least some of the proposed plans. The likelihood of tiered plans increased in January, when the Connector told insurers who had submitted proposals to come back with lower monthly premiums for their plans than they first quoted. (Initially proposed premiums averaged \$380 per month.) The Connector board is scheduled to revisit the matter of premium affordability later this month.

“One of the ways to try to control costs without sacrificing quality is to design limited networks or tiered networks,” observed Jon Kingsdale, the Connector's executive director.

Kenneth R. Peelle, M.D., MMS president, said he understands the Connector's need to make premiums affordable. At the same time, though, the MMS continues to believe that for now, tiered physician networks are most effective and fairest when implemented at the physician-group level rather than with individual doctors. “The science suggests that tiering at the individual level is not ready for general use at this point because the

tools have to be further refined,” Dr. Peelle said.

Kingsdale said he does not object to tiering physicians individually “in principle.” But he was quick to add that the Connector is “not demanding that plans tier. And we're not suggesting if they

do, that we would tell them how to do it.” He said health plans with select physician networks — he described them as plans that do not include “virtually every physician or hospital in the Commonwealth” — have fallen out of favor with commercial insurers in the Northeast.



Jon Kingsdale,  
Commonwealth  
Connector Executive  
Director

#### Choice Is the Objective

The Connector's objective, Kingsdale said, is to offer uninsured people who can afford coverage a choice of different plans. He added that he hopes

final offerings will include both broad provider networks and select, high-performance networks. And, Kingsdale said, those who opt for a higher-cost option should expect to pay a higher premium.

“Beyond that,” he said, “we're not giving the carriers any direction. We were just pointing out in our RFR a way to bridge the gap between what people want — which is access to good hospitals and physicians — and affordable out-of-pocket costs and a monthly premium they can afford.”

Massachusetts physicians and their patients will soon learn what those plan options look like. **VS**

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

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

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

**PHYSICIAN EDITORIAL ADVISORY BOARD:** Elsa Aguilera, M.D.; Barbara Herbert, M.D.; Bruce Karlin, M.D.; Dubravko Kufnec, M.D.; Devi E. Nampiaparampil, M.D.; Kenneth R. Peelle, M.D.; Ravin Ratan; Jack K. Ringler, M.D.; Jennifer Rosen, M.D.; Ashish J. Sitapara, M.D.

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

**PRESIDENT:** Kenneth R. Peelle, M.D. **EXECUTIVE VICE PRESIDENT:** Corinne Broderick  
**DIRECTOR OF COMMUNICATIONS:** Frank Fortin

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

*Vital Signs* lists external websites for information only. MMS is not responsible for their content and does not recommend, endorse, or sponsor any product, service, advice, or point of view that may be offered. MMS expressly disclaims any representations as to the accuracy or suitability for any purpose of the websites' content. ©2007 The Massachusetts Medical Society. All Rights Reserved.



## CIGNA Care Network Introduced in Western Mass.

Earlier this year, physicians in Western Massachusetts received notification letters if they met the necessary criteria to be designated as part of the CIGNA Care Network. Physicians in 21 specialties (see box) were evaluated for the network based on quality and efficiency measures. Two-thirds of the 820 physicians, measured at a group level, achieved designation.

Patients who select a designated physician will have lower copayments or coinsurance levels. Patients who sign up for this plan option will receive a CIGNA Care Network identification card that shows the appropriate specialist copayment and other cost-sharing levels. Physicians who have been designated as part of the network should collect the lower copayment. Primary care physicians should continue to collect the PCP visit copayment listed on the card. (CIGNA

plans to begin evaluating primary care physicians in 2008.)

MMS leadership met with CIGNA to understand and evaluate the methodology used to create the network. Physicians are rated on CIGNA's board-certification criteria, quality criteria, and efficiency measures to achieve designation. If physicians meet any of the following quality criteria, they are automatically designated as part of the CIGNA Care Network regardless of the efficiency data:

- A National Committee for Quality Assurance physician recognition award recipient for diabetes, cardiac/stroke, or Physician Practice Connections
- A bariatric surgeon who meets selection criteria and is practicing at a CIGNA-certified bariatric facility
- A physician with adherence to evidence-based medicine standards in certain disease categories with performance in the top quartile

### Specialties Eligible for CIGNA Care Network Designation

Allergy & Immunology	Gastroenterology	Obstetrics/Gynecology
Cardiology	General Surgery	Ophthalmology
Cardiothoracic Surgery	Hematology/Oncology	Orthopedics & Surgery
Colon and Rectal Surgery	Infectious Disease	Pulmonology
Dermatology	Nephrology	Rheumatology
ENT	Neurology	Urology
Endocrinology	Neurosurgery	Vascular Surgery

The MMS was pleased to learn that CIGNA is willing to provide non-designated physicians with detailed data regarding their status and will allow these physicians to correct their data and appeal the decision. However, deficiencies still exist in the program, such as a measurement threshold of only 20 cases per group, which may not constitute statistical significance.

The CIGNA Physician Directory identifies designated physicians with one to three stars in each of the quality and efficiency categories. Designation status is reviewed annually. **VS**

– Dana Cooper

For more information about the CIGNA Care Network, call (800) 88-CIGNA (800-882-4462). If you experience problems or have general concerns, contact Dana Cooper, MMS manager of health systems services, at dcooper@mms.org or (781) 434-7218.

## How Will This Claim Pay?

“Transparency” is today’s health care buzzword. The word suggests a two-way transmission of light, yet many physicians feel that lately the light has been shining only on them. True transparency goes both ways, so the light should also be directed at health plans’ payment policies, medical policies, and claims edits, just as it is at physician practices.

Physicians can, in fact, access medical and payment policies for the health

plans in their provider manuals and, in many cases, on the plans’ websites. Some plans in Massachusetts have enhanced their websites to support Clear Claim Connection technology, which allows physicians to determine the CPT level-payment policy for a claim and the rationale by which a claim is processed.

The table below outlines the information available to physicians on the various plans’ websites. **VS**

– Dana Cooper

Health Plan Website	What’s on the Site
Aetna <b>www.aetna.com</b> (Click on Doctors & Hospitals)	Clinical policy bulletins, a code editing tool (Clear Claim Connection), provider manual, physician newsletters/mailings
Blue Cross Blue Shield of Massachusetts <b>www.bluecrossma.com/provider</b>	Medical policy, specialty-specific fee schedules, member level benefits, the Blue Book, a CPT code level-payment policy tool (Clear Claim Connection)
CIGNA <b>www.cignaforhcp.com</b>	Policies and procedures (including provider newsletter, reference guides, and administrative guidelines); refer-to fee schedules; an e-mail resource for questions about fee schedules, specific member benefits, claim-coding logic, and coverage positions
Fallon Community Health Plan <b>www.fchp.org/providers</b>	Medical and payment policies (including provider manual), procedure code look-up tool, health care guidelines, provider newsletters
Harvard Pilgrim Health Care <b>www.harvardpilgrim.org/providers</b>	Payment policies (click on Provider Manual); clinical guidelines (click on Medical Management); HPHConnect for claims reports and diagnosis, procedure, and revenue codes
Tufts Health Plan <b>www.tuftshealthplan.com/providers</b>	Clinical coverage resources, payment policies, provider manual, code review edit tool (Clear Claim Connection), provider bulletins
United <b>www.UnitedHealthcareOnline.com</b>	Payment policies, medical policies, access to fee schedules, network bulletins

## PIAM and CMIC Offer Malpractice Premium Credit for EHRs

Physicians Insurance Agency of Massachusetts (PIAM) recently announced the first-ever malpractice premium credit available to Massachusetts physicians for the use of electronic health records (EHRs).

This new credit program offered by Connecticut Medical Insurance Company (CMIC) is part of a joint venture with the Massachusetts eHealth Collaborative (MAeHC), the MMS, and PIAM. “This comprehensive credit program takes into account claims experience, practice management, and the use of EHRs,” explained Denise Funk, president of CMIC. “A quality EHR system and a well-trained staff can increase the quality of patient care while addressing important risk management issues.”

“We’re delighted to have the support of a professional liability insurance carrier that understands the potential offered by the latest generation of EHR systems to protect patients from many common medical errors and make health care delivery more effective,” added Micky Tripathi, CEO of the MAeHC.

An EHR credit of 5 percent will be available to physicians who are using

either one of the MAeHC’s approved systems or an EHR system endorsed by the MMS (see box) for at least one year. “We anticipate that the list of EHR systems eligible for the discount will continue to grow,” added Jack King, PIAM president.

To be eligible for the program, a practice must also meet certain underwriting and claims-experience requirements

and be willing to participate in CMIC-approved risk management programs. When combined with claim-free and risk management credits, the practice discount could potentially climb to 20 percent.

CMIC is a Connecticut-based insurance carrier that entered the Massachusetts professional liability market in 2004. PIAM, a subsidiary of the MMS, is the exclusive broker for this program. **VS**

– Barbara Lawrence

For more information about this new EHR credit, call PIAM at (800) 522-7426. For more information about MMS member discounts on software products, contact the MMS Physician Practice Resource Center at (800) 322-2303, ext. 7222.

## Hep C among 15- to 25-Year-Olds on the Rise in Massachusetts

Recent analysis of surveillance data has shown an increased proportion of hepatitis C cases among Massachusetts adolescents and young adults between 15 and 25 years of age. From 2002 to 2005, the percentage of reported hepatitis C cases in this age group rose from 6.9 percent to 10.4 percent. Since risk history is available only on approximately one-quarter of the cases in this group, little is known about what is driving the increase.

Given the age of the patients, it is likely that they were infected recently, which makes prevention a high priority in this demographic. Consequently, the Massachusetts Department of Public Health (MDPH) will begin enhanced surveillance of hepatitis C in adolescents and young adults to better understand the trend and ensure appropriate services are provided.

According to the National Health and Nutrition Examination Survey (NHANES) for 1999–2002, an estimated 3.5 million Americans are chronically infected with the hepatitis C virus (HCV). Most were born between 1945 and 1964, and most are adults who have a history of injection drug use or who received a blood transfusion prior to 1992.

The NHANES 1999–2002 data suggest a low prevalence of anti-HCV antibody in adolescents and young adults as compared with older adults. However, only a small number of younger people participated in NHANES. Other studies have found that the annual incidence of HCV infection ranges from 10 to 25 percent in young injection drug users, a popula-

tion that has also been underscreened. More data comes from the Vancouver Injection Drug Users Study, which found that addicted youth 24 years of age or younger demonstrated an incidence rate of 52 percent for new HCV infection at

36 months after enrollment.

The Centers for Disease Control and Prevention recommends hepatitis C testing for anyone who:

- Has ever injected illegal drugs
- Received a blood transfusion or solid organ transplant before July 1992
- Received clotting factors made before 1987
- Has been on long-term kidney dialysis
- Has been notified that they received blood from a donor who later tested positive for hepatitis C
- Has evidence of liver disease

The MDPH encourages providers to assess the HCV-related risks of all their patients, regardless of age. Patients who test positive for HCV need to receive or be referred to medical management. Resources for people living with HCV infection are available on the MDPH website at [www.mass.gov/hepc](http://www.mass.gov/hepc).

Patients who are at ongoing risk but do not test positive should receive information on HCV prevention (including drug-treatment and syringe-exchange programs), and they should be encouraged to get vaccinated against hepatitis A and B.

— Shauna Onofrey, M.P.H.  
Massachusetts Department  
of Public Health

*An estimated 3.5 million Americans are chronically infected with hepatitis C. In Massachusetts, an increasing proportion of cases are occurring in people 15 to 25 years of age.*

## State to Cease Providing Adult Patient Flu Vaccine to Private Physicians

Starting with the 2007–2008 flu season, private providers of health care must purchase their own supply of influenza vaccine for adults, announced the Massachusetts Department of Public Health (MDPH) earlier this year. With the exception of long-term care facilities, the MDPH will not be providing flu vaccine for adult patients of private providers.

This decision will affect approximately 1,047 physician practices across the state, according to the MDPH, which accounted for approximately 58,000 doses, or 8 percent of the MDPH's total allocation this past flu season.

With four manufacturers now in the marketplace, the companies expect to produce a record number of flu vaccine doses — approximately 115 million — this coming year.

### Prepare Now

Physicians are encouraged to order influenza vaccine for the 2007–2008 flu season directly from vaccine manufactur-

ers and distributors. Both state-supplied and privately purchased influenza vaccine are likely to arrive in multiple shipments between September and December 2007. Flu vaccination is recommended for all health care workers, children from 6 months to 5 years of age, people older than 50, people with certain chronic illnesses, pregnant women, and those who come in close contact with these high-risk persons.

### Reimbursement Rates

Influenza vaccine is covered by Medicare and most other insurance plans. In 2006, the Medicare reimbursement rates for influenza vaccine were \$12.06 per dose for the vaccine and \$19.76 per dose for administering the vaccine.

For more information about flu vaccine and to sign up for the MMS Flu Advisory Listserve, which provides updates on flu and flu vaccine, visit [www.massmed.org/flu](http://www.massmed.org/flu). **VS**

— Robyn Alie

## CME Program Will Help Physicians Balance Patient Privacy and Public Health

Clinical medicine focuses on individual patients, while public health concentrates on the health of the community. This dynamic tension is the focus of a CME program sponsored by the MMS and the Volunteer Surveillance Corps (VSC), in collaboration with the Massachusetts Department of Public Health (see box).

According to MMS policy, "The patient has a fundamental right to privacy and confidentiality in his/her relationship with a physician. It is the physician's responsibility to do his/her best to protect the patient's privacy." Yet reporting disease data can help track the incidence and patterns of injury and disease and facilitate rapid identification of health needs.

On the other hand, protecting individual privacy is necessary in order to moti-

vate patients to fully and truthfully participate in public health efforts that yield accurate, complete, and useful health information. This dynamic becomes in-

creasingly complex in a public health emergency, where standards of care may be altered.

The purpose of "Balancing Your Practice: Protecting the Public Health and Preserving Your Patients' Privacy" is to frankly address these competing interests and provide attendees with increased knowledge of how to interact with patients and public health au-

thorities when dealing with communicable diseases or when faced with a pandemic or other health emergency. The program will also address the role of surveillance and the human rights aspects of emergency preparedness.

— Vanessa Kenealy

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

Wed., March 7, 5:45 to 9:30 p.m.

MMS Headquarters, Waltham

Faculty: Alfred DeMaria, M.D.; Wendy Parmet, Esq.; and Jean McGuire, Ph.D.

CME Credit:  
3.0 AMA PRA Category 1 Credits™

The program is free for Volunteer Surveillance Corps (VSC) members.

For more information about the program or the VSC, contact Vanessa Kenealy at [vkenealy@mms.org](mailto:vkenealy@mms.org) or (781) 434-7319.

### WEBSITE OF THE MONTH

#### National Nutrition Month Promotes Fad-Free Lifestyle

March is National Nutrition Month, and this year's campaign, "100% Fad Free," encourages people to develop sound nutrition and physical activity plans for lifelong health.

The "Food and Nutrition" section of the American Dietetic Association's website, [www.Eatright.org](http://www.Eatright.org), includes physician-directed resources, such as a guide to nutrition screening and intervention resources for older adults.

For patients, the site features nutrition fact sheets on topics such as vitamins, fats, and weight management; a "Good Nutrition Reading List"; and links to MyPyramid — the federal government's food guidance system to help individuals improve diet and lifestyle.



## STATE UPDATE

## Health Access Remains a State House Priority for the MMS

The 2007–2008 state legislative session is already underway, and the Massachusetts Medical Society has filed an array of bills aimed at improving the physician practice environment. These include legislation aimed at reforming professional liability, Medicaid, and antitrust laws, and new initiatives regarding quality measures, the physician workforce, and hospital staff organizations (see *Vital Signs*, February, page 5).

The Society's State House priorities also include health care access. MMS advocacy on access issues has best been addressed by working with broad-based coalitions of diverse organizations that share our interests. Our coalition partners include groups ranging from provider organizations and patient advocacy groups to religious organizations and labor unions.

At present, the MMS actively participates in three such alliances housed at Health Care For All. The goal of these alliances is to promote universal access to health insurance coverage, children's health access, and the elimination of ra-

cial and ethnic disparities in health and health care.

The MMS was a key member of the Affordable Care Today (ACT) coalition's advocacy for passage of last session's landmark health reform law. To date, more than 47,000 uninsured have been added to Medicaid (MassHealth) rolls, and nearly 50,000 uninsured have been determined eligible for subsidized insurance under the Commonwealth Care Health Insurance Plan for low-income patients.

While the number of enrollees is steadily growing, enactment of this legislation did not mark an end to the Society's long-standing efforts to achieve universal access. The Society remains an active member of ACT, and that alliance remains committed to monitoring the implementation of the health care reform law and making recommendations for its improvement.

The MMS has also been an important partner in the Children's Health Access Coalition (CHAC), which has a record of success in securing appropriate funding for the Children's Medical Security

Plan, a basic health insurance plan administered by MassHealth. This year, the CHAC has expanded its focus to include pediatric mental health, due largely to a report last fall from Children's Hospital Boston and the Massachusetts Society for the Prevention of Cruelty to Children. The report described a system in which 100,000 children in Massachusetts do not receive the mental health care they need. The CHAC is sponsoring comprehensive legislation that would make such care more available.

The Society is also working to eliminate racial and ethnic disparities in health care through participation in national and state initiatives. MMS Assistant Secretary-Treasurer Alice A. Coombs, M.D., has represented the Society on both the AMA and the state commissions aimed at addressing the issue. (See related article on page 7.) Last year, a new coalition — the Disparities Action Network — was formed with MMS support to seek state legislative solutions to health disparities problems. **VS**

— Steve Shestakofsky

## LEGISLATOR OF THE MONTH

## Senator Robert O'Leary (D)

**District:** Barnstable (part), Brewster, Chatham, Dennis, Eastham, Harwich, Mashpee, Orleans, Provincetown, Truro, Wellfleet, Yarmouth, and the Islands

**Committees:** Higher Education (chair); Housing (vice chair); Elder Affairs; Environment, Natural Resources & Agriculture; Revenue



**QUOTE:** Massachusetts is failing when it comes to medical malpractice policy. A report issued by the American College of Emergency Physicians gave Massachusetts a grade of D– for our medical liability environment. Doctors can't afford the sky-high premiums for malpractice insurance, and many are refusing to practice certain specialties or are leaving the state altogether. We must find innovative options for medical malpractice reform.

That is why I filed a legislative package to improve Massachusetts' environment for professional liability. The legislation I filed includes proposals that would make statements of apology from health care providers regarding an unanticipated outcome inadmissible in legal and administrative proceedings. I am also supporting a "cooling-off period" before a person files a claim for malpractice. Such a pause will enable parties to share information in hopes of a settlement that bypasses the need for expensive litigation.

We should also require that physicians who testify as expert witnesses be board certified in the same specialty as the defendant physician. Finally, I am advocating for the creation of a pilot health court system that would benefit patients and doctors alike. Within this non-adversarial system, decisions would be made by neutral medical experts, and injured patients would not be pitted against their health care providers.

## FEDERAL UPDATE

## 110th Congress Renewing Momentum for Health Care Reform

With health care reform a priority for the Democratic leadership, several proposals to expand health insurance coverage have emerged both on and off Capitol Hill.

Sen. Edward Kennedy, chair of the Senate Health, Education, Labor, and Pension Committee, focused on health insurance reform at the committee's first hearing in the new session. The senator used this forum to introduce "Medicare for All by 2010," his proposal to expand the federal employee health benefits plan to all Americans. Sen. Kennedy emphasized that the plan would retain patients' freedom of choice and allow doctors, hospitals, and other providers to operate as independent entities. He noted further that this measure would foster the use of health information technology and provide incentives for cost-efficient, quality health care. The senator calculated that the proposal would save more than \$380 billion a year.

The AMA joined with a diverse group of 12 other organizations to form the Health Care Coalition for the Uninsured. After months of deliberation, the

group unveiled a comprehensive proposal to expand health insurance to most of the 46 million uninsured. Focusing initially on children, this initiative would include significant expansions to the State Children's Health Insurance Program (SCHIP). SCHIP was created in 1997, thanks largely to the leadership of Sen. Kennedy and with the strong support of the MMS. With SCHIP up for reauthorization this year, the MMS joined with Children's Hospital Boston, the New England Council, and a number of state and national organizations to advocate for reauthorization and expansion of SCHIP to cover the more than nine million children nationwide who are currently uninsured.

On Capitol Hill, a bipartisan group introduced legislation that would provide grants to individual states and groups of states to test various health reform efforts. Grants could be used to fund initiatives such as tax credits, Medicaid and SCHIP expansions, or health savings accounts.

Meanwhile, the President unveiled his health access initiative during the State

of the Union address. His approach, which would define health insurance as taxable income, would allow tax credits of \$7,500 to individuals and \$15,000 to families for purchasing health insurance, but families and individuals would pay income tax on employer-based health insurance that exceeded those amounts. The President's plan would be funded in part by a controversial \$30 billion reduction in disproportionate share hospital payments to "safety-net" hospitals that serve the uninsured.

Finally, the 110th Congress is also expected to reopen the debate on small business health insurance proposals. Such measures were defeated in the last session, but advocates continue to push for this proposal, which would typically preempt state requirements for health benefits offered and the financial solvency of the companies offering coverage. The MMS joined with many of our colleagues in the patient advocacy and health care communities to oppose this legislation. **VS**

— Alex. Calcagno

## Another Dose of “Reality Medicine” for Minority Students and Residents

For the fifth consecutive year, the Committee on Diversity in Medicine will host “Reality Medicine for Minority Physicians in Massachusetts.”

This popular program gives medical students and residents the opportunity to hear from minority internists and other specialists about important issues and challenges they face while practicing medicine, including partnerships and financial arrangements, practice barriers, personal and professional goals, and discrimination in the workplace.

Hundreds of students and residents have attended this program in the past. To encourage medical students and residents to become involved in the MMS,

the Committee on Diversity will offer free MMS membership for the remainder of 2007 to students and residents who attend the Reality Medicine program. **VS**

### Reality Medicine for Minority Physicians in Massachusetts

**Fri., March 30  
6:00–8:00 p.m.**

**Tufts University School of Medicine  
Sackler 826D**

To register, please contact Erin Tally at (800) 322-2303, ext. 7413, or [etally@mms.org](mailto:etally@mms.org).

## Medical Malpractice: Will Michigan’s Approach Work in Massachusetts?

The MMS and the *Massachusetts Medical Law Report* will cosponsor a forum on professional liability at MMS Headquarters on Tuesday, March 27, from 8 a.m. to noon called “Beyond the Blame Game: Can We Transform the Medical Liability Experience in Massachusetts?” The forum will look at Michigan’s experience with a new approach to professional liability to see if similar changes are possible in Massachusetts.

For years, the medical malpractice experience has been a blame game, a deny-and-defend enterprise by physicians, and a demonizing of attorneys by physicians and of physicians by attorneys. This system has bred distrust of our legal process, impeded patient safety efforts, established a culture of fear, and added unnecessary costs to our health care system.

In 2001, the University of Michigan Health System drastically changed its approach to medical malpractice litigation. Since then, claims have fallen by two-thirds, legal expenses have shrunk by one-half, and processing times have dropped from an average of 21 months to less than 10 months.

The featured speaker at this event will be Richard C. Boothman, chief risk officer for the University of Michigan Health System. Panelists will include a physician, risk officer, plaintiff and defense attorneys, and a legislator. The event is free, but registration is required.

For more information or to register, contact Richard P. Gulla, media relations manager, at [rgulla@mms.org](mailto:rgulla@mms.org). **VS**

— Richard P. Gulla

## Women’s Lecture Series: Family and Childhood Obesity

More than half of Massachusetts adults and one in seven children are too heavy for optimal health.

To help physicians gain a better understanding of the obesity epidemic and how to provide treatment, the MMS and its Committee on Women in Medicine will present a CME program on family and childhood obesity (see box).

For more information about the program or the Committee on Women in Medicine, contact Erin Tally at (800) 322-2303, ext. 7413, or [etally@mms.org](mailto:etally@mms.org). **VS**

### Family and Childhood Obesity: Evaluation and Treatment Methods

**Wed., April 25, 5:45–8:00 p.m.  
MMS Headquarters, Waltham**

**Faculty:** Caroline M. Apovian, M.D., director of the Nutrition and Weight Management Center at Boston University Medical Center; and Lynda M. Young, M.D., chief of the Division of Community Pediatrics at UMass Memorial Children’s Medical Center

CME Credit:

1.5 AMA PRA Category 1 Credits™ (RM)

## PHYSICIAN HEALTH MATTERS

### Study Shows Success in Rehabilitating Physicians with Mental and Behavioral Health Problems

Authored by five members of the Physician Health Services (PHS) Research Committee, a study in the January *Journal of Psychiatric Practice* demonstrates that physicians with mental and behavioral health problems (MBH) can safely be monitored while continuing to practice medicine. The success rate for those physicians is virtually identical to that seen when physicians with substance use disorders (SUDs) are monitored.

#### Study Methods and Results

Researchers followed and examined data on Massachusetts physicians with both SUD and MBH problems over a 10-year period. Fifty-eight of the physicians studied had MBH problems, and 120 had SUD problems. All had signed contracts with PHS and thus voluntarily agreed to monitoring as part of their recovery program. Monitoring included regular psychotherapy, attendance at support group meetings, monthly meetings with a program associate director, and regular reports from professional colleagues. Physicians with SUDs also had weekly random laboratory screens for alcohol and drugs.

Seventy-four percent of physicians with MBH problems and 75 percent of physicians with SUD problems completed the program successfully.

According to lead author John R. Knight, M.D., associate professor at Harvard Medical School, director of the Center for Adolescent Substance Abuse Research at Children’s Hospital, and chair of the Physician Health Services Research Committee, the study demonstrated “a high rate of success” in helping physicians with mental and behavioral issues using strategies proven to successfully address SUDs.

#### Alternative to Discipline

The authors urge all states to develop MBH monitoring programs for physicians and encourage all state licensing boards to recognize MBH monitoring as a reasonable alternative to discipline,

in much the same way most boards recognize SUD monitoring.

Dr. Knight said the study revealed other key findings:

- Women monitored for both SUD and MBH disorders were found to relapse significantly sooner than men, which suggests a need to develop treatment and monitoring services specifically tailored to women physicians.

- Anesthesiologists and emergency medicine specialists were found to be at greater risk of SUDs than those in other specialties, a finding that confirms results found in previous studies. Psychiatrists were found to be over-represented in the mental health and behavioral group, which

the authors speculate could result from psychiatrists’ greater awareness of mental disorders, early life stress, or the demands of practice. Together, these findings suggest that more education and prevention programs

should be conducted during residency training for physicians in at-risk specialties. “Prevention is one of medicine’s best tools,” Dr. Knight said. “Physicians must do a better job of taking care of themselves and each other.”

- Physicians who had involvement with the state licensing board appeared to have a higher success rate than those who did not. The effect was strongest for physicians with SUD problems. Monitored physicians who self-report their difficulties to the state registration board as part of the license-renewal process should therefore be reassured that their involvement with the board can contribute to a positive outcome. **VS**

For a copy of the study or for more information about PHS, visit [www.physicianhealth.org](http://www.physicianhealth.org) or call (781) 434-7404.



## ACROSS THE COMMONWEALTH

### District News and Events

**Charles River – Delegates Meeting.** Tues., March 27, 6 p.m. Location: MMS Headquarters, Waltham. For more information, contact the Northeast Regional Office.

**Essex South – District Membership Meeting.** Thurs., March 8, 6 p.m. Location: Danversport Yacht Club, Danvers. For more information, contact the Northeast Regional Office.

**Hampden – Legislative Breakfast.** Fri., March 30, 7:30 a.m. Location: Best Western Sovereign Hotel and Conference Center, West Springfield. **High School Doctor for a Day Program.** Thurs., April 12, breakfast 7:30 to 8:30 a.m., and debriefing 5:30 to 6:30 p.m. Location: Baystate Health Learning Center, Holyoke. **Annual Meeting.** Wed., April 11, 6 p.m. Location: Munich Haus, Chicopee. Speaker: Congressman Richard Neal. Topic: “Now that Democrats Have the Majority, What Will They Do about Health Care?” Also, 2007 Community Clinician of the Year Award presentation to Sara Mullan, M.D. For more information, contact Suzanne Skibinski at (413) 736-0661.

**Hampshire/Franklin – District Meeting.** Wed., March 21, 6 p.m. Location: Deerfield Inn, Deerfield. Speakers: Dale Magee, M.D., MMS president-elect, and Dolores L. Mitchell, executive director, Group Insurance Commission. Topic: Physician Performance Reporting. For more information, contact the West Central Regional Office.

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

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

**Worcester – The First Annual Louis A. Cottle Medical Education Conference.** Wed., March 21, 5:30 p.m. Location: Beechwood Hotel, Worcester. Topic: “From Socrates to \*S.O.D.I.U.M. \*(Study of Dying in an Urban Milieu): The Dying Experience in Worcester.” For more information, contact Joyce Cariglia at (508) 753-1579.

**Worcester North – Annual Meeting.** Thurs., March 29, 6 p.m. Location: Wachusett Mountain, Princeton. Speaker: Jeffrey Drazen, M.D., editor-in-chief, *New England Journal of Medicine*. Topic: “Responsibilities of Medical Journals.” For more information, contact the West Central Regional Office.

### Statewide News and Events

**Art, History, Humanism & Culture Member Interest Network – MIN Executive Committee Meeting.** Wed., March 7, 6 p.m. Location: MMS Headquarters. For more information, contact the West Central Regional Office.

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

### In Memoriam

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

**Richard M. Abbott, M.D.,** 88; Gilmanton, NH; Yale University School of Medicine, 1943; died January 26, 2007.

**Alan P. Freedberg, M.D.,** 97; Salem, MA; Rush Medical College, 1935; died January 13, 2007.

**William L. Hayden, M.D.,** 79; Lynnfield, MA; Tufts University School of Medicine, 1954; died January 16, 2007.

**John J. McGillicuddy, M.D.,** 93; Framingham, MA; Yale University School of Medicine, 1938; died January 14, 2007.

**Calvin H. Plimpton, M.D.,** 88; Westwood, MA; Harvard Medical School, 1943; died January 30, 2007.

## Medem Offers Physicians Individual Interactive Websites

As part of the MMS member benefits package, members are eligible to receive a \$100 discount on Medem products and services. Medem offers alternative ways for patients to communicate with their physicians while reducing the administrative burdens of practice and increasing efficiency.

The Medem Network began with three basic offerings to physicians: *Your Practice Online* enables physicians to create a website for their own practice. *Secure Messaging* provides confidential communication between patients, physicians, and office staff. And the *Medical Library* allows for selection of the content included on the website.

Further product development resulted in *Online Consultation* (OC). As an option within *Secure Messaging*, OC allows secure, fee-based e-mail communication for clinical questions. OC is encrypted, confidential, and meets HIPAA standards.

The most recent addition to Medem products and services is *iHealthRecord* — a secure and confidential personal health record system combined with interactive educational programs to help patients understand medical conditions and medications. **VS**

For more information on Medem products and services, call (877) 926-3336, e-mail [info@medem.com](mailto:info@medem.com), or visit [www.medem.com](http://www.medem.com) or [www.massmed.org/medem](http://www.massmed.org/medem).

## MMS to Host AMA Commission to Eliminate Health Care Disparities

On March 4 and 5, the MMS will host a meeting of the American Medical Association’s Commission to Eliminate Health Care Disparities. With representation from more than 55 medical and health professional organizations, the commission — chaired by the AMA in collaboration with the National Medical Association — promotes systematic approaches to the following:

- Increasing awareness of health care disparities based on race and ethnicity
- Expanding improvements in the accumulation of data
- Promoting workforce diversity
- Improving education and training regarding diverse populations

Jeffrey Drazen, M.D., editor in chief of the *New England Journal of Medicine*, will discuss the role of peer-reviewed medical journals and the media in addressing racial and ethnic disparities. The event will also include a panel discussion covering the history of health care disparities, advocacy, and universal coverage.

MMS Assistant Secretary-Treasurer Alice Coombs, M.D., is a member of the AMA commission and lobbied to hold this meeting in Massachusetts. **VS**

For more information about this meeting, please contact Erin Tally at [etally@mms.org](mailto:etally@mms.org) or (781) 434-7413.

## Call for Abstracts

**Second Annual Research Poster Symposium for Residents, Fellows, and Students – Saturday, April 21**

**Deadline for Abstract Submission: Tuesday, March 6**

**Notification Date: Friday, March 16**

Abstract Guidelines: Submissions in the areas of basic research, clinical research, clinical vignettes, or health policy/education should be a maximum of 400 words, including introduction, methods, results, and discussion sections. Primary author must be a resident, fellow, or student member of the MMS and must be able to attend the symposium on April 21.

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



### MASSACHUSETTS MEDICAL SOCIETY

EVERY PHYSICIAN MATTERS, EACH PATIENT COUNTS.

## WHAT'S ON THE WEB?



### ▶ Patient Safety Week, March 4–11

The MMS will join hundreds of organizations nationwide to observe **National Patient Safety Awareness Week**, March 4 through 11. The theme of this year's observance is *Cultural Competency: A Road Taken Together*. Visit the Society's website ([www.massmed.org/patient\\_safety\\_week](http://www.massmed.org/patient_safety_week)) during Patient Safety Awareness Week for access to programs and resources such as:

- Free patient safety online CME programs and podcasts
- Updated physician- and patient-oriented resource guides



### ▶ MMS Annual Meeting

The theme of the **2007 MMS Annual Meeting** is *Patient Centered Medicine: Bringing Health Care Home*. For more details, including registration information, visit [www.massmed.org/annual2007](http://www.massmed.org/annual2007).



### ▶ National Doctors' Day, March 30

Join the MMS Alliance on this day to show appreciation for the physicians who care for you and your loved ones. For more information, go to [www.massmed.org/alliance](http://www.massmed.org/alliance).

**WWW.MASSMED.ORG**

## MMS Education Programs

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

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

### On-Site CME Programs

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

March 7, 6:30–9:30 p.m.  
MMS Headquarters. Sponsored by the MMS and the Volunteer Surveillance Corps, in collaboration with the Massachusetts Department of Public Health. CME Credit: 3.0 AMA PRA Category 1 Credits™ (RM)

#### 2007 Literature and the Professions Seminar: Management of End-of-Life Care

April 20, 9:00 a.m.–3:15 p.m., Beechwood Hotel, Worcester. April 27, 9:00 a.m.–3:15 p.m., MMS Headquarters, Waltham. May 11, 9:00 a.m.–3:15 p.m., Southeast Regional Office, Lakeville. Sponsored by the MMS. CME Credit: 6.0 AMA PRA Category 1 Credits™ (RM)

### Online CME Programs

To access the following programs, go to [www.massmed.org/cme](http://www.massmed.org/cme).

#### Avian Flu and Pandemic Preparedness

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

#### 2nd Annual Public Health Leadership Forum: Examining Health Disparities

Modules include Health Disparities: A Social Determinants Approach, A National Perspective on Disparities in Health Care Quality, Boston's Campaign to Reduce Racial and Ethnic Health Disparities, Public Health Preparedness, and panel presentations on health disparities and the homeless, children, and the elderly. CME Credit: up to 5 AMA PRA Category 1 Credits™ (RM)

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

- Let the Record Show
- Nursing Home Malpractice Litigation: Physician-Focused Risks\*
- Terminating the Physician-Patient Relationship\*
- Hospitalists\*
- The Electronic Health Record in the Office Practice\*
- Medical Malpractice Litigation: The Attorney's Perspective\*
- Nonsurgical Cosmetic Procedures: Risk Issues in the Quest for Youth
- Difficult Patients
- Closing a Practice
- Patient Satisfaction
- Cultural Diversity

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

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

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

#### The New England Journal of Medicine Weekly Online CME Program

CME Credit: 1 AMA PRA Category 1 Credit™ per exam. New exams every week.

#### Journal Watch Online CME Program

CME Credit: 1 AMA PRA Category 1 Credit™ per exam. New exams every week.