

VITAL SIGNS



MASSACHUSETTS
MEDICAL SOCIETY

*Every physician matters,
each patient counts.*

VOLUME 14, ISSUE 3, MARCH 2009



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2009 Annual Meeting —
See Brochure
Inside for
Preview

Payment Reform Commission Hits the Ground Running

Panel Hopes to Deliver Recommendations to State Legislature by June

BY TOM WALSH

Most everyone who experiences today's health care system — patients, providers, and payers alike — finds fault with the way in which care is paid for.

The recently convened state Special Commission on the Health Care Payment System is charged with addressing payment-system shortcomings from A to Z. And many believe that reforming payment systems will go a long way toward improving patient outcomes and relieving some of health care's cost burden.

"My hope is that the commission will be comprehensive in tackling all the issues," said Alice T. Coombs, MMS vice president and the only physician member of the payment reform commission. "Major payment reform has to happen. But it has to happen on all fronts — not just among physicians, but among hospi-

tals and health insurers. Everyone has to play a role in balancing efficient care and the cost of care."

The commission was created by the sweeping health care cost-containment law enacted by the state Legislature last year. At its inaugural meeting in January, the panel cited as its core objective to "investigate reforming and restructuring the payment system to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care."

All Eyes on Cost

Leslie Kirwan, secretary of the Executive Office for Administration and Finance and a co-chair of the commission, said, "This commission is a cornerstone of our comprehensive efforts to contain health care costs." The basic assumption behind the commission's draft principles is that "significant reform of the provid-

er health care payment system is required to significantly slow the high rate of health care cost growth."

Eliminating Waste

"This is a hugely complicated issue, and an incredibly difficult task," said Bruce Auerbach, M.D., MMS president. Dr. Auerbach said the commission could help doctors — and reduce cost — by recommending simplification and standardization of administrative tasks such as coding, billing, and reporting. "We need to reduce the work burden that does nothing to enhance the care of patients," he said.

In fact, one of the commission's draft principles declares that a redesigned payment system "should be organized in such a way as to minimize provider and payer administrative costs that do not add value."

Fee-for-Service Targeted

The commission's draft principles document describes fee-for-service payments as tending to reward "overuse of services," which makes it "not a preferred model for most provider payments."

A Health Industry Forum policy brief prepared last year by Brandeis University's Robert Mechanic found that fee-for-service payment:

- Encourages doctors and hospitals to do more, resulting in their being paid more
- Discourages quality outcomes and improvement because "care that 'gets it right the first time' frequently reduces revenues"
- Gives doctors and hospitals no "business case" for excelling at prevention, chronic care management, or efficient use of technology

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New MMS Website Coming in March



The new MMS website is scheduled to launch during the month of March. Its new, member-centered focus is designed to make material easier to find and use. A new online CME center will provide ready access to outstanding medical education, and daily news feeds will deliver the latest medical and health policy news. The site culminates more than 12 months of member research and extensive testing. Later in the year, the site will include new social media tools such as blogs, reader comments, subscription feeds, and user polls.

Regional Forums on Payment Reform

Share your thoughts on how the payment system should evolve by attending one of the following regional forums for physicians:

- March 5** — MMS headquarters, Waltham (RSVP fkeefe@mms.org)
- March 12** — Holyoke Community College, Holyoke (RSVP csalas@mms.org)
- March 17** — MMS Regional Office, Lakeville (RSVP lhoward@mms.org)

Light refreshments will be served at 6:00 p.m., with programs beginning at 6:30. There will be limited teleconferencing from Berkshire Medical Center to Holyoke on March 12.

For more information and background materials, visit www.massmed.org/paymentreform.

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PRESIDENT'S MESSAGE



How We Should Respond to Payment Reform Proposals

I'm writing this after attending a meeting here at the MMS during which representatives from the

Special Commission on the Health Care Payment System listened to physician ideas on payment reform. I'm impressed by the time the commission has devoted to gathering input from all stakeholders as part of this very challenging process.

While unanimous consent about payment reform — even among physicians — is unlikely, I think we can agree on certain key principles.

First, all stakeholders should practice "principled negotiation." Dartmouth's Elliott Fisher defines that as a willingness to collaborate and to frame issues in a way that everyone will interpret as valid rather than self-seeking.

I think all participants in the dialog would also agree that a redesigned payment system could promote better coordination of care, preventive care, and chronic disease management. Shortcomings in these crucial areas adversely affect patient health and drive up costs.

However, those reforms could take several years to show a "return on investment." If we compensate providers for better management of patients with diabetes, for example, fewer complications will arise down the road, but we won't take a huge bite out of the disease burden or health care costs this year or next.

Circulating around payment reform are related issues that could yield shorter-term benefits. Eliminating non-value-added administrative tasks is one area. Another is weeding out counterproduc-

tive variability of care. However, medicine is an evolving science, so physicians must have the latitude to develop and refine evidence-based clinical standards in areas where agreement on best practices is lacking. And, where there is broad agreement, physicians should expect to be held accountable for following practices that have a solid evidence base.

Passing meaningful malpractice reform could also have a more immediate impact. Our recent study on defensive medicine — a practice driven entirely by fear of lawsuits — identified cost savings of at least \$1.4 billion a year if the liability climate changed. An MMS-filed bill that would make provider statements of regret or apology inadmissible as evidence in legal proceedings would help change the malpractice climate.

We encourage the commission to move with all deliberate speed — quickly but carefully. We also caution against a one-size-fits-all solution. The law of unintended consequences will raise its harmful head if hasty, inflexible changes to the payment system are made. For vetting purposes, the Society favors a series of high-intensity pilot projects with different models, such as the advanced medical home programs under development throughout New England.

The MMS remains committed to helping the commission and the Commonwealth arrive at solutions that will improve patient care, preserve the physician-patient relationship, and halt the cost spiral.

— Bruce S. Auerbach, M.D.

Payment Reform

continued from page 1

The policy brief goes on to say that "fee-for-service has enabled significant geographic variation in health care spending across the U.S. with high cost regions often delivering lower quality care... Payment reform is essential for moving the U.S. health care system onto a sustainable cost trajectory while improving quality."

Members of the payment reform commission also cited shortcomings with fee-for-service. Lynn Nicholas, president and CEO of the Massachusetts Hospital Association (MHA), noted that fees paid under fee-for-service often don't relate to the actual cost of services provided. Nancy Kane, professor of management at the Harvard School of Public Health, emphasized that fee-for-service systems don't recognize differences in quality or efficiency within a provider class. In addition, she said, "Fee for service can't be made to reflect affordability, and with it there's no way to slow the rate of growth of health care costs."

In Search of a Smooth Transition

Despite this litany of deficiencies, several commission members noted that scrapping fee-for-service concepts altogether may not be feasible or wise, at least in the early stages of reform. "We can't throw out fee for service entirely, but there are better ways to do it," said Harvard's Kane. The MHA's Nicholas proposed "a blended approach to make the transition from fee for service to another model."

Brian J. Battista, M.D., who practices internal medicine in Weymouth, has a similarly moderate view of fee-for-service reimbursement. "It's about human nature," Dr. Battista said. "If people are paid on a fee-for-service basis, they tend

to be more productive and work harder. I can see the concern about the present fee-for-service system and how it can raise overall costs. But eliminating it completely would not necessarily be productive in the long run."

Dr. Battista, who expressed his thoughts about the commission and its work in January on the MMS blog (go to <http://massmed.typepad.com>), suggested that the commission look at a hybrid payment system "where physicians are rewarded for working hard but do not have an incentive to drive up costs, for example, by ordering unnecessary consultations."

Many Issues on the Table

Dr. Coombs, a South Shore critical care medicine specialist and anesthesiologist,

said payment problems span both government and private insurance payers. "Many offices have personnel assigned just to get claims filed and to deal with denials," she said.

Dr. Coombs said a comprehensive payment reform plan must also address cherry picking. "Physicians should not be penalized in reimbursement because they see sicker patients, who because of comorbid conditions may have worse outcomes," she said.

Dr. Coombs added that the commission should also consider "how the absence of a medical home impacts the ultimate

outcome of patients who have care that's disjointed or not connected." One of the commission's draft principles addresses the need for "care coordination across the spectrum of health care providers," a key aspect of the medical home model.

The bottom line for MMS president Dr. Auerbach is fair payment that at least covers the cost of service. "All

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Blue Cross Blue Shield Alternative Payment Model Gaining Traction

As the state's payment reform commission embarked on its ambitious objectives, Blue Cross Blue Shield of Massachusetts signed two large provider groups — Tufts Medical Center and the Caritas Christi Health Care System — to its new "alternative" five-year payment program.

The health plan describes its so-called Alternative Quality Contract as a "significant change from traditional fee-for-service contracts." The payment program combines a global "fixed" payment per patient adjusted for age, sex, and health status, plus a second payment with "substantial" performance incentives.

Blue Cross initially rolled out this program a year ago, but until recently uptake among physician groups was slow.

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; Adam Shlager, Managed Care; Stephen Phelan, Membership; Cathy Salas, West Central Regional Office; Stephen Shestakofsky, Government Relations; Jessica Vautour, Physician Health Services

PRODUCTION AND DESIGN: Department of Premedia and Publishing Services; Department of Printing Services

PRESIDENT: Bruce S. Auerbach, 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.

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Letters to the editor should be 200 words or fewer, and all are subject to editing. Send to the MMS Department of Communications, 860 Winter Street, Waltham, MA 02451-1411; vitalsigns@mms.org; or fax to (781) 642-0976.

Preparing for the Future of Health Care: What Every Medical Practice Should Do

With the health care system under fire and a new administration in the White House, there have never been as many projections, predictions, and proposed paradigms for the future of health care as there are now. Among the models being put forth are Prometheus Payment, the medical home, single payer, and of course, a national version of the Massachusetts initiative on universal health care. All the models are ambitious and could have a significant impact on the practice of medicine, from service delivery to payment for those services.

Whichever proposal is implemented, physicians will be affected. Several capable organizations, such as the Commonwealth Fund (www.commonwealthfund.org) and the Rand Corporation, are working to track and evaluate these proposals. The MMS is also actively monitoring the proposed methodologies by way of task forces, committees, and surveys.

The physician voice in this debate needs to be heard clearly. All physicians in all practices should participate in the

debate on health care reform. It will likely affect everyone, and some practices may experience profound changes in the delivery and payment of health care services. At the very least, physicians should work to understand the various proposals being debated.

Perhaps the most critical effort physicians should undertake, especially in small practices, is to continue to work toward making their practice productive and financially sound. It will likely take time to implement any large-scale change in the existing system, and in the meantime practices need to stay viable.

Until it's clear what the new health care landscape will look like, all practitioners should continue to build their practices and exercise financial prudence. Make sure you have adequate reporting mechanisms in place to allow you to model the effects of various system changes as they occur. But above all, make sure you maintain a thriving practice as changes take place. **VS**

— Adam Shlager

Make Sure Your CPA's Skills Match Practice Needs and Expectations

The role of a certified public accountant (CPA) in medical practice is often not well defined. While CPAs have specific expertise in accounting, many also have significant skill with tax preparation, and some may have experience with tax law.

In medical practices, CPAs are often retained to reconcile the practice's accounts on a monthly, quarterly, or annual basis. A general ledger is provided, along with basic financial statements, including a profit-and-loss statement, balance sheet, and an income statement. These baseline metrics provide a snapshot of the practice's financial state.

What these documents don't provide is an analysis of the practice's overall well-being. A statement of fact is not the same as an evaluation of operations or an analysis of performance. Some CPAs know how to perform these additional business-analysis tasks through experience or specialized training, but such analyses are not part of the general services that might be expected of a CPA.

When providers retain a CPA, they should be clear about the scope of service they expect and then search out a CPA with a track record of meeting those expectations. Many attorneys are also CPAs, and there are a number of highly qualified CPAs with significant experience in health care environments. If a practice is looking for tax guidance only and is large enough to have its own bookkeeper, it may want to retain an attorney/CPA to help reconcile at year's end. Smaller practices might want a CPA with health care consulting experience, so that as the CPA works the practice's finances, he or she will also look for trending data and analyze productivity levels and operational efficiency.

Defining a practice's needs is critical to defining the role of the accountant. Be sure your accountant's skill set matches those defined needs. Be aware of your accountant's skills and experience, and use that knowledge to manage your expectations of the CPA's output. **VS**

— Adam Shlager

Basic Documents Will Help Small Practices Add Partners Responsibly

Many solo or two-provider practices have wrestled with the concept of growing by the addition of a partner. Doing so may present a number of challenges:

Decision making — In a solo practice, the provider makes all the decisions. The addition of a partner will likely change that process, making it vital to ensure clarity. A similar shift in decision-making dynamics applies to a two-provider group that adds a third partner. There will be the possibility of a majority-rules vote, where none existed in the previous formation.

Evaluation — In a solo practice, the provider's performance can be assessed simply. In the two-provider practice, there are often tacit agreements that carve all items (revenue and expenses) equally. The addition of a new partner may alter the parity of the existing circumstances, which could create a need for more sophisticated evaluation processes to ensure fairness.

Documentation — Many small practices operate as "gentlemen's agreements," with minimal support documentation related to practice structure, compensation, work volumes, schedules, and benefits. The addition of a partner to an existing agreement should be accompanied by sufficient

documentation of the structure and processes of the practice.

To prepare for the addition of a partner, practices of all sizes should create a set of basic documents consisting of at least the following:

- Corporate structure and bylaws
- Employment contracts
- A detailed accounting of revenue and expense allocations
- Guidelines for salaries and other compensation
- Procedures for evaluating productivity

In addition, the group should consider creating a summary report that provides detail on monthly or quarterly operations. Regular meetings should be scheduled and minutes of the meetings should be recorded and maintained in a secure location. These meetings should have some business component in which operations and financial status are reviewed.

Bringing a new provider into a group can be a time-intensive process.

Putting this documentation in place will help create a transparent process that will assist in evaluating the diverse aspects of partnership and ensuring the group's success. **VS**

— Adam Shlager



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PAYER ALERT

Blue Cross Changes Payment Policy for Some Non-par Doctors

Non-participating providers should always keep up with changes in health plan payment policies. For example, Blue Cross Blue Shield of Massachusetts recently announced changes to its PPO and HMO payment policy for non-participating anesthesiology, pathology, radiology, and emergency medicine providers. For more details about these changes and regular updates on Blue Cross provider issues, go to www.bluecrossma.com/member-central/member-news/general-plan-updates.html.

Physicians, State Urge Colorectal Screening

In March, the state Department of Public Health (DPH), in conjunction with the American Cancer Society (ACS) and the Massachusetts Chapter of the American Gastroenterological Association, will conduct a pilot program to provide free colorectal cancer screening for low-income adults at nine sites throughout the state. The Massachusetts pilot, which takes place during March — Colorectal Cancer Awareness Month — is part of the group's effort to raise awareness about colorectal cancer screening.

Because early-stage colorectal cancer is asymptomatic, screening tests are necessary for early detection. Screening promotes more effective treatment, before polyps develop into cancers, or when cancers are in early stages. Adherence to screening guidelines is credited with the rapid decline in recent decades in colorectal cancer incidence and the increase in survival rates. Yet, national screening rates remain relatively low.

Physician Advice Is Key

A survey published in the February 2008 edition of *Cancer* found that discussion with a physician about colorectal screening tests was the strongest predictor of a patient actually getting screened.

"The most common barriers to patient screening are lack of awareness and physician recommendation," said Carla Ginsburg, M.D., a gastroenterologist at Newton-Wellesley Hospital and assistant clinical professor of medicine at Harvard Medical School. Other barriers include embarrassment and anxiety about the test, fatalistic views about cancer, and test cost and/or lack of insurance coverage.

Dr. Ginsburg added, "There are many different screening options available to the patient, and the individual's level of risk — based on personal, family, and

medical history — will determine the appropriate approach to screening in each patient."

In Massachusetts, colorectal cancer is the second leading cause of cancer death. According to a December 2008 ACS report, half of the U.S. population 50 years of age and older has not been tested. Screening rates are even lower among minority groups, those without health insurance, and people with low levels of education.

The new screening guidelines, developed by the ACS in collaboration with the U.S. Multisociety Task Force on Colorectal Cancer and the American College of Radiology, aim to help doctors and patients make more informed decisions about colon cancer screening.

The new guidelines recommend that both men and women at average risk for developing colorectal cancer begin regular screening at age 50. That screening regimen should include at least one of the following:

- Flexible sigmoidoscopy every 5 years*
- Colonoscopy every 10 years
- Double contrast barium enema every 5 years*
- CT colonography (virtual colonoscopy) every 5 years*

Procedures marked with an asterisk () should be followed by colonoscopy if test results are positive.*

The ACS recommends earlier or more frequent screening for patients with certain risk factors, including personal history of colorectal cancer or adenomatous polyps, personal history of chronic inflammatory bowel disease, or strong family history of colorectal cancer or polyps in a first-degree relative of any age. **VS**

— Robyn Alie

QuitWorks Expansion Seeks to Help Young Patients' Caregivers Quit Smoking

A free resource is now available to help pediatric providers assist their young patients' caregivers with smoking cessation: QuitWorks for Child and Family Health Care Practitioners.

The Massachusetts Department of Public Health (DPH), the Massachusetts Chapter of the American Academy of Pediatrics (AAP), and the Massachusetts Medical Society partnered to develop the resource, which is an expansion of the state's fax-referral program that enables providers to refer patients to a free, phone-based tobacco-cessation counseling service.

All residents of Massachusetts are eligible for QuitWorks services, regardless of their insurance status.

The Massachusetts Tobacco Control Program estimates that 200,000 Massachusetts children are exposed to tobacco smoke in their own homes. The AAP recommends that pediatricians counsel par-

ents about the adverse effects of second-hand smoke exposure, and studies have demonstrated that parents are receptive to this advice.

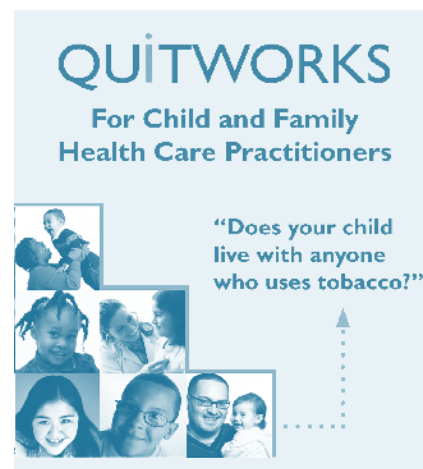
Here's the simple process for provider use of QuitWorks for Child and Family Health Practitioners:

- First, providers ask caregivers a simple question: "Does your child live with anyone who uses tobacco?"
- After offering counseling and advice to quit smoking, providers then use the QuitWorks fax-referral form to enroll the caregiver in the program.
- A counselor from the Massachusetts Smokers' Helpline will then contact the client, complete an assessment, and offer free smoking-cessation services. These services include telephone-based counseling, referral to community tobacco treatment programs, and educational materials.
- Finally, the Helpline counselor sends a follow-up report on client progress to the referring provider.

QuitWorks services and materials are funded through the DPH and are provided at no cost to patients or providers.

Kits explaining QuitWorks for Child and Family Health Care Practitioners will be sent to Massachusetts pediatricians in March. They will also be available by request by contacting John Bry at (617) 624-5973 or john.bry@state.ma.us. Information is also available at www.quitworks.org. **VS**

— Robyn Alie



Public Health Leadership Forum to Feature National Violence Expert

The fifth annual Public Health Leadership Forum on April 29 will feature Mark Rosenberg, M.D., who will open the program with a presentation on the societal impact of violence.

Dr. Rosenberg is the executive director of the Task Force for Child Survival and Development, a nonprofit organization formed in 1984 as a collaboration between the World Health Organization, UNICEF, the United Nations Development Program, the World Bank, and the Rockefeller Foundation. The task force focuses on international and domestic health and human development.

Previously, Dr. Rosenberg led the CDC's work in violence prevention and later became the first permanent director of the National Center for Injury Prevention and Control. He is board certified in both psychiatry and internal medicine, with additional training in public policy.

The April 29 leadership forum, which will be moderated by WCVB-TV's Liz Brunner, will address the health implications of violence. The forum is jointly sponsored by the MMS and the Harvard School of Public Health's Division of Public Health Practice. **VS**

WEBSITE OF THE MONTH

Vaccinate Adults Newsletter Now Exclusively Online

Vaccinate Adults is a semiannual 12-page publication written for health professionals who provide services for adults. Formerly printed and mailed to 150,000 adult medicine providers, the newsletter is now available only online. Visit www.immunize.org/va to view content and subscribe to receive newsletters by e-mail.

Each issue includes an "Ask the Experts" feature in which CDC experts answer questions about vaccines and administration, and a "Vaccine Highlights" section with news from the CDC and the Advisory Committee on Immunization Practices (ACIP). The newsletter's technical content is reviewed for accuracy by the CDC. The main site of the newsletter's publisher, the Immunization Action Coalition (www.immunize.org), provides childhood, adolescent, and adult immunization information for health care professionals, including screening questionnaires, ACIP recommendations, copyright-free downloadable patient information, and printed materials in 12 languages in addition to English.

STATE UPDATE

Physicians to Advocate at the State House on April 8

Election Day has long since passed, and the governor and Massachusetts Legislature have already begun to work their way through the 2009–2010 agenda. The session is complicated by a state budget shortfall of billions of dollars that has already resulted in significant cuts to health care and public health programs.

With the worsening economy taking center stage, it has become all the more important that the voice of physicians be heard by our elected leaders to assure that the health care infrastructure of physician practices and facilities is maintained. While the MMS fully supports the state's laudable commitment to universal access to health insurance coverage, that commitment is meaningless without a viable community of physicians able to deliver health care to the insured citizenry.

Even before the recent recession, the state's physician practice environment

was weakened by more than a decade of rising costs and inadequate reimbursements, which took its toll on the physician workforce. It has become increasingly difficult for hospitals — particularly community hospitals — and physician practices to recruit and retain doctors in Massachusetts, and the MMS has documented severe and critical shortages in the Massachusetts physician labor market. All of this has resulted in difficulties for patients seeking medical care in a timely manner.

While the difficulty in recruiting and retaining physicians is a statewide phenomenon, it is much more of a problem in the western and southeastern regions of the state. Meanwhile, with the implementation of the Health Reform Law, thousands of previously uninsured patients are finding it difficult to secure primary care physicians. At the same

time, our population is aging and the demand for care is increasing.

While gains were made during the last legislative session in recognizing these workforce needs and in moving toward administrative simplification in billing and coding, new challenges have emerged around cost control and how physicians should be reimbursed for their services (see article on page 1). Physicians no longer have the luxury to sit by the sidelines and watch. They must become an active part of the solution.

Because it's so urgent that the voice of physicians be heard on Beacon Hill, members of the Massachusetts Medical Society will be at the State House on Wednesday, April 8, for a day of advocacy. Will *you* be there? **VS**

— Steve Shestakofsky

For more information about how you can participate, visit the MMS website at www.massmed.org or call (800) 944-5562 or (781) 434-7205.

LEGISLATOR OF THE MONTH

Representative
Sean Garballey (D)

District: Arlington (part),
Medford (part)

Committees: Environment, Natural Resources and Agriculture; Labor and Workforce Development; House Global Warming and Climate Change



QUOTE: As the creator of an anti-tobacco organization at Arlington High School and the sponsor of a bill in the House of Representatives, An Act Restricting the Sale of Tobacco Products at Locations Where Health Professionals Are Employed, I am deeply concerned about tobacco products being used in our Commonwealth. This bill will mandate a cigarette-free environment at every pharmacy, or wherever pharmacists are employed in Massachusetts. The city of Boston has already put this bill into actual practice, and I am looking forward to replicating this action throughout all 351 cities and towns in the Commonwealth. As a legislator, I will continue to dedicate myself to making Massachusetts smoke-free.

Massachusetts continues to receive terrific scores from the American Lung Association for our smoke-free air quality and our cigarette tax. But Massachusetts needs to vastly improve in the areas of funding for tobacco prevention and control and cessation services.

In Massachusetts, the high school smoking rate is close to 18 percent and the adult smoking rate is close to 17 percent. These smoking rates prove that the Massachusetts Legislature needs to commit itself even more to programs that will reduce tobacco use. I look forward to working with the Massachusetts Medical Society to address these challenges.

FEDERAL UPDATE

Rapid Action Extends SCHIP to Four Million More Kids,
Stimulus Package Passed Amid Partisan Wrangling

Both chambers of the new Congress and President Obama took rapid action and quickly enacted a four and a half-year reauthorization of the State Children's Health Insurance Program (SCHIP). The \$33 billion measure, financed through a 62-cent per pack increase in the federal excise tax on cigarettes, expands coverage to more than four million children.

The Senate passed the bill by a vote of 66 to 32, with the support of all senators from New England except New Hampshire Republican Sen. Judd Gregg. (Sen. Kennedy did not vote.) In the House, the bill passed by a 289 to 129 margin, with all members of the Massachusetts delegation voting in favor. The MMS worked for several years with the New England Alliance for Children's Health to support reauthorization of this crucial legislation.

The new law enables coverage for children of families earning up to 300 percent of the federal poverty level. It also restores Medicaid benefits to eligible children and pregnant women who have resided in the U.S. for five years or less, repealing a 1996 ban on coverage for those populations. Because millions of

SCHIP-eligible children remain unenrolled, the law also offers bonus payments to states that increase their SCHIP enrollments by certain amounts and will give grants to local communities for enrollment-outreach campaigns.

Also, both chambers of Congress passed a \$787 billion stimulus package on February 13, largely along party-line votes. As this issue of *Vital Signs* went to press, President Obama was poised to sign the measure, which includes a number of health care provisions:

- \$86.6 billion over 27 months to help states maintain and expand Medicaid
- \$19 billion in new funds to increase adoption of health information technology by physicians, hospitals, and other providers. Physicians who use electronic medical records (EMRs) can receive up to \$44 million in bonus payments over five years. With certain hardship exceptions, penalties for non-use begin in 2015, with a 1 percent reduction in Medicare payments. If this initiative succeeds, experts estimate that 90 percent of doctors and 70 percent of hospitals will be using EMRs in the next decade.

- \$1.1 billion in new funds for health care comparative effectiveness research. Part of that will go to the National Institutes of Health, which will receive an overall funding boost of \$10 billion. The bill explicitly prohibits government mandates establishing national clinical guidelines or national coverage decisions in clinical comparative effective research.
- \$24.7 billion in new funds to extend subsidies for COBRA, the law that gives workers who lose their health benefits the right to continue coverage under their former group health plan.

On the administrative level, the AMA was successful in getting the Department of Health and Human Services to change the implementation date for the new ICD-10 codes and the new HIPAA transaction standards. The new adoption date for HIPAA version 5010 will be January 1, 2012 (one year later for small health plans); the new adoption date for ICD-10 codes will be October 1, 2013, two years later than originally proposed. **VS**

— Alex. Calcagno

Helping Medical Students Bolster Primary Care in Massachusetts

The results of the last two workforce studies conducted by the Massachusetts Medical Society indicate that the primary care specialties of internal medicine and family medicine are in critically short supply. In response, the Society has taken several steps to encourage medical students to enter primary care.

For the past four years, the MMS has provided scholarships for students from the four Massachusetts medical schools to attend the Society of Teachers of Family Medicine's regional annual meeting.



Photo by Linda Quain

More than 100 attendees enjoyed this year's fourth annual MMS Career Day/Job Fair.

This past year's event brought together nearly 400 family practice faculty and residents as well as 250 medical students.

In 2008, the MMS formed an Ad Hoc Committee on Medical Student Debt Reduction. The committee is exploring methods to reduce the burden of educational debt for young physicians in Massachusetts, encourage young physicians to practice in Massachusetts, and alleviate the shortages in underserved areas and specialties.

Various MMS committees, including the Committee on Women in Medicine and the Committee on Diversity in Medicine, host mentoring nights for medical students. Panelists include primary care physicians who provide a detailed overview of the current primary care environment and answer specific student questions.

PHYSICIAN HEALTH MATTERS

Malpractice Carriers See Benefits of Managing Physicians' Health Risks

Providing excellent patient care is the cornerstone of a physician's practice in medicine. That includes the appropriate diagnoses and treatment of illness, along with an emphasis on prevention and patient well-being. The role of a physician today includes coaching patients on healthy lifestyles, such as those related to nutrition, exercise, and sleep.

But, as stress on physicians increases amid an increasingly complex and demanding practice environment, sometimes physicians themselves fail to adopt healthy lifestyles, promote their own well-being, and work to prevent illness in themselves. Adding to the stress on physicians is the expectation that they be competent in interpersonal relationships with patients, nurses, staff, administrators, and others. Throw increased patient loads, diminished reimbursements, and the threat of malpractice suits into the mix, and the stress can become overwhelming.

So it's no wonder that malpractice insurers in Massachusetts are very interested in helping physicians manage stress and risk in their practice. Just as physicians practice so as to minimize adverse patient outcomes and the risk of a malpractice suit, it is also in the interest of insurers to diminish risk.

For example, the insurance industry is increasingly aware that good communication between a patient and physician diminishes the risk of an adverse outcome. The Joint Commission has also recognized the importance of appropriate behaviors and effective communication in establishing its new standards (see *Vital Signs*, February 2009, page 3).

Assisting physicians in assessing underlying health issues that could be causing

problems with communication, workplace relationships, and the effective management of patients is a primary role of a physician health program.

On a more proactive level, Physician Health Services (PHS) enhances a physician's self-awareness of stressors and knowledge of when and where to get help. These preventive roles of PHS include:

- Promoting physical health
- Helping ensure that physicians have and visit their own doctors and provide timely and pertinent medical histories
- Advising on the appropriate use of alcohol and how to avoid the misuse and abuse of medications and other drugs
- Recognizing and attending to mental health issues such as anxiety and depression

These are all components of the assessment, referral to treatment, and monitoring services of PHS.

Therefore, it is no surprise that malpractice insurers generously support PHS. Insurers view PHS as a significant risk-management benefit to physicians in Massachusetts, and their financial support of PHS enables us to be available to physicians with health-related issues.

While there is a paucity of research demonstrating the precise risk-management benefit of a physician health pro-

gram, an Illinois study of its physician health program a few years ago demonstrated that physicians who were being monitored by the program appeared to have fewer malpractice suits filed after treatment. A recent *British Medical Journal* article on state physician health programs in the United States reaffirmed the high success rate of monitoring physicians for substance use. And similar findings were reported in a PHS study two years ago (see *Vital Signs*, March 2007, page 6).

PHS remains grateful for the continued support and involvement of the Massachusetts malpractice carriers and the captive insurance companies, including Risk Management Foundation, ProMutual Group, Tufts Medical Center, Connecticut Medical Insurance Company, Boston Medical Center, Baystate Medical Center, Lahey Clinic, Berkshire Health Systems, UMass Memorial Health Care System, and Caritas Christi Health Care. Their support is vital to our mission of assisting physicians with health-related problems and enhancing the health and wellness of all Massachusetts medical students, residents, and physicians. **VS**

— Luis Sanchez, M.D.
PHS Director

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



Photo by Dan McQuaid

Richard Brewer, (center) president and CEO of ProMutual Group, presents a donation check to Luis Sanchez, M.D., director of Physician Health Services (PHS). Corinne Broderick, (right) executive vice president of the MMS; Edward Khantian, M.D., (left) president of Physician Health Services; and Bruce Auerbach, M.D., (second from left) president of the MMS, attended the check presentation. ProMutual Group has supported Physician Health Services for more than a decade, donating in excess of \$2.5 million to help facilitate the assessment and referral to treatment of thousands of physicians. Visit www.physicianhealth.org for information about donating to PHS.

ACROSS THE COMMONWEALTH

District News and Events

Barnstable — Executive Committee Meeting. Thurs., Mar. 5, 6:30 p.m. Location: Alberto's Ristorante, Hyannis. For more information, contact the Southeast Regional Office.

Charles River — Winter Meeting Rescheduled. Thurs., Mar. 12, 6 p.m. Location: Marriott, Newton. Speaker: Martin A. Samuels, M.D. Topic: Voodoo Death Revisited.

Delegates Meeting. Tues., Mar. 17, 6 p.m. Location: MMS headquarters, Waltham. For more information, contact the Northeast Regional Office.

Essex South — Legislative Breakfast. Fri., Mar. 20, 7:30 a.m. Location: Beverly Hospital, Beverly. For more information, contact the Northeast Regional Office.

Franklin — High School Doctor for a Day. Tues., Mar. 24, 7:30 a.m. to 5 p.m. Location: Baystate Franklin Medical Center, Greenfield. For more information, contact the West Central Regional Office.

Hampden — Legislative Breakfast. Fri., Mar. 27, 7:30 to 9 a.m. Location: Clarion Banquet and Conference Center, West Springfield. Contact Suzanne Skibinski with any comments/questions to be submitted to legislators. **High School Doctor for a Day.** Thurs., Apr. 2, 7:30 a.m. to 5 p.m. **Annual Meeting.** Tues., Apr. 14, 6 p.m. Location: Delaney House, Holyoke. Speaker: Edward O'Neil, M.D., author of *Awakening Hippocrates*. For more information, contact Suzanne Skibinski at (413) 736-0661 or hdms@massmed.org.

Hampshire — High School Doctor for a Day. Wed., Mar. 25, 7:30 a.m. to 5 p.m. Location: Cooley Dickinson Hospital, Northampton. For more information, contact the West Central Regional Office.

Hampshire/Franklin — Annual Meeting. Wed., Apr. 1, 6 p.m. Location: Monkey House, Amherst. Speakers: Bruce Auerbach, M.D., MMS president, and Jackie Wolf, Ph.D. Topic: Benefits and Challenges of Single Payer Health Care. For more information, contact the West Central Regional Office.

Middlesex Central — Annual Meeting. Tues., Mar. 31, 11:45 a.m. Location: Emerson Hospital. Speaker: Mario Motta, M.D., MMS president-elect. For more information, contact Carol Marshall at (978) 287-3017.

Norfolk South — District Meeting. Tues., Mar. 24, 6 p.m. Location: Neighborhood Club of Quincy. Speaker: Bruce S. Auerbach, M.D., MMS president. **Legislative Breakfast.** Fri., Apr. 3, 7:30 a.m. Location: South Shore Hospital, Weymouth. For more information, contact the Southeast Regional Office.

Suffolk — Membership Meeting. Thurs., Mar. 19, 6 p.m. Location: Mass General Hospital, Boston. Speaker: David Urion, M.D. For more information, contact the Northeast Regional Office.

Worcester — National Acrobats of China: They Dazzle and Bedazzle. Amaze and Enthral. Wed., Mar. 4, 7 p.m. reception; 8 p.m. concert. Location: Mechanics Hall, Worcester. Discounted tickets available for members and guests. **Medical Education Conference.** Wed., Mar. 11, 5:30 p.m. Location: Beechwood Hotel, Worcester. Speaker: David Eisenberg, M.D. Topic: Complementary and Alternative Medicine. For more information, contact Joyce Cariglia at (508) 753-1579.

*Reception is cosponsored by the Physicians Insurance Agency of Massachusetts, (PIAM).

Worcester North — District Meeting. Thurs., Mar. 5, 6 p.m. Location: Fay Club, Fitchburg. Speaker: Richard Aghababian, M.D. Topic: Lessons Learned from Recent Disasters. For more information, contact the West Central Regional Office.

Statewide News and Events

Art, History, Humanism and Culture Member Interest Network — The Nancy N. Caron Annual Art Exhibit and Silent Auction. Fri., May 8, 6 to 9 p.m. Members interested in displaying a piece of art and/or displaying art to be donated for the Silent Auction should 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.

For In Memoriam, please see page 8.

MMS to Celebrate 125th Anniversary of First Woman Member

Do you know the name of the first woman physician member of the MMS? You will soon, because in 2009, the Society's Committee on Women in Medicine will commemorate the 125th anniversary of her entry into the Society. A series of spring, summer, and fall celebratory events has been slated to mark this historic milestone.

On May 7, at the MMS Annual Meeting, the Committee will host a reception to honor the first woman member of the Society and to acknowledge those who were instrumental in opening up the Society to women physicians.

Then, on June 24, the Society will offer a CME program titled "Pioneering Women Physicians of the Past and Present: What's Been Accomplished and What Lies Ahead." This program will

take an in-depth look at past accomplishments of women physicians and will be followed by a detailed discussion of future challenges.

The third event, on the evening of September 25, is the theatrical performance of *A Lady Alone: Elizabeth Blackwell, The First American Woman Doctor*. Linda Gray Kelley is cast in the role of Dr. Blackwell, and the play is written by Harvard playwright N. Lynn Eckhart, M.D. Dr. Eckhart will be available after the performance for a question-and-answer period.

All are encouraged and invited to attend these events. **VS**

To learn more, contact George Dudley at (781) 434-7308 or gdudley@mms.org.

Senior Volunteer Physician Award Goes to K. Robert McIntire, M.D.

At the upcoming Annual Meeting in May, K. Robert McIntire, M.D., will receive the 2009 MMS Senior Volunteer Physician of the Year Award. The award recognizes Dr. McIntire for his exemplary dedication to volunteerism and his lifelong sharing of medical expertise.

A graduate of the University of Virginia School of Medicine, Dr. McIntire was one of the first physicians to volunteer his services to the Cape Cod Free Clinic in 1998, and he eventually served the clinic as chief medical officer. In that role, he developed clinical protocols, helped implement quality programs, and most importantly, recruited and scheduled volunteer physicians to staff the clinic. As a result of his efforts, the clinic became a highly respected and efficient organization.

Dr. McIntire served as a member of the clinic's board of directors for al-

most eight years, and he continues to offer his services as a volunteer physician to what is now known as the Community Health Center of Cape Cod. He is often called in on a moment's notice

to lend a hand during busy days at the clinic when physician availability is limited. Colleagues describe him as universally respected by patients and well loved by the entire clinic staff.

For physicians interested in volunteering their services, the MMS Committee on Senior Volunteer Physicians Health Center Program provides professional liability insurance to retired physicians and other physicians who are no longer engaged in clinical practice

but who want to provide free health care services to patients at health centers and clinics across the state. **VS**

For more information, contact George Dudley at (781) 434-7308 or gdudley@mms.org.





MASSACHUSETTS MEDICAL SOCIETY

EVERY PHYSICIAN MATTERS, EACH PATIENT COUNTS.

WHAT'S ON THE WEB?

► Payment Reform Commission Updates

Stay current on the fast-track work of this panel.

www.massmed.org/paymentblog

► Legislation Status Report

Track MMS-filed bills through the legislative process.

www.massmed.org/status

► 2009 Annual Meeting

Find out what's scheduled and register online.

www.massmed.org/annual2009



WWW.MASSMED.ORG

Payment Reform

continued from page 2

doctors should be paid fairly for what they do," he said. "We need to bring those doctors at the bottom — such as primary care physicians — up, and leave alone those whose reimbursement is close to being right."

Can We Ease the Burden of Disease?

Through the creation of smaller working groups and a slew of meetings scheduled throughout the spring, the commission seems committed to soliciting and consolidating input from all health care system stakeholders. At a public hearing on February 6, speakers included JudyAnn Bigby, M.D., secretary of health and human services; patient safety advocate Lucian Leape, M.D.; David Mariotta, executive director of the Massachusetts Association of Behavioral Health Systems; and Rick Weisblatt, M.D., of Harvard Pilgrim Health Care.

As this issue of *Vital Signs* went to press, the commission was holding two town meeting-style forums on February 10 and 11 specifically for physicians to discuss alternative payment systems (see box on page 2). The commission hopes to deliver a report with concrete, action-

able recommendations to the state Legislature by the end of May.

Ultimately, concluded Dr. Coombs, "the bottom line is what you do with the management of disease. When we're done with all this, if we've decreased the disease burden in our society, it will have been worth it."

To track the activities of the Special Commission on the Health Care Payment System, go to www.mass.gov/dhcfp/paymentcommission. **VS**

For more information and background materials on payment reform, visit www.massmed.org/paymentreform.

In Memoriam

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

Robert D. Leffert, M.D., 75; Chestnut Hill, MA; Tufts University School of Medicine, 1958; died December 7, 2008.

Norman C. Leigh, M.D., 82; Braintree, MA; Tufts University School of Medicine, 1954; died January 7, 2009.

Marjorie J. LeMay, M.D., 91; Cambridge, MA; University of Kansas School of Medicine, 1942; died November 27, 2008.

Paul R. Levesque, M.D., age unknown; Brighton, MA; University of Montreal Faculty of Medicine, 1957; date of death unknown.

Reevan I. Levine, M.D., 89; Media, PA; Tufts University School of Medicine, 1943; died January 30, 2009.

Donald L. Mahler, M.D., 83; Newton, MA; University of Pennsylvania School of Medicine, 1947; died January 18, 2009.

William A. Meissner, M.D., 95; Sun City Center, FL; University of Oregon Medical School, 1938; died December 6, 2008.

James I. Peters Jr., M.D., 82; Duxbury, MA; Harvard Medical School, 1953; died December 28, 2008.

Charles V. Pryles, M.D., 90; Jensen Beach, FL; Medical College of Georgia, 1947; died January 2009.

Morris Ringer, M.D., 85; Sarasota, FL; Case Western Reserve University School of Medicine, 1948; died December 14, 2008.

Arthur A. Veno Jr., M.D., 76; Ipswich, MA; Tufts University School of Medicine, 1958; died February 4, 2009.

MMS Sponsored & Jointly Sponsored CME Activities

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

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

Live CME Activities

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

Disclosure and Apology — What's Missing? Advancing Programs that Support Clinicians

March 13, 8:00 a.m.–4:00 p.m.
MMS headquarters, Waltham.
Jointly sponsored by the MMS and Medically Induced Trauma Support Services. 6.5 Credits (RM)

Disaster and Primary Care: How to Protect Your Patients and Your Practice

March 31, 6:30–9:00 p.m. MMS headquarters, Waltham. Sponsored by the MMS in collaboration with the Massachusetts Department of Public Health. 2.5 Credits (RM)

2009 Shattuck Luncheon and Lecture — The Hypertension Paradox: Remarkable Advances in Therapy

May 9, 12:30–2:00 p.m.
Seaport Hotel, Boston.

Sponsored by the MMS and the *New England Journal of Medicine*.
1.0 Credit

Pioneering Women Physicians of the Past and Present: What's Been Accomplished and What Lies Ahead

June 24, 6:30–8:00 p.m. MMS headquarters, Waltham. Sponsored by the MMS and its Committee on Women in Medicine. 1.5 Credits

Online CME Activities

Go to www.massmed.org/cme.

Massachusetts Medical Law Report Quarterly Risk Management CME Series

Office Compliance 101
1.0 Credit (RM)

"Minute Clinics" Raise Round-the-Clock Risks
1.0 Credit (RM)

E-Prescribing Regulations Applauded by Doctors, Lawyers
1.0 Credit (RM)

How to E-mail Patients without Worrying about Liability
1.0 Credit (RM)

Reducing Errors and Liability in Patient Handoffs
1.0 Credit (RM)

Dealing with Difficult Patients
1.0 Credit (RM)

A New Kind of Bedside Manner: The Rise of Apology Policies
1.0 Credit (RM)

Preparedness Risk Management CME Series

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

Know the Response: Disaster Management and Communication for the Health Care Provider
3.0 Credits (RM)

E-Prescribing Courses

Electronic Prescribing Education
2.5 Credits (RM)

National E-Prescribing Conference (15 courses) 1 or 2 Credits each

Save the Dates

March 12 — E-Prescribing Conference

May 7 — Ethics Forum: Racial and Ethnic Disparities in Care

May 9 — 2009 Annual Education Program: To Age or Not to Age

June 10 — 7th Annual Men's Health Symposium

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