

VITAL SIGNS



MASSACHUSETTS
MEDICAL SOCIETY

*Every physician matters,
each patient counts.*

VOLUME 13, ISSUE 10, NOVEMBER 2008



2 PRESIDENT'S MESSAGE The Three-Legged Stool: Coverage, Workforce, Cost

3 YOUR PRACTICE BCBS Settlement Compliance • Medical Confidentiality for Minors
• Tips for Transferring Medical Records



4 THE PUBLIC'S HEALTH Expedited Partner Therapy for STDs • Holiday-Season Depression • Talking about End of Life • Health Care Proxy Day



5 GOVERNMENT AFFAIRS State: MMS Advocacy Will Influence Cost-Bill Implementation
• Federal: Federal-Agency Advocacy at CMS and DEA

6 PROFESSIONAL MATTERS Substance Use Disorders among Physicians • Caring for Gay and Lesbian Patients • IMG Workshop in February • 2009 MMS Award Nominations

7 INSIDE MMS Online Renewals • Health Care Reform's Effects on Minorities • Across the Commonwealth/In Memoriam

8 MMS EDUCATION PROGRAMS What's on the Web?

Society and Medical Board Tackle Tough Issues Amid New Spirit of Collaboration

BY TOM WALSH

In an extraordinary public meeting, MMS officers met with the state Board of Registration in Medicine (BRM) to inaugurate what both sides hope will be a new era of cooperation and collaboration on matters important to patients, physicians, and regulators.

The 90-minute session, held as the BRM was still settling into new headquarters in Wakefield, was friendly and completely without rancor — in contrast to the more contentious atmosphere in recent years when the MMS appeared before the board in opposition to proposed new regulations. Long-time observers of the board said such a collegial meeting has not occurred in many years.

"I'm very happy with this," declared Bruce S. Auerbach, M.D., MMS president, as he left the meeting. "We'll have continued dialogue, and it appears we're facilitating a better working relationship with the new board."

The board is "new" in that its chair, John Herman, M.D., a psychiatrist at Massachusetts General Hospital, was

elected last spring after serving as a board member for six years (see *Vital Signs*, August 2008, page 5). Recent appointees Myechia Minter-Jordan, M.D., and Herbert H. Hodos, Esq., joined holdovers Peter G. Paige, M.D., Guy Fish, M.D., and Dr. Herman at the MMS meeting. Two seats on the panel remain to be filled.

After learning that MMS officers hoped to discuss several matters with the board, Dr. Herman extended the invitation that set up the mid-September session. "The theme is quality and safety, and the means to get there," Dr. Herman said. "We've asked [the MMS officers] to tell us what's up and especially where collaboration between the board and the Society can yield improvements."

MMS leaders outlined for the board their concerns on several issues, including physician due process when complaints or concerns are raised, the medical licensing process, and a clinical skills assessment program in the works at the Society.

Physician Due Process a Thorny Issue

Achieving physician due process in matters before the board remains an often-contentious issue. Dr. Auerbach told the board that there is a "perception among much of the medical community" that the board's procedures for handling complaints against physicians need improvement in both "process and quality." The current impression among physicians, he said, is that the process is "more confrontational and punitive and not necessarily as efficient as one would like."

To that end, the MMS joined with numerous attorneys who defend physicians before the board in signing what Dr. Auerbach described as an "extraordinary letter" to the board. The letter asks the board to consider "that physicians under investigation are routinely unable to respond to board inquiries because they are unaware of the nature and specifics of the charges to which they are required to respond." The letter maintains that the board's "official (but unwritten) position" is to provide such materials only after it votes on a "statement of allegations." The signatories question the legality of that procedure and further observe that physicians are often tried in the court of public opinion based on

continued on page 2

Pressure Mounting on Massachusetts Physician Workforce, Study Finds

BY TOM WALSH

For the second consecutive year, the number of primary care physicians practicing in Massachusetts is at a "critical" low, according to the seventh annual MMS Physician Workforce Study.

Of the 18 specialties examined by the 2008 study, the primary care specialties of internal medicine and family medicine were the only two in which physician labor market conditions were found to be critical. But 10 others — dermatology, emergency medicine, general surgery, neurology, neurosurgery, oncology, orthopedics, psychiatry, urology, and vascular surgery — are facing "severe" shortages. Neurosurgery is the one specialty to have had either a critical or severe labor shortage in each of the seven years the study has been conducted. This year's study included three new categories — dermatology, neurology, and oncology.

"One must conclude that patient demands on these specialties have outstripped supply," the study asserts.

"The success of health care reform in insuring hundreds of thousands more people is a great step forward," said Bruce S. Auerbach, M.D., MMS president. "But it has put enormous pressure on primary care, and we now know that

continued on page 2



Photo by Frank Fortin

Participants in the MMS/BRM meeting included (left to right) board member Guy Fish, M.D.; MMS President-Elect Mario Motta, M.D.; board member Peter Paige, M.D.; MMS President Bruce Auerbach, M.D.; Board Chair John Herman, M.D.; and board members Myechia Minter-Jordan, M.D., and Herbert Hodos, Esq.

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PRESIDENT'S MESSAGE



The Physician Workforce: One Leg of a Three-Legged Stool

Our 2008 Physician Workforce Study created quite a stir. It has always generated significant

media attention, but at last count the 2008 study — which found “critical” shortages among internal and family medicine physicians for the second consecutive year — was picked up by more than 30 media outlets.

One reason for the intensified public interest is that the shortage of physicians — especially in those two primary care specialties — has been accentuated by the expansion of insurance coverage facilitated by our state’s 2006 health care reform law.

We’re seeing now that addressing coverage alone is not enough, which leads me to the three-legged stool metaphor. The coverage problem is the first leg. The two huge challenges that have arisen since Massachusetts tackled coverage — physician shortages and cost — are the other two legs.

The interconnectedness of coverage, workforce, and cost is nowhere more evident than in the environment I work in — the emergency department — as a recent *Boston Globe* article pointed out. Increased coverage has enabled hundreds of thousands of “new” patients to enter the system. Many of them are having trouble finding a primary care physician, and, if they do find one, they confront long wait times for a routine

appointment. So, when they get sick, they often go to the emergency department, where costs for nonurgent care are much higher than in an office setting. The *Globe* article suggested that part of the solution lies in more intensive patient education and outreach. I agree, but such efforts won’t link people to primary care physicians if those doctors don’t exist.

I commend all stakeholders in the Massachusetts health care reform process for recognizing that there are three legs to the stool. But ideally, future reforms — at the state and national levels — will address coverage, workforce, and cost concurrently, not sequentially.

In Massachusetts, we addressed coverage first and did so boldly and successfully. We’ve opened discussions and made some difficult decisions about cost, but there’s a long way to go. But we’re still at the starting line when it comes to the physician workforce. The workforce-related elements of Chapter 305 will undoubtedly help (see related article on page 5). Administrative simplification and reimbursement reform may provide short-term improvement. But the impact of other aspects may not be seen for years. Regardless, the MMS stands ready to help ensure prompt and sensible implementation of those provisions.

— Bruce S. Auerbach, M.D.

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MMS and BRM Tackle Tough Issues

continued from page 1

the statement of allegations, which is a public pronouncement of the charges. The board maintains that patient privacy laws prevent disclosing this information to doctors.

“We are very interested in working together with [the board] to ensure as positive and open a process as confidentiality permits, and to ensure that physicians get all the information they need to review the complaint against them so they can respond appropriately,” Dr. Auerbach said.

“We are all extremely aware of how momentous it is when a physician comes before this board to answer questions,” Dr. Herman added. “This is not a ‘next case’ kind of thing. We agonize over each case.”

W. Scott Liebert, a former BRM attorney who now defends physicians before that body, said the board and its general counsel “take their jobs seriously and are not out to hurt doctors.” However, he added, “They are getting their information from one side only. Doctors have a right to information they need to respond completely and fully to complaints and investigations.” Liebert, who attended the meeting, signed the letter to the board concerning this matter.

Addressing the issue of disciplinary efficiency, Dr. Herman said that about a year ago the board had approximately 140 open cases to be resolved. Now, he

said, that number is down to 40. “It took a lot of work to get there,” he said.

Licensing Cooperation Pledged

In recent years, MMS leaders have heard from members about difficulties encountered by physicians seeking licenses in Massachusetts. “It has to be acknowledged that this can be an onerous process,” Dr. Auerbach told the board. “We’re interested in how we can partner and work together to ensure an adequate physician workforce for the citizens of our Commonwealth.”

Mario E. Motta, M.D., MMS president-elect, brought full details of the licensing issues to the board’s attention. He said that MMS concerns about the process extend to both full licenses for physicians looking to enter practice in the state as well as limited licenses for residents accepted to training programs.

“The MMS strongly supports high standards for the practice of medicine,” Dr. Motta said. “We strongly believe that no one should practice medicine in Massachusetts without legitimate credentials that have been fully verified.” But, Dr. Motta added, no hospital or practice should ever lose the services of a doctor for lack of a timely licensing decision. “If there are legitimate reasons to deny a physician a license, that should be done, and done publicly as a reportable action,” he said. “But a de facto denial by delay serves no one.”

continued on page 8

Physician Workforce

continued from page 1

insurance without access to care is a hollow victory.” Adding to the pressure are an aging population and rising rates of obesity and chronic disease. Consequently, “demand is overwhelming supply, and our physician workforce is coming under more stress and strain,” Dr. Auerbach said.

Massachusetts is not the only place in the United States experiencing physician labor shortages. The study cited a recent report by the American Association of Medical Colleges (AAMC), which found more than 15 states with “difficulties in meeting the health care demands of their population.” The AAMC report concluded that “the shortfall of physician labor supply will inevitably have an adverse effect on patients’ access to care and will likely result in further escalating costs of health care.”

Workforce Strategies Focus on Improving Practice Environment

The 2008 Workforce Study concluded that “addressing these deteriorating physician labor markets is a policy area in which the MMS can play a key role,” and it encouraged continued collaboration between the Society and “medical schools, hospitals, employers, payers, and the state and federal government.”

The study offered policy recommendations that the MMS and these stakeholders can pursue to address its key findings. They would bolster the physician workforce by creating a more physician-friendly practice environment that:

- Enables physicians to remain current with technology

continued on page 8

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.

National Blue Cross Settlement Compliance Process Is Under Way

With final court approval of the Blue Cross Blue Shield (BCBS) national class action settlement (see *Vital Signs*, September 2007, page 1), the process is now under way to ensure that BCBS fully complies with the “prospective relief” provisions of the agreement. These provisions include a number of physician-favorable changes to BCBS business practices, especially in the area of claims processing. These provisions are detailed on the MMS website at www.massmed.org/ProspectiveRelief.

The most significant benefits for Massachusetts physicians are those not previously addressed by Chapter 141 (the Massachusetts Managed Care Reform Act of 2000) or prior BCBS contracts — namely, an extended claims-submittal period, payment rule and coding disclosures, greater allowances for coding submissions, and tighter recoupment rules.

The national settlement also includes a formal dispute process designed to monitor and enforce BCBS compliance. Physicians who believe that BCBS of Massachusetts has not met those obligations can file a compliance dispute with the compliance dispute facilitator, Deborah J. Winegard, who can be contacted at dwinegard@gmail.com or (404) 607-8222. The process is simple and free of charge. A step-by-step guide and the dispute form are available at www.hmosettlements.com/pages/bluecross.html, and a compliance enforcement toolkit is available at www.hmosettlements.com/pages/compliance.html.

Once the facilitator receives a completed dispute form, she will advise the physician whether, in her opinion, the alleged conduct is a compliance dispute, and whether to prosecute the dispute on the physician’s behalf. The facilitator then works with BCBS to resolve the dispute. Disputes that remain unresolved are referred to a dispute review officer, who conducts a formal legal review. Decisions of the review officer are final, except that some decisions may be appealed to the federal court on limited grounds.

The ultimate measure of success of the business-practice changes mandated by the settlement will depend on actual BCBS compliance with its terms. Physicians can help monitor compliance by filing compliance disputes when they reasonably believe that BCBS has not met its obligations under the settlement agreement.

Compliance disputes must be filed with the compliance dispute facilitator within 90 days of the date the dispute arose or reasonably could be known, whichever is later.

In addition, the MMS has arranged for the Managed Care Advisory Group (MCAG) to assist MMS members, on a discounted basis, with BCBS payment claims during the settlement implementation period, which runs until May 30, 2011. To contact the MCAG, call (800) 355-0466.

— Dean P. Nicastro, Esq.
Pierce & Mandell, P.C., Boston

Confidentiality Issues for Minors Can Pose Challenges for Physicians

As a general rule, Massachusetts law requires a minor who seeks medical care to obtain the consent of a parent or guardian. There are a few exceptions meant to encourage minors to get the medical treatment they need.

First, Massachusetts law sets forth a list of conditions whereby a minor is, by law, considered “emancipated” and therefore may consent to confidential health care (except for abortion and sterilization) on his or her own. Second, Massachusetts courts have adopted the “mature minor rule” (again, except for abortion and sterilization). This rule says that if a doctor believes the minor is mature enough and able to give informed consent to the medical care, and it is in the best interest of the minor not to notify the parents, the physician may accept the child’s consent alone. Third, the law also has special provisions regarding minors consenting to their own treatment for drug addiction, family planning services, treatment for sexually transmitted diseases, and mental health treatment. Lastly, there are special rules relating to abortion.

By law, if the physician reasonably believes there is a danger of serious risk to life or health, the minor should be notified that the physician must inform the parent or guardian. Additionally, confidentiality may not be possible in cases of suspected child abuse or neglect, or if the minor threatens self or others.

Generally, when a minor has the capacity to consent to medical treatment, that child also has the right to control his or her medical records. Therefore, such information is confidential and may not be released except with the consent of the minor or upon a judicial order. To help ensure the confidentiality of such records, physicians may want to discuss insurance, billing, and alternative forms of payment with the minor.

Furthermore, physicians should investigate ways to create systems to protect a minor’s confidentiality. For example, physicians using electronic record systems must be able to identify and segregate, as necessary, any confidential portions of their patients’ records before disclosing them. If not well-designed or well-managed, EHR technology can increase the chance of wrongful disclosures. Additionally, physicians and their staff should be prepared to address inquiries from parents (or guardians) seeking or demanding full access to their child’s records. While new technology may change the media, the old rules still apply. **VS**

— Sarah Elisabeth Curi, J.D., M.P.H.

The “Law and Ethics” column is provided for educational purposes and should not be construed as legal advice. Readers with specific legal questions should consult with a private attorney.

Transferring Medical Records Is Becoming More and More Complex

Once upon a time, if one physician office asked another for a copy of a medical record, someone in the first office simply made a paper copy and mailed or faxed it to the other office. For several reasons, the transfer process has become more complex.

Back in 1996, HIPAA introduced a set of federal rules regarding how to protect health information contained in the medical record. Medical offices also had to be sure that they abided by state statutes. If state laws governing information release were more stringent than HIPAA rules, the medical office needed to comply with the stricter state standard.

More recently, electronic health records have added to this complexity. While it might be possible to export elements of a patient’s record electronically, the ability to *import* that record into another office’s

EHR is problematic. At this time, the lack of existing standards between EHRs makes it impossible to accomplish a simple electronic transfer of records. Moreover, a lack of standardized documentation within same-system EHRs could reduce the effectiveness of a transfer between practices with similar EHR setups.

That means, once again, printing a paper copy of the record and mailing or faxing it to the requesting office. If it’s EHR-enabled, the receiving office can then scan the pages into its EHR, resulting in an electronic/paper chart residing beside the patient’s electronic record.

There is also confusion about what part of a record should be sent when a patient transfers out of a primary care practice. One legal opinion says to transfer only those records generated within the practice. Another opinion

says that any portion of the record that has been consulted or reviewed, including portions transferred in from a previous provider’s office, should be passed on to the next provider.

When requests for records come into your office, a clear, concise set of guidelines should be available for the staff. Those guidelines should detail various types of requests (e.g., those from attorneys, courts, other physician offices, and

hospitals) and the appropriate responses. Office policy regarding which portion of the record should be transferred to a provider assuming primary care responsibility for the patient should also be clarified and approved by the practice’s legal counsel. In addition, your office should develop and periodically review policy related to handling record transfers between paper and electronic media. **VS**

— Adam Shlager

Masspro Offering Free Help to Boost EHR-Based Preventive Care

Masspro will work with a select group of physician practices to optimize their use of EHRs to improve preventive care rates for breast and colorectal cancer screening and flu and pneumococcal immunization. The service includes on-site consultation and coaching, technical assistance, and education — all at no cost to participating providers.

For more information, go to www.masspro.org/POS/documents/HIT%20datasheet.pdf.

Expedited Partner Therapy in Managing Sexually Transmitted Diseases

Medical treatment is recommended for all sexual partners of a person with certain STDs, within a specified time interval, to prevent morbidity in the partner(s) and to curtail re-infection and/or further transmission. According to CDC treatment guidelines published in 2006 (www.cdc.gov/std/treatment), therapy is not contingent on clinical or laboratory examination and is presumptive with respect to known exposure to the STD.

The traditional method of STD partner notification is patient referral, where the clinician asks the patient to notify his or her partners and refer them for treatment. Alternatives include provider referral (where partners are contacted by the health care provider or a public health worker for treatment) and conditional referral (where patient referral is supplemented by provider referral for partners not reached within a specified period of time). The literature indicates that patient referral of partners is at best modestly successful, and that overall partner treatment rates average only about 50 percent.

Another approach to partner notification and management is expedited part-

ner therapy (EPT). EPT refers to the treatment of partners without personal assessment by the clinician, usually via patient-delivered partner therapy. The clinician provides the patient with medication intended for partners, either by prescribing extra doses of medication under the patient's name or by writing prescriptions in the partners' names — all without seeing the partners. In 2006, CDC guidance (www.cdc.gov/std/treatment/EPTFinalReport2006.pdf) stated that "EPT is at least equivalent to patient referral in preventing persistent or recurrent gonorrhea or chlamydial infection in heterosexual men and women, and in its association with several desirable behavioral outcomes."

EPT raises some concerns, however. Clinically, if partners receiving EPT don't seek evaluation, the practice could lead to missed opportunities for diagnosis and treatment of other STDs or STD syndromes. To mitigate this possibility, EPT should be accompanied by educational materials that instruct recipients to seek STD/HIV testing, regardless of whether they take the medication. There is also concern about possible adverse

medication effects, which could have both clinical and legal consequences.

The CDC guidance says the legal barriers to implementation of EPT need to be addressed at the state level. In Massachusetts, the Legislature has considered but not yet passed bills that would explicitly permit a clinician who is authorized to prescribe and dispense prescription drugs, and who diagnoses a sexually transmitted infection in an individual patient, to prescribe and dispense prescription drugs to the patient's sexual partner(s) for treatment without an examination.

The Massachusetts Department of Public Health (MDPH) feels that the scientific evidence supports this approach, which would allow for something that is not currently explicitly allowed, but the MDPH cautions that this does not imply endorsement of EPT as the first choice for contact management. EPT should be considered as a treatment option when current practice is neither feasible nor effective in protecting the individual's and the public's health.

— Katherine Hsu, M.D., M.P.H.
Massachusetts Department of Public Health

Tips for Effective Conversations about End of Life

A recent program co-sponsored by the MMS, CRICO/RMF, the Kenneth B. Schwartz Center, and Beacon Hospice focused on the necessary but difficult end-of-life conversations between physicians, other caregivers, and patients. The program provided personal vignettes from the perspectives of family, physician, social worker, nurse, and dying patient. Some "best practices" are summarized below.

Physicians are often uncomfortable in end-of-life discussions because of their own fears and concerns around death. Providers who come to terms with their own feelings about death may be better prepared for end-of-life conversations with patients. Experienced physicians should model compassionate listening for interns and residents.

It is imperative for the physician to hear the concerns and fears of the patient and the family and support their wishes. The patient's end-of-life choices could preempt heroic measures by the physician. Understand the part your patient's culture or religion may play in end-of-life decision making.

One goal of the Massachusetts Health Care Quality and Cost Council is to "develop processes and measures to improve adherence to patients' wishes in providing care at the end of life." The council encourages providers to "ask about and follow patients' wishes with respect to invasive treatments, do-not-resuscitate orders, hospice and palliative care, and other treatments at the end of life."

Finally, urge patients to complete a health care proxy (see box below) while they are well, eliminating the potential for confusion and contention when the patient is facing an illness or crisis. **VS**

— Candace Savage

Keep an Eye Out for Depression during the Holidays

For many people, the pressure of the holiday season can be overwhelmingly stressful. For someone who is at risk, that added stress may lead to a depressive episode.

Anthony Rothschild, M.D., professor of psychiatry at the University of Massachusetts Medical School, cited three reasons why depression seems to be more prevalent in this country between Thanksgiving and New Year's.

"Biologically, there is an increased rate of depression in the months with less sunlight," said Dr. Rothschild. In addition, "during this time, there are often family gatherings where there can be increased family conflicts," Dr. Rothschild observed. Finally, the societal and economic demands and expectations during the holidays can be daunting.

Pace and Preparation

"People should try to avoid putting unrealistic expectations upon themselves," recommended Dr. Rothschild. "They need to pace themselves." And when it comes to seeing family members at gatherings, he suggested patients prepare themselves. "It may be an unnatural situation to get together with those you don't get along with, but try to avoid conflict with people you don't see the rest of the year."

Finally, Dr. Rothschild insisted that anyone who develops symptoms of depression should seek treatment. "Primary care physicians will often see the symptoms first," he observed, and he encouraged physicians to follow up when a patient says something like, "I'm feeling overwhelmed

by the holidays, and I feel sad." Follow-up conversations should revolve around other symptoms of major depression, such as thoughts of suicide, losing interest in activities or people, sleep disturbances, and changes in appetite or weight.

— Rebecca Lynch
Families for Depression Awareness

Families for Depression Awareness (FFDA) is a national nonprofit organization that helps families and friends of people with depressive disorders by providing education, outreach, and advocacy.

In April 2008, FFDA received a \$10,000 grant from the MMS and Alliance Charitable Foundation to support the Teen Depression and Suicide Prevention Program, which focuses on middle and high schools in Chelsea, Revere, Lynn, Medford, and Arlington. To date, 20 schools have received a copy of a wellness guide for parents of children and teens with depression or bipolar disorder. Additionally, FFDA is using the grant to schedule presentations at those schools on the proper use of the guide, and it has distributed the guide to clinicians at hospitals and mental health clinics in the aforementioned towns.

For more information about FFDA, go to www.familyaware.org.

WEBSITE OF THE MONTH

Clearinghouse for Health Statistics

Are you looking for reliable data regarding an important health issue, or do you need statistics from credible sources such as the Centers for Disease Control and Prevention, the National Cancer Institute, the National Library of Medicine, or the Health Resources and Services Administration? If so, go to www.phpartners.org, hosted by Partners in Information Access for the Public Health Workforce. The site also includes education and training resources, grant information, and resources to support legislative advocacy.

Health Care Proxy Day

The day after Thanksgiving, November 28, is Health Care Proxy Awareness Day. A health care proxy is a simple, written document that helps ensure individuals receive the type of care they want in the event they are unable to communicate their choices at the end of their lives or during a disabling illness. Urging your patients to complete proxies can begin the conversation around end-of-life issues. Visit www.healthcareproxy.org for details and forms.

STATE UPDATE

Society to Weigh in Frequently on Implementation of Chapter 305

The Massachusetts Medical Society was successful in significantly improving the comprehensive “cost control” bill filed by Senate President Therese Murray (D-Plymouth) last March (see *Vital Signs*, September 2008, page 5). But critical decisions still have to be made around the implementation of the law (Chapter 305 of the Acts of 2008), and the MMS will have an active role in that process.

The legislation created a number of new entities that will benefit from representation by the Society, and it expanded or re-established the roles of other entities that currently have MMS representation. In addition, the Society will participate in an array of hearings on topics ranging from patient safety to professional liability and restrictions on “gifts” from industry sources.

Payment and Workforce Issues

The MMS is a member of the Special Commission on the Health Care Payment System, which was created by Chapter 305. The commission’s goal is to “investigate reforming and restructuring the system to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care.” In a related provision, the

existing MassHealth Payment Policy Advisory Board has had its mission expanded to include studying the need for increasing Medicaid reimbursement for “primary care physicians, nurse practitioners, and subspecialists who provide primary care services.” The board has also been asked to provide input on establishing a Medicaid medical home demonstration project. Long-standing MMS involvement on this and other MassHealth boards has helped shape Medicaid reimbursement policies.

Many MMS-supported provisions regarding the physician workforce were incorporated in Chapter 305, including a loan-forgiveness program and the creation of a Healthcare Workforce Center at the Department of Public Health (DPH). The MMS is on the center’s advisory council, which is charged with looking at disincentives to recruitment and retention across specialties, ranging from existing laws, regulations, and policies to contracting and reimbursement practices. The new law also mandates that all payers — including Medicaid — use standard claims forms and billing codes by 2012, eliminating considerable unnecessary paperwork. In addition, the MMS has a seat on the new Advisory Committee to the Division of Insurance’s Bureau of Managed Care, which is

charged with monitoring the implementation of that aspect of Chapter 305.

The new law also gives enhanced responsibilities to the Advisory Committee of the Health Care Quality and Cost Council, the Massachusetts Commission on End of Life Care, and the Health Disparities Council — all entities in which the Society is already represented.

Hearings, Hearings, and More Hearings

The MMS will also continue to monitor and comment at public hearings mandated by Chapter 305 and those designed to help establish regulations for new initiatives. For example, the legislation mandated that the Division of Insurance study the “costs of medical malpractice coverage” for health care providers, and the MMS has already testified at those hearings. Furthermore, the DPH indicated that it will move quickly in developing regulations relative to limiting “gifts” to health care providers from pharmaceutical and medical device manufacturers, as well as regulations regarding the reporting of and reimbursement for “serious reportable events” (see *Vital Signs*, October 2008, page 1). The MMS will testify at those hearings, as well. **VS**

— Steve Shestakofsky

FEDERAL UPDATE

MMS Maintains Busy Administrative-Agency Advocacy Agenda

Amid all our advocacy with legislators in Washington, the Society’s advocacy with federal administrative agencies is often overlooked. In recent months, these agencies have been engaged in rulemaking that will affect physicians, and the MMS has been very active in responding, as summarized below.

CMS: Inpatient and Outpatient Prospective Payment

The MMS’s comments to the Centers for Medicare and Medicaid Services (CMS) Inpatient and Outpatient Prospective Payment rulemaking included objections to the proposed list of hospital-acquired conditions and complications deemed “reasonably preventable” — the so-called “never events” that would be ineligible for reimbursement (see *Vital Signs*, October 2008, page 1). The MMS also cited the CMS’s failure to analyze the impact of the nonpayment policy on the quality of care or to develop appropriate risk adjustment techniques to ensure that

chronically ill and high-risk patients are not jeopardized. The Society also emphasized that physician offices need to be treated differently from inpatient settings.

CMS: 2009 Physician Payment

MMS advocacy on the 2009 Physician Payment rulemaking focused on problems with the Medicare Physician Quality Reporting Initiative (PQRI). The MMS advocated for physician review of data before it is made public, an appeals process, and an analysis of the impact of the PQRI on quality of care. The Society also questioned CMS’s failure to comply with all the measurements developed by the AMA’s Physician Consortium for Performance Improvement.

DEA: E-Prescriptions for Controlled Substances

The MMS joined with the AMA and many national medical specialty societies in commenting on the Drug Enforcement Agency’s proposed rule to allow electron-

ic prescribing of controlled substances. The rule would require physicians to secure in-person proof of identity, maintain a separate system for electronic prescribing for controlled and noncontrolled substances, install automatic two-minute “time outs” for computers, and use third-party auditing and prescribing logs. While the MMS stated its strong support for implementation of e-prescribing, including controlled substances, the Society maintained that the proposed rule was overly burdensome. The MMS stated that “the challenge is for the DEA to find the balance between creating pragmatic security protection while enabling busy practitioners to utilize this technology for its greatest efficiency and impact.”

The full text of MMS comments on Medicare rulemaking can be found at www.massmed.org/inpatient_comments and www.massmed.org/outpatient_comments. Comments on DEA rules are at www.massmed.org/DEAcomments. **VS**

— Alex. Calcagno

LEGISLATOR OF THE MONTH

Representative Christopher J. Donelan (D)

District: Athol, Erving, Gill, Greenfield, Orange, Warwick

Committees: Public Safety and Homeland Security; Higher Education; Public Service



QUOTE: Public policy in Massachusetts needs to recognize that primary care doctors are the key to keeping the cost of health care down.

I share the credit for successfully passing physician recruitment legislation with the primary care doctors from my district and throughout western Massachusetts. My education regarding the challenges facing primary care doctors came entirely from physicians who are struggling to make the system work for them and their patients.

The more I met with doctors, the more I realized that billing, recordkeeping, reimbursements, and insurance company practices were not only working against them, but also were working against the success of our new health care law.

I realized my communities in western Massachusetts would be without primary care doctors if we did not take steps to make Massachusetts an attractive place to live and practice medicine. Loan forgiveness as a tool for physician recruitment was the issue I focused my time and energy on. I am pleased that the bill I filed was included in Chapter 305 of the Acts of 2008.

Because of this and other reforms, I remain hopeful we have taken positive steps in improving the practice of primary care. Neighborhood doctors still exist where I live. My goal is to make them stronger and more successful.



MASSACHUSETTS MEDICAL SOCIETY ANNUAL MEETING

Call for Nominations: 2009 MMS Awards

The Massachusetts Medical Society's Committee on Recognition Awards is currently seeking nominations for the 2009 Annual Meeting Awards Program in May. Nominate your colleague today for one of these prestigious awards!

For more information regarding awards criteria, application information, and submission deadlines, visit www.massmed.org/awards2009, or call (800) 322-2303, ext. 7208.

CME Program to Focus on Caring for Gay and Lesbian Patients

Recognizing that lesbian, gay, bisexual, and transgendered (LGBT) patients have unique health concerns, the MMS Committee on Lesbian, Gay, Bisexual, and Transgender (LGBT) Matters is sponsoring a CME program to discuss the particular health care challenges of this patient population.

By focusing on best-practice models for culturally appropriate care and strategies for creating movement toward more appropriate practice, this program will address the differences among the LGBT population. Specific topics will include unique LGBT needs regarding substance abuse counseling, cancer screening, domestic violence prevention, improving mental health, and identifying suicide risk factors.

Attendance will give providers a series of tools that will help them better serve their LGBT patients, including a better understanding of how to develop a LGBT-inclusive practice.

To learn more about the Committee on LGBT Matters, contact Erin Tally at (781) 434-7413 or etally@mms.org. **VS**

Caring for Your Gay and Lesbian Patients

November 13, 5:45 to 8:00 p.m.
MMS Headquarters, Waltham
(Networking from 5:45 to 6:30 p.m.)

Speaker: Marshall Forstein, M.D., associate professor of psychiatry at Harvard Medical School and director of adult psychiatry residency training at the Cambridge Health Alliance

1.5 AMA PRA Category 1 Credits™ (RM)
To register, call (800) 843-6356 or visit www.massmed.org/cmecenter.

IMG Workshop to Address Licensing, Residency, and Immigration Issues

On Saturday, February 7, 2009, the MMS will host its 17th Annual Career Day/Job Fair for Massachusetts physicians from 9:00 a.m. to 1:00 p.m. During this event, a workshop specifically geared toward international medical graduates (IMGs) will take place from 11:00 a.m. to noon.

This workshop will serve as an open forum for IMGs to discuss immigration, residency, and licensing issues. Speakers

will include Attorney Samia Chandraker and chair of the IMG Section, Anil Chandraker, M.D. This workshop is free, and all member and nonmember IMG residents and physicians are welcome to attend.

To learn more about the MMS Career Day/Job Fair or the IMG Section, e-mail etally@mms.org, or call Erin Tally at (800) 322-2303, ext. 7413. **VS**

PHYSICIAN HEALTH MATTERS

PHS Associate Directors Author Chapter on Substance Use Disorders among Physicians

"In years past, the prevalence of addictive disorders in the medical profession was widely exaggerated. In fact, physicians have rates of substance abuse and dependence that are very similar to those of the general population."

So begins chapter 43 of the *Textbook of Substance Abuse Treatment*, 4th edition, written by Physician Health Services, Inc. (PHS) Associate Directors J. Wesley Boyd, M.D., and John R. Knight, M.D. The chapter's introduction goes on to note that "physicians most often misuse prescription drugs and do so for reasons of self-treatment. Physicians have greater access than most to very potent psychoactive medications and are subject to unique stresses, and when they become impaired as a result of psychoactive substance use, other people may be placed in jeopardy as well."

Edited by Marc Galanter, M.D., and Herbert Kleber, M.D., and published by the American Psychiatric Association, the textbook is considered by many to be the preeminent text in its field. It contains chapters written by leaders across a wide range of topics, including biological and psychological treatments and how they apply to specific populations. The chapter by Drs. Boyd and Knight on substance use disorders among physicians covers topics such as epidemiology, signs of substance use, intervention strategies, the role of state physician health programs, treatment options, approaches to monitoring, and strategies for prevention.

Early intervention is essential, and the authors say the best approach is one that is highly structured and that leads to an independent evaluation with a required report back. Regarding treatment, residential programs of two to four months in duration are often recommended, but controversy exists as to whether this level of intensity is needed in all cases. The authors say aftercare plans should include monitoring by the state physician health program; such programs have high rates of success.

In addition, the chapter by Drs. Boyd and Knight includes discussion of the legal and ethical considerations that arise with substance use disorders among physicians. The chapter concludes by summarizing several key points, including the contention that the term "impaired physician" is archaic and demeaning to physicians suffering from substance use disorders. The authors say the phrase should be replaced with less pejorative language that "describes the nature or source of the problem without simultaneously assuming that the physician is either impaired or unable to safely practice medicine." They also emphasize that although physicians are vulnerable to substance abuse and dependence at rates comparable to nonphysicians, the success rate for physicians who undergo substance abuse treatment is quite high, with most programs reporting positive outcomes in the 75 to 85 percent range. **VS**

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

Save the Date — February 6, 2009

4th Annual Women's Cardiac Health Conference Heart Healthy Strategies to Empower Your Patients

February 6, 2009 • 8:00 a.m. to 3:15 p.m.
MMS Headquarters, Waltham



Sponsored by the MMS and its Committee on Women in Medicine, in collaboration with the American Heart Association and the Institute of Lifestyle Medicine

5.5 AMA PRA Category 1 Credits™ (3.25 RM)

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

ACROSS THE COMMONWEALTH

District News and Events

Essex North/Essex South — Joint Delegates Meeting. Wed., Nov. 12, 6 p.m. Location: Hawthorne Hotel, Salem. For more information, contact the Northeast Regional Office.

Middlesex North — Membership Meeting. Wed., Nov. 5, 6 p.m. Location: D'Youville Senior Center, Lowell. Speaker: George P. Behrakis. Topic: "The Future Evolution of Health Care: Biotechnology and Molecular Medicine." For more information, contact the Northeast Regional Office.

Middlesex West — Delegates Meeting. Wed., Nov. 5, 6 p.m. Location: McPherson Hall, Framingham Union Hospital. **Middlesex West Women Physicians.** Tues., Dec. 9, 6:30 p.m. Location: 20 Fieldstone Lane, Natick. Topic: The Angry Patient. For more information, contact the Northeast Regional Office.

Norfolk South — District Holiday Event. Thurs., Dec. 11, 6 p.m. Location: Atlantica on Cohasset Harbor. Each member and his or her guest are invited to attend. There will be a presentation by Dr. Juan Ortega-Barnett on medical mission work in Mexico, along with musical entertainment. The district will also sponsor its annual Toys for Tots Program. For more information, contact the Southeast Regional Office.

Suffolk — Delegates Meeting. Wed., Nov. 12, 6 p.m. Location: Spaulding Rehab, Boston. For more information, contact the Northeast Regional Office.

Southeast Regional Caucus — Wed., Nov. 5, 6 p.m. Location: LeBaron Hills Country Club, Lakeville. Delegates from Barnstable, Bristol North, Bristol South, Norfolk South, and Plymouth will meet to discuss resolutions prior to the Interim Meeting.

Worcester — Fall District Meeting. Wed., Nov. 12, 5:30 p.m. Location: Beechwood Hotel, Worcester. The dinner includes the A. Jane Fitzpatrick Community Service Award, the WDMS Career Achievement Award, and scholarship presentations. For more information, contact Joyce Cariglia at (508) 753-1579.

Statewide News and Events

Arts, History, Humanism, and Culture Member Interest Network — Executive Committee Meeting. Wed., Nov. 5, 6 p.m. Location: MMS headquarters, Waltham. 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 September and October 2008. We also note member deaths on the MMS website at www.massmed.org/memoriam.

Joao S.V. Barreto, M.D., 71; Marblehead, MA; Escola Medico, Goa, India, 1962; died July 20, 2008.

Selim R. Chakar, M.D., 71; Chestnut Hill, MA; St. Joseph's University, Beirut, Lebanon, 1962; died September 27, 2008.

Louis C. Clarke Jr., M.D., 81; Scarborough, ME; University of Rochester School of Medicine, 1952; died September 7, 2008.

Francis L. Colpoys Jr., M.D., 87; Milton, MA; Tufts University School of Medicine, 1945; died October 5, 2008.

Robert F. Tilley, M.D., 89; South Yarmouth, MA; Tufts University School of Medicine, 1944; died September 12, 2008.

I. David Todres, M.D., 73; Waban, MA; University of Cape Town, South Africa, 1958; died September 26, 2008.

How Has Health Care Reform Affected Minority Patients and Physicians?

The Committee on Diversity in Medicine will host a program on November 20 to examine the current state of health insurance coverage in Massachusetts and the demographics of those enrolled. The program will devote special attention to the care of racial and minority populations since the implementation of the health care reform law in Massachusetts, with particular focus on workforce diversity and access to primary care and other services.

The legislative and financial challenges of health care reform will also be highlighted. Featured speakers will include Rep. Byron Rushing and Alice Coombs, M.D., vice president of the MMS. **VS**



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The Impact of Health Care Reform on Minority Populations and Their Providers

Thursday, November 20 • 6:30 to 9:00 p.m.

MMS Headquarters, Waltham

2.5 AMA PRA Category 1 Credits™

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

Online Renewal Saves Time, Postage, and Paper

As more MMS members look to save time and help the environment, online membership renewal is more popular than ever. The 2009 MMS Renewal Campaign is under way, and we encourage you to renew your commitment to the MMS online. Log on to www.massmed.org and click on "Join/Renew." It's quick, so you save time; it's online, so you save a stamp; and you can recycle the mailed renewal materials, so you save a tree.

Receive a Medical Images 2009 Calendar

In early November, you will receive your first 2009 renewal notice by mail. We will include important information about advocacy and discount choices, as well as instructions on how to renew your membership online. And, with an online renewal, you will receive a free Medical Images 2009 Calendar.

Our online functionality also allows you to:

- Pay your MMS state and district medical society membership dues by credit card
- Pay your AMA membership dues by credit card
- Check your payment status or review and update your personal contact information at any time

Enrollment Options

Newly improved group discounts that range from 5 to 30 percent are available to groups of five or more physicians. For solo practitioners and small groups, the same discounts are available through our multiyear options. Look for information on these discounts when you receive your renewal notice.

For more immediate information about new enrollment options or membership renewal, contact the Membership Department at (800) 322-2303, ext. 7311, or info@massmed.org. Remain a part of the fastest-growing state medical society in the country. Renew today! **VS**

— George Dudley





MASSACHUSETTS MEDICAL SOCIETY

EVERY PHYSICIAN MATTERS, EACH PATIENT COUNTS.

WHAT'S ON THE WEB?

- ▶ **MMS Physician Workforce Study**
Executive summary and full report
www.massmed.org/workforce
- ▶ **MMS Interim Meeting**
Schedules, resolutions, and registration forms
www.massmed.org/interim08
- ▶ **Web Exclusive: NQF Official Discusses "Never Events"**
Chair of NQF committee says payment denials were not the goal of creating the list.
www.massmed.org/schyve

WWW.MASSMED.ORG

MMS and BRM Tackle Tough Issues

continued from page 2

Noting that licensing is the board's primary responsibility, Dr. Motta suggested adding staff to the board's licensing division, simplifying the physician licensing process, and making online applications available for all applicants.

"This is another area that we have to look to the Massachusetts Medical Society for feedback," said Dr. Fish, who added that "denial by delay is something that should not happen." He expressed hope that the board and the MMS could work together to "streamline the process."

Clinical Skills Assessment Moves Forward

The board also warmly greeted news that the MMS was well on its way toward developing a new clinical skills assessment program for physicians. Kenneth R. Peelle, M.D., an MMS past president and chair of the Society's Clinical Skills Assessment Task Force, described how the voluntary, confidential program — based on ones now running in California and Colorado — might work.

The general perception of such programs is one obstacle, Dr. Peelle noted. "This is not about punishing bad apples," he said. "This is about assessing and enhancing skills."

Financing is another issue. "We need to start small because of finances," Dr.

Peelle said. He appealed to the board for help with that, adding that any such program must eventually sustain itself.

Dr. Fish called the skills assessment plan a "great concept," and he volunteered to serve as the board's liaison to the MMS on the project.

"We will succeed only with cooperation between the board and the Society," Dr. Peelle concluded. He said he envisioned the board and the MMS sharing information on program development going forward and that the board would be a primary referral source for doctors who eventually take part in the program.

Nothing New on Board Regulations

Another lingering issue that has stirred controversy between the board and the MMS was barely discussed at the meeting. "There are these things called the regulations," Dr. Herman declared toward the end of the proceedings. He said board members have received all the MMS testimony on proposed changes to the board's regulations. "We are all trying to get up to speed," Dr. Herman said.

With that, the unusual meeting ended, amid handshakes and photographs.

Because the board has jurisdiction over licensing and discipline, "there will always be an adversarial nature to some of our relations with the board,"

Dr. Auerbach said afterward. "But today was a demonstration of a much more collaborative working relationship." **VS**

Physician Workforce

continued from page 2

- Streamlines the processes for establishing a practice
- Reduces barriers to recruiting and retaining physicians
- Significantly reduces administrative burdens to allow time for more patient care
- Enables better coordination of care across specialties
- Encourages a healthy balance of work and nonwork activities

As in the past, the 2008 MMS Physician Workforce Study evaluated the status of the current physician workforce through both primary and secondary research. This included surveys of practicing physicians, medical staff presidents, teaching hospital department chiefs, medical groups, residency and fellowship directors, and the public. **VS**

To download the executive summary or full Physician Workforce Study, go to www.massmed.org/workforce.

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.

Strategies for Safely Managing Patients on Warfarin

November 4, 8:00 a.m.–12:30 p.m.
MMS headquarters, Waltham.
Jointly sponsored with the Mass. Coalition for the Prevention of Medical Errors. 4.25 Credits (RM)

Managing Workplace Conflict

November 5, 8:00 a.m.–4:00 p.m.
November 6, 8:00 a.m.–3:00 p.m.
MMS headquarters, Waltham.
Jointly sponsored with Physician Health Services. 12.5 Credits (RM)

2008 Directors of Medical Education Conference

November 6, 8:00 a.m.–3:00 p.m.
MMS headquarters, Waltham.
5.75 Credits (2.0 RM)

Caring for Your Gay and Lesbian Patients

November 13, 6:30–8:00 p.m.
MMS headquarters, Waltham.

Sponsored by the MMS and its Committee on Lesbian, Gay, Bisexual, and Transgender Matters.
1.5 Credits (RM)

Ethics Forum: Poverty, Access, and Health Status

November 14, 3:30–5:30 p.m.
MMS headquarters, Waltham.
Sponsored by the MMS and its Committee on Ethics and Grievances.
2.0 Credits (RM)

Impact of Health Care Reform on Minority Populations and Their Providers

November 20, 6:30–9:00 p.m.
MMS headquarters, Waltham.
Sponsored by the MMS and its Committee on Diversity in Medicine.
2.5 Credits (RM)

Health Policy Forum

January 30, 8:30 a.m.–5:30 p.m.
MMS headquarters, Waltham.
Jointly sponsored by the MMS and Brandeis University. 7.5 Credits (RM)

4th Annual Women's Cardiac Health Conference

February 6, 8:30 a.m.–3:15 p.m.
MMS headquarters, Waltham.
Jointly sponsored by the MMS and its Committee on Women in Medicine.
5.5 Credits (3.25 RM)

Online CME Activities

Go to www.massmed.org/cme.

NEW Massachusetts Medical Law Report Quarterly Risk Management CME Series

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

Reducing Errors 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)

NEW Preparedness Risk Management CME

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)

The following audio and/or PowerPoint activities are available online:

Electronic Prescribing Education
2.5 Credits (RM)

Unmasking Depression in Primary Care Practice
4.5 Credits (RM)

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.