

VITAL SIGNS



- 2 **PRESIDENT'S MESSAGE** An Important Election for Patients
- 3 **YOUR PRACTICE** Admin Aspects of Federal Reform • Legal Issues in Interstate Medicine • Fee Schedule Reconciliation
- 4 **THE PUBLIC'S HEALTH** Foundation Supports Wellness for Homeless • Preventing Hockey Injuries • 16th Anti-Tobacco Poster Contest Underway
- 5 **GOVERNMENT AFFAIRS** Federal: Fighting against Geography-Based Medicare Cuts
- 6 **PROFESSIONAL MATTERS** Enhanced Prescription-Drug Monitoring Program • Hospital Visitation Rights for LGBT Families • Webster Bank Benefit for MMS Members
- 7 **INSIDE MMS** Changes Announced for 2011 Annual Meeting • Across the Commonwealth • In Memoriam
- 8 **MMS EDUCATION PROGRAMS**

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Mass. System Changes Can't Happen Overnight

BY LLOYD RESNICK

With several federal and state initiatives on accountable care organizations underway, many physicians in Massachusetts have a simple message for policymakers: go slowly.

"All along, we've said that the physician community can and will help solve the cost problem," said MMS President Alice T. Coombs, M.D. "But we have real concerns about the potential for unintended consequences if laws are passed and regulations made without ample physician input and thorough vetting."

Prove It First

Those viewpoints were echoed at a series of MMS-sponsored focus groups this past summer.

Amid the plethora of opinions and concerns emerged one overriding and unanimous observation: the need to move carefully and thoughtfully, with checks, balances, and assessments along the way.

"Right now, all this is an experiment," said one focus group participant. "You have to prove it first."

Many said physicians need help with infrastructure and risk management, while others worried about the loss of clinical autonomy and misaligned incentives that emphasize cost above quality.

This "go slow" message is one the MMS has emphasized ever since the state Payment Reform Commission issued its recommendations in July 2009.

Pilots Should Precede Legislation

The Patrick administration, seeking to have payment reform and ACO

Sec. Bigby Calls for Flexibility, Diversity in Massachusetts ACO Formation

BY TOM WALSH

Accountable care organizations (ACOs), an integral piece of payment reform proposals in Massachusetts and elsewhere, should be diverse, flexible, and numerous across the Commonwealth if they are to succeed, according to JudyAnn Bigby, M.D., secretary of the state Executive Office of Health and Human Services.

"A one-size-fits-all approach to this will not work," Dr. Bigby told *Vital Signs* in an exclusive interview.

She said ACOs may not work for some rural communities, and some physician specialties may be so specific that they will not fit easily into the ACO concept.

"I think if we put the [ACO] challenge in front of communities and give them some help, they'll come up with a solution that will work for their community," Dr. Bigby said. "Just two weeks ago I was in a region of the state where there are lots of small communities, two hospitals, several community health centers, and primary care providers. They're already working together in informal ways that are very forward looking. It includes not only community health centers and hospitals thinking about how to work together, but also school-based clinics and dental programs for kids."

As for specialties that would need to be present in a successful ACO, Dr. Bigby said, "Necessary specialties would encompass the type of services we know the population needs. We need the type of collaboration between primary care and specialties that will best manage the chronic diseases in the population."

When asked to name a specialty that might fall out of the ACO realm, she said that pediatric cardiac surgeons are an example of a specialty that will not have to be in every ACO. "It's an issue of volume and expertise," she said.

A Good Vision for Doctors?

Alice T. Coombs, M.D., MMS president, said she was encouraged by Dr. Bigby's comments on ACOs, an issue that has prompted physician concerns across the state. Dr. Coombs said she agrees that ACOs "shouldn't be homogenized to the point where they all look alike. We have a wide diversity of patients in this state, and it should be the same for ACOs."

Dr. Coombs added that ACOs should be voluntary and should benefit from appropriate and necessary support and complete transparency regarding quality and cost information. "The ACO vision

encompasses some of the things that doctors really want — a way to improve patient care and to ensure a sustainable delivery system," she said.

Accountable care organizations are part and parcel of recommendations put forth last year in a report by the state's Special Commission on the Health Care Payment System. The report defines ACOs as organizations "that accept responsibility for all or most of the care that enrollees need. ACOs will be composed of hospitals, physicians, and/or other clinicians and non-clinician providers working as a team to manage both the provision and coordination of care for the full range of services that patients are expected to need."

Reflecting Dr. Bigby's view, the report said, "The Special Commission envisions there will be a broad array of ACO models and encourages the development of a large number of ACOs."



"There is no way we can reform the system without physician involvement."

— JudyAnn Bigby, M.D.
Health and Human
Services Secretary

Regulation Not the Answer

Speaking with *Vital Signs*, Dr. Bigby amplified her view on ACO heterogeneity. "Whatever legislation we end up with in Massachusetts should allow this type of diversity. It should not dictate that there's only one way an ACO can be organized. And it should recognize that different communities may need different things," she declared. "The legislation should allow for enough oversight of the way ACOs develop so we have this diversity and a lot of ACOs. I think the worst thing that could happen in Massachusetts is that we end up with four or five ACOs. I don't think that would be good for the market unless we regulated to the point where people would not be happy."

Dr. Bigby emphasized that last point. "I don't think regulation is the answer to this problem," she said. "I think providing the framework for allowing the

continued on page 2

continued on page 5

PRESIDENT'S MESSAGE



An Important Election for Massachusetts Patients

The outcome of the Massachusetts gubernatorial race will substantially influence the future of health care reform in our state.

I encourage all MMS members to go to www.massmed.org/governor for video-taped interviews that summarize the health care platforms of Deval Patrick, Charlie Baker, Tim Cahill, and Jill Stein, M.D. Equip yourself with the information you need to make an educated choice. We thank all four candidates for speaking directly to the physician community through the MMS.

In your private deliberations, think about which candidate you think will move us toward a high-quality, efficient, and sustainable health care system in Massachusetts. Ascertain who you think will do the most to address barriers to physician practice viability, not the least of which is the high cost of practicing medicine in this state. In making my choice, I'm also going to mull over which candidate is most likely to maintain the significant access-to-care improvements we've made since 2006.

We all believe in the "patients first" credo — and that high health care costs are an urgent problem. But this problem cannot be resolved at the expense of the physician-patient relationship. Think carefully about your personal vision of a healthy health care system, and vote for the candidate that best represents it.

As a group, physicians typically go to the polls in large numbers. I encourage you to follow that trend in this important election, no matter how busy you are. Also, be prepared for discussions about the election that your patients may initiate. Finally, rest assured that the MMS will work constructively with whichever leaders are elected.

— Alice T. Coombs, M.D.

Not So Fast with ACOs

continued from page 1

legislation ready early in the next legislative session, has recently front-burned these issues. The state Health Care Quality and Cost Council, chaired by Health and Human Services Secretary JudyAnn Bigby, M.D., is one of several entities attempting to create blueprints for legislation.

At a council hearing last month, MMS President-Elect Lynda Young, M.D., reiterated the call for careful deliberation. "The diverse nature of the physician community and the experimental nature of current proposals support Sec. Bigby's admonition that 'one size does not fit all,'" said Dr. Young. (See related article on page 1.)

In written testimony to the council (go to www.massmed.org/ACOTestimony), the MMS called for piloting ACO models, prior to the filing of legislation. "We urge pilots," the Society's testimony said, "and support legislation that would allow and support these activities on a voluntary basis."

Other Laws Must Change

The MMS also identified three legal prerequisites that must precede any payment-reform or ACO bill being passed:

- Revision of medical malpractice laws to curtail defensive medicine practices
- Amendment of anti-trust laws to allow independent practices to form ACOs

- Expansion of medical peer-review laws to include ACOs

The MMS is also insisting that any eventual oversight body for ACOs be comprised of "a majority of experienced practicing physicians...[who] reflect the diverse provider community."

"Progressing too rapidly will impact the patient-physicians relationship."

— Lynda Young, M.D.
MMS President-Elect

Success Takes Time

"Providing 97.4 percent of our residents with health insurance took time and hard work," concluded Dr. Young. "These next steps need the same level of consideration. Progressing too rapidly will result in consequences that will impact patient access, the patient-physician relationship, the quality of care delivered, and the physician workforce."

The MMS will continue to monitor developments and speak clearly for all our members wherever these issues are discussed. We will advocate for changes that will help ensure physician success, and we will provide educational resources for physicians who are ready to start making changes.

Most importantly, we will continue to solicit — and listen to — the thoughts and opinions of our members on these issues. **VS**

Do You Get Our Free E-Newsletters?

If you don't, you should. These news-packed publications, delivered directly to your e-mail box, are the most efficient way to stay informed about pressing matters that affect your practice. Go to www.massmed.org/newsletters to sign up for, among others:

MMS Media Watch — Roundup of major health care news and commentary. (Every Weekday)

Vital Signs This Week — Summary of MMS news and events and local and national health care news. (Every Friday)

MMS ARRA Advisor — The latest information about the federal stimulus program, EMR adoption, and other technology subjects. (Bi-weekly)

MMS Payer Watch — News about health plans, insurers, and other payers. (Monthly)

MMS Health Policy Watch — Summaries of health care policy research projects in Massachusetts and across the country. (Monthly)



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

EDITORIAL STAFF: Charles Alagero, Office of General Counsel; Robyn Alie, Public Health; Lori DiChiara, Government Relations; Adam Shlager, Managed Care; Stephen Phelan, Membership; Cathy Salas, West Central Regional Office; Jessica Vautour, Physician Health Services

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

PRESIDENT: Alice T. Coombs, M.D.

EXECUTIVE VICE PRESIDENT: Corinne Broderick

DIRECTOR OF COMMUNICATIONS: Frank Fortin

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The Administrative Side of Health Care Reform

When federal health reform is discussed, much of the talk centers on cost and coverage. However, the Patient Protection and Affordable Care Act contains a number of provisions that will affect physician practices in less direct but still potentially helpful ways.

For example, the legislation directs health plans to simplify and standardize administrative transactions. In one section of the act, the secretary of Health and Human Services (HHS) is directed to “adopt a single set of operating rules for each transaction... with the goal of creating as much

uniformity in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under [HIPAA].”

In another section of the act, the HHS is directed to “seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers.”

The law aims to standardize and simplify eligibility, health

claims status, electronic claims status, payment and remittance advice, enrollment and disenrollment, and referral certification and authorization.

Compliance is directed at health plans; provider compliance is not mentioned in the legislation’s text. Compliance deadlines stretch from 2013 to 2016 depending on the transaction, and the schedule calls for adoption of operating rules two years prior to the effective dates for compliance, so we should see some proposed rulemaking in 2011. **VS**

—Adam Shlager

LAW AND ETHICS

Technology Raises Legal Issues in Interstate Medicine

A radiologist in Massachusetts interprets a digital copy of a CT scan made in Rhode Island. A pathologist in Connecticut analyzes and reports on a tissue sample sent from a physician in Massachusetts. A Massachusetts physician participates via teleconference in the examination of a patient in rural Virginia.

Each of these situations is intended to raise the overall quality of patient care, but each also raises serious licensure issues. Currently, there is no nationwide standard for licensure for telemedicine or interstate practice. Some states have provisions for a separate license for this practice, while Massachusetts and other states require a full license for any physician consulting in state more than once a year.

Before becoming involved in a case outside Massachusetts, a physician should be familiar with

the regulations of the state in which the case is located. In addition, the physician should take care when seeking input from an out-of-state physician, as Board of Registration in Medicine (BRM) regulations prohibit a physician from aiding an unlicensed individual to perform actions for which a license is required.

of individual patient data by electronic or other means from the originating site to such physician...” The BRM Task Force on Telemedicine recommended the addition of sections that address the credentialing of telemedicine providers, but it is not clear yet what form that credentialing will take.



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Clearly, the evolution of technology creates the need for new policies and regulations. Massachusetts physicians should be aware of the legal landscape before engaging in or asking others to engage in any form of interstate practice, including telemedicine. **VS**

—Liz Rover Bailey, Esq.

Newly proposed BRM regulations address the issue of telemedicine, defining the practice of medicine to include “rendering treatment to a patient located at an originating site within this state by a physician at a distant site... as a result of transmission

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.

Fee Schedule Reconciliation More Important than Ever

The traditional model of unilateral fee schedule adjustments made once a year by health plans has changed. Now, many plans review their payment policies quarterly and update fees and administrative requirements on a rolling basis, creating more complications for physician practices. Also, as the economy continues to suffer and health care reform provisions take effect, the plans will probably continue to seek methods of reducing payments for services.

For these reasons, practices should ensure they are receiving the reimbursement to which they are entitled. Here’s a two-step approach:

Look at Top 20 Codes

First, assign someone (your billing department or billing company, for example) to reconcile what you are getting paid with your contracted amounts. Optimally, this should occur on a rolling basis, but quarterly reconciliation would be sufficient. Evaluate your top 20 codes ranked by utilization and by reimbursement. Areas where discrepancies exist should be investigated. Pay particular attention to visits that are reimbursed at 100 percent of charges, visits that are reimbursed at a different rate than contracted, and visit charges that are denied.

Pass Info to the Right People

Second, make sure all communications issued by the plans are passed on to the appropriate person in the practice. Many mailings about changes in reimbursement or payment policy are sent directly to physicians. While it is important for the doctors to read and understand the changes (and comment on them if appropriate), administrative staff and billing personnel should also be apprised of modifications so revenue flow continues uninterrupted.

This year in particular, practices should take the time to make sure their fee schedules and reimbursements are in line. Reform efforts will prompt further changes, and having benchmarks will be useful as these changes roll out. **VS**

—Adam Shlager

MMS Anti-Tobacco Contest Underway

The MMS and MMS Alliance will mail Anti-Tobacco Poster Contest kits early this month to elementary schools, pediatricians, and family physicians throughout Massachusetts.

Now in its sixteenth year, the contest is open to children in grades one through six. Participation encourages children to eschew tobacco and to carry the anti-tobacco message to their friends and loved ones.

In addition to entry information, the contest kit includes a 2011 calendar featuring the 12 winning entries from last year's poster competition.

Entries must be received by February 11, 2011. Entries will be judged on originality, creativity, and adherence to the contest themes.

Artists submitting the 12 winning posters will be invited to a formal State House ceremony, receive a \$50 gift certificate, and be recognized on the MMS website and in news releases sent to local media outlets. **VS**



For more information, including a downloadable entry form, go to www.massmed.org/tobacco. To request 2011 calendars free of charge, e-mail dph@mms.org, or call (800) 322-2303, ext. 7373.

MMS and Alliance Charitable Foundation Supports Wellness for Homeless Patients

A new homeless guest at Pine Street Inn came to the medical clinic seeking ibuprofen for a headache. But before he left, nurse Trish Bowe gave him a tuberculosis test, took his vital signs and a short history, weighed him and measured his height, brought him up to date on immunizations, and hooked him up with a primary care provider.



Photo by Vicki Ritterband

Barbara Vitale, a nurse at the Boston Health Care for the Homeless Program's Pine Street Inn clinic, treats a homeless patient.

For Bowe, every new patient represents a new opportunity. "It's our chance to engage them, to connect someone with health care who may not have been connected before," said Bowe, nurse manager at the Boston Health Care for the Homeless Program's (BHCHP's) clinic at Pine Street Inn. "And an important part of that engagement is preventive care."

With a \$10,000 grant from the MMS and Alliance Charitable Foundation awarded in April, the BHCHP will ensure that everyone who visits its Pine Street Inn clinic is offered vaccinations for hepatitis A, hepatitis B, influenza, tetanus, and Pneumovax — as well as a tuberculosis screening. The goal is to have more than 70 percent of patients receive one or more of these preventive services.

The clinic at Pine Street Inn is one of more than 80 sites where

the BHCHP delivers medical services that go way beyond treating simple sore throats and headaches. For example, wound care is more intensive among homeless patients because they face greater potential for infection.

Nurses like Bowe are the lifeblood of the clinic, educating patients about their conditions and steering them to resources, including addiction-recovery programs. Past trauma among homeless patients challenges nurses to break down walls of fear and mental illness, and nurses help patients navigate through a complex health care system.

"This very generous gift from the MMS and Alliance will help get a great number of our homeless patients on a path to a healthier future," said BHCHP executive director Robert Taube.

— Vicki Ritterband

2011 Charitable Foundation Grant Deadline

January 15, 2011, is the deadline for submitting letters of inquiry to the MMS and Alliance Charitable Foundation for its 2011 grant cycle. Preference is given to organizations with track records of working with interdisciplinary groups that address health care issues and where strong physician involvement exists. For more information, visit www.mmsfoundation.org or call (800) 322-2303, ext. 7044.

Prevent Sports Injuries with Anticipatory Guidance

A study published this fall found significant increases in emergency department visits for hockey-related injuries among children and teens, and among female sports participants in general.

While the increase is likely due mostly to increased participation, particularly among girls, the study does highlight the importance of sports-injury prevention.

Physicians can use the annual visit or the preparticipation physical as an opportunity to guide patients in injury prevention for any sport, said Katherine Riggert, D.O., sports medicine physician and assistant professor at UMass Medical School.

Prevention includes equipment that fits properly and is worn during practice and games. In hockey, even no-contact drills are high-risk situations because contact with the ice, a skate blade, a stick,

or the boards can result in serious injury, including concussion.

Proper conditioning and learning sport-specific techniques and skills may also help prevent injury. Injuries skyrocket in girls once they hit puberty, so it's important that girls learn injury-prevention techniques before they reach that stage of development, said Dr. Riggert.

To reduce the risk of musculoskeletal injuries, players of any sport might participate in pre-season injury-prevention programs and strengthening and conditioning programs offered by a local physical therapy practice or gym.

Most importantly, said Dr. Riggert, physicians should talk to patients and parents about concussion history and describe concussion symptoms. Many people don't know that even

mild headaches and fatigue could be signs of concussion.

A law passed in August to prevent young athletes from returning to play prematurely after concussion (see *Vital Signs*, October, page 4) may bring more concussed players into the primary care physician's office for supervised treatment and gradual return to play.

Physicians should make sure athletes don't return to play while they are symptomatic, and they should be aware of risk factors that may predict prolonged recovery, said Dr. Riggert. These include having a learning disorder, a previous or recent concussion, being under 18 years of age, being female, and having a history of migraine, depression, or sleep disorders. **VS**

— Robyn Alie

STATE UPDATE

MMS Fighting Against Geography-Based Cuts in Medicare Payments

As the national spotlight focused on other aspects of federal health care reform this past year, a less-publicized but highly significant debate over Medicare funding based on geography was taking place. Depending on which side prevails, billions of dollars could be redirected away from urban patients, physicians, and hospitals to their rural counterparts.

The funding-shift proposal was fueled by the longstanding belief among rural physicians and hospitals that Medicare underpays them, leading to workforce shortages and access problems.

While the MMS has traditionally sympathized with that position, in a budget-neutral world, increased funding for rural areas means decreased funds and under-reimbursement for urban areas, which is how Medicare classifies Massachusetts.

Meanwhile, some published studies that compare regional health care cost and value depicted Massachusetts as a high-cost, low-

value state. Funding-shift proponents used that data as a rationale for misguided amendments to redirect dollars away from Massachusetts and several other states to rural areas.

At the core of our argument against such changes were two points:

- Data has consistently shown that practice costs (rent and wages) in urban areas are higher than in rural zones, which is why the Medicare formula, from its inception, has included a geographic adjustment.
- The national cost/value findings do not sufficiently account for socioeconomic status and urban versus rural disparities in health status.

With the support of the entire Massachusetts Congressional delegation, Reps. Michael Capuano and Richard Neal led the fight to prevent the redirecting of Medicare funds. As an influential member of the Senate Finance Committee, Sen. John Kerry made sure that any plan to allocate more Medicare money to rural states did not take money away from urban areas. As a result of these efforts, the Accountable Care Act passed in March protected our state from any geography-based funding shifts and mandated a number of studies into these issues.

In September, MMS President Alice Coombs, M.D., testified before an Institute of Medicine meeting of a commission studying geographic adjustments. She made three main points:

- Real practice expenses are dramatically higher in Massachusetts than the national average.
- Underfunding practice expenses will exacerbate physician shortages and impede patient access.
- Cutting Medicare reimbursements to urban providers will worsen access and outcomes for already underserved and vulnerable populations.

In a separate move this past summer, the Centers for Medicare and Medicaid Services (CMS) issued proposed rulemaking that would redirect billions of dollars away from Massachusetts and other states by changing geographic-variable calculations in the Medicare Economic Index. If this rule is finalized, all physicians in metro Boston would see a 6 percent reduction in Medicare payments, and all other Massachusetts physicians would experience a 3 percent cut.

Sen. Kerry and Rep. Capuano both took the lead in their respective chambers opposing this proposal. Rep. Capuano cosponsored a letter of opposition to Health and Human Services Secretary Kathleen Sebelius. Nearly 80 representatives signed the letter, including the entire Massachusetts House delegation. Sen. Kerry sponsored a similar letter opposing the proposal, which garnered significant Senate support, including Sen. Scott Brown's signature. **VS**

—Alex. Calcagno



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ACO Flexibility

continued from page 1

system to mature and develop to get the outcomes we know we can achieve is really what we need to be doing."

Dr. Coombs expressed concern over Dr. Bigby's mention of ACO oversight. "I am somewhat apprehensive about that," the MMS president said, adding that the makeup of any ACO oversight board would be critical. If such a board were to "have sway over how providers function in an ACO, it would have to include physicians as members," she said. Dr. Coombs continues to advocate strongly for physician participation on such panels.

Three ACO Models Envisioned

Acknowledging again that Massachusetts is made up of "markedly different communities across the state," Dr. Bigby said, "I don't share the assumption held by many people that hospitals are the building blocks of ACOs." She outlined three types of ACOs she would welcome.

The first model, she said, revolves around the patient-centered medical home concept to better support primary care delivery. "I believe that an ACO model could represent 5 or 6 or 15 or 20 patient-centered medical home practices that are geographically close to each

other and might want to work together to best serve a particular community. That ACO model could include a community hospital, or the practices might independently contract with a hospital and pay that hospital in whatever way the group of primary care providers wants to." Under this model, ACO leaders would decide whether or not to contract with other types of services such as home care or rehabilitation. They would also determine a process for working with specialists.

Dr. Bigby's second ACO model would put together groups of specialists, primary care physicians, and hospital services with other support services in one integrated system. ACO providers would decide if they collectively have sufficient knowledge, information, and infrastructure "not only to receive payments, but also to take on risk."

Finally, she envisions a larger, integrated system with not only primary care and specialty physicians, but also hospitals, including tertiary care hospitals. This comprehensive model would include skilled nursing facilities and rehabilitation centers. "Such a fully integrated system, if thoughtfully developed, would have the infrastructure and expertise to take on financial risk," Dr. Bigby said.

Physician Participation Essential

Dr. Bigby said she has spoken about this and other health care reform issues with physicians from around the state. "There is a lot of concern about the magnitude of this change and whether or not doctors will actually benefit from it," she acknowledged.

Dr. Coombs said that overall, Dr. Bigby's remarks demonstrate that "she has really gotten the message. She understands the plight of the physician trying to deliver good patient care, especially in an environment that can be coercive."

Dr. Bigby concluded with the key message she wants to deliver to Massachusetts physicians: "We can't make these changes without physicians being engaged, understanding, and helping us figure out how to do this."

She said that unlike other aspects of health care reform, "This is really about how we do health care delivery, how providers on the ground function. And there is no way we can reform the system without physician involvement in figuring out the best way to do it. My bottom line is that we want people to get the clinical care they need." **VS**

To read an edited transcript of the interview with Dr. Bigby, go to www.massmed.org/Bigbyinterview.

New MMS Benefit: Webster Bank Merchant Services

When your patients want to make copayments or pay off balances, debit or credit cards have become a convenient, often safer, method. The Society is pleased to announce a new arrangement with Webster Bank Merchant Services that will facilitate such transactions and help your practice operate efficiently while saving you time and money.

With a Webster Bank Merchant Services account, you can receive secure payments from every major credit card, as well as PIN-secured and signature-based debit transactions. Through Webster's check-conversion service, you can turn a paper check into an electronic purchase at the point of sale. The bank's secure transaction management moves the burden of protecting credit card data from the practice to Webster Bank Merchant Services.

Webster Bank is offering unique MMS member discounts on upfront and monthly fees ranging from 50 to 100 percent. In addition, MMS members are eligible for special introductory financial incentives.

To learn more about these special MMS member discounts, call a Webster Bank Merchant Services representative at (800) 298-4266, or visit www.websterbankmerchantservices.com/my-business/medical.php. **VS**

—Carolyn Maher

Annual MMS Oration Conflict Violence Against Women: Moral and Ethical Obligations of Physicians

**Friday, December 3,
2:00 to 3:00 p.m.**

MMS Headquarters, Waltham

This year's oration will document the extent of violence against women and how physicians can address the needs of women affected by violence.

The featured orator is Gloria White-Hammond, M.D., pediatrician and co-pastor at Bethel African Methodist Episcopal Church in Boston.

For more information and to register, go to www.massmed.org/interim2010. **VS**

PHYSICIAN HEALTH MATTERS

Massachusetts' Enhanced Prescription Drug Monitoring Program

In recent years, Massachusetts has made a concerted effort to stem the abuse of prescription drugs by enacting a prescription monitoring program (PMP). The program is intended to prevent potential abusers from "doctor shopping" to obtain multiple prescriptions from several prescribers who are unaware of the patient's other gambits.

Efforts in this regard began in 1992, but were significantly enhanced in 2008 when the Department of Public Health and the Board of Registration in Pharmacy promulgated regulations to allow prescribing physicians and pharmacies to receive information about a patient's prescription history. Initially, the PMP provided information only about prescriptions for Schedule II controlled substances such as Percocet and OxyContin, which are known for their high abuse potential.

In August of this year, state legislators unanimously approved

amendments to these regulations such that the PMP will also share information with providers about prescriptions written for medications in Schedules III, IV and V. In addition, reporting will now also be required for out-of-state (mail order) pharmacies that dispense medications to residents of the Commonwealth, eliminating the potential for those seeking substances to avoid detection by using remote distributors.

Other enhancements to the program include more frequent pharmacy data reporting (now weekly instead of monthly) and a requirement that customers obtaining medications in Schedules II through V show identification to the pharmacist.

Prescription drug abuse is a substantial problem in Massachusetts, with an estimated 9,000 individuals suspected of doctor shopping each year. In the past, obtaining multiple prescriptions

was relatively easy. Since prescribers had no means of knowing that a patient was obtaining medication from a number of sources, each would naively write a prescription that was legitimate on its face. Now, with the added information provided by the PMP, both the prescribing physicians and the dispensing pharmacists will be better equipped to evaluate the legitimacy of the patient's needs.

It's too early to tell whether a more robust PMP will be a deterrent to "curbside consults" or facilitate physician adherence to the prescribing parameters discussed in last month's Physician Health Matters column. But it will certainly assist physicians in identifying patients with possible substance-use problems. **VS**

For more information about the Massachusetts prescription monitoring program, go to www.mass.gov and enter "prescription monitoring program" in the search box.

CME Program to Highlight Hospital Visitation Rights for LGBT Families

Last spring, President Obama issued a memo directing the Department of Health and Human Services to develop new hospital visitation guidelines to help ensure respect for the families of lesbian, gay, bisexual, and transgender (LGBT) patients. This directive was inspired by the experiences of Janice Langbehn, who was denied access to her dying partner, Lisa Pond, in a Florida hospital.

Historically, hospital policies regarding critically ill and end-of-life patients have not recognized the lesbian and gay family members of the patient. In response, the MMS Committee on LGBT Matters developed a program to provide an overview of LGBT hospital visitation rights (see box). Attendees will gain a better understanding of the implications of the new guidelines and learn about the documents required for establishing a patient-visitor relationship. **VS**

Joint Commission Guidelines on Hospital Visitation Rights: Removing Barriers to Quality Health Care for LGBT Patients

**Thursday, December 2,
6:30 to 8:00 p.m.**

MMS Headquarters, Waltham

To register, call (800) 843-6356 or visit www.massmed.org/interim2010.

Pri-Med East Returns to Boston, November 18–21

Boston Convention and Exhibition Center

The MMS is a partnering organization for Pri-Med East, a comprehensive medical conference that provides extensive continuing medical education opportunities. Focused on diagnosis and treatment,

Pri-Med's core three-day program, *Current Clinical Issues in Primary Care*, is developed and presented by nationally recognized faculty from Harvard Medical School.

A large exhibit area will provide opportunities to review the

latest in pharmaceuticals, medical devices, and technologies. **VS**

For more information and to register, log on to www.pri-med.com/east.

Annual Meeting 2011: Format Changes Afoot

The format for the 2011 Annual Meeting will be different than it has been in recent years. To conserve resources and streamline processes, we're shifting to a shorter, more cost-effective format that uses both MMS headquarters in Waltham and the Seaport Hotel in Boston.

This year's Annual Meeting will still begin on a Thursday (May 19), but the opening session of the House of Delegates (HOD) and reference committee hearings will take place at MMS headquarters in Waltham.

Friday, May 20, will be devoted to the Annual Education Program and the Shattuck Lecture, also to be held at MMS headquarters. On Friday evening, the venue shifts to the Seaport Hotel for the awards and officer inauguration ceremony and dinner. This year, several awards that were presented at the ceremony in the past will be presented at other events.

The HOD will reconvene for its final session on Saturday morning at the Seaport and adjourn on Saturday afternoon, allowing delegates to spend

additional weekend time with their families. Splitting HOD activities between Thursday and Saturday will allow delegates to work in their practices on Friday if they choose not to attend the educational program. The split HOD session will also allow additional time for reference committees to prepare their reports and enable those who wish to return home Thursday night to do so.

Both delegates and the Society will realize cost savings as a result of lower hotel rates and parking fees in Waltham. Further significant cost savings arise from combining the officer inauguration with the awards ceremony and eliminating Saturday-night festivities. In accordance with MMS policy, delegates staying overnight at the Seaport Hotel may request reimbursement. The president may also authorize additional hotel nights as requested by delegates based upon travel time or extenuating circumstances. **VS**

For further details about the 2011 Annual Meeting format changes, go to www.massmed.org/2011format.

IN MEMORIAM

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

Diane M. DeBenedetto, M.D., 61; Northampton, MA; University of Massachusetts Medical School, 1975; died September 23, 2010. **Vijay V. Joshi, M.D.**, 74; Holyoke, MA; BJ Medical College, Pune, India, 1960; died September 23, 2010. **Robert P. Masland Jr., M.D.**, 89; Needham, MA; Columbia University College of Physicians and Surgeons, 1945; died March 27, 2010. **David W. Parsons, M.D.**, 86; West Lebanon, NH; Harvard Medical School, 1948; died August 5, 2010. **James P. Walsh, M.D.**, 80; Worcester, MA; Georgetown University School of Medicine, 1956; died July 17, 2010.

ACROSS THE COMMONWEALTH

District News and Events

Berkshire — Executive Committee Meeting. Tues., Nov. 16, 6:00 p.m. Location: Mazzeo's Ristorante, Pittsfield. For more information, contact the West Central Regional Office.

Charles River — Delegates Meeting. Thurs., Nov. 18, 6:00 p.m. Location: MMS headquarters, Waltham. **Caucus Meeting.** Sat., Dec. 4, 7:30 a.m. Location: Westin Hotel, Waltham. **Executive Committee Meeting.** Wed., Dec. 15, 6:00 p.m. Location: Hotel Indigo, Newton. For more information, contact the Northeast Regional Office.

Essex South/Essex North — Joint Delegates Meeting. Wed., Dec. 1, 6:00 p.m. For more information, contact the Northeast Regional Office.

Hampden — 16th Annual Medical Legal Forum. Rescheduled date: Thurs., Nov. 4, Registration 5:30 p.m., Dinner and meeting 6:00 p.m. Panel: Rep. Richard E. Neal and Alex. Calcagno, MMS director of federal relations. Topic: "Consequences of the New Health Care Law." **Caucus Meeting.** Tues., Nov. 23, 6:30 p.m. Location: HDMS, West Springfield. For more information, contact Suzanne Skibinski at (413) 736-0661 or hdms@massmed.org

Hampshire/Franklin — Social Event, UMass Basketball Game (vs Rhode Island). Sun., Jan. 30, 2011. Location: UMass, Amherst. For more information, contact the West Central Regional Office.

Middlesex — Executive Committee Meeting. Wed., Dec. 8, 12:00 p.m. Location: Winchester Country Club, Winchester. For more information, contact the Northeast Regional office.

Middlesex North — Vienna Boys Choir Event and Reception. Fri., Dec. 10, 5:30 p.m. Location: Lowell Memorial Auditorium, Lowell. For more information, contact the Northeast Regional Office.

Middlesex West — Delegates Meeting. Wed., Dec. 1, 6:00 p.m. Location: Framingham Union Hospital, Conference Room C, Framingham. For more information, contact the Northeast Regional Office.

Norfolk — Business Meeting. Wed., Oct. 27, 6:00 p.m. Location: Sheraton Hotel, Needham. Speaker: Susan Briggs, M.D., director of the MGH International Trauma and Disaster Institute. Topic: Disaster Medicine. For more information, contact the Northeast Regional Office.

Norfolk South — Holiday Event. Thurs., Dec. 9, 6:00 p.m. Location: The River Club, Scituate. The district will sponsor its Annual Toys for Tots Program, along with dinner and dancing. For more information, contact the Southeast Regional Office.

Southeast Caucus — Thurs., Nov. 19, 6:00 p.m. Location: Lebaron Hills Country Club, Lakeville. Delegates from Barnstable, Bristol North, Bristol South, Norfolk South, and Plymouth District Societies will meet and discuss the resolutions prior to the MMS HOD Interim Meeting. For more information, contact the Southeast Regional Office.

Suffolk — Delegates Meeting. Tues., Nov. 30, 6:00 p.m. Location: MGH Trustees Room, Boston. For more information, contact the Northeast Regional Office.

Worcester — Fall District Meeting. Wed., Nov. 10, 5:30 p.m. Location: Beechwood Hotel, Worcester. The dinner meeting includes the A. Jane Fitzpatrick Community Service Award, the WDMS Career Achievement Award, and scholarship award presentations. For more information, contact Joyce Cariglia at (508) 753-1579.

Statewide News and Events

Arts, History, Humanism, and Culture Member Interest Network — Wreath Workshop. Sat., Nov. 20, 10:00 a.m. to 12:00 p.m. Members are invited to attend this workshop for making and taking home their own wreaths. Materials will be supplied. For more information, contact the West Central Regional Office.

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

MMS Website Summarizes Candidates' Health Care Platforms



Gov. Deval Patrick



Tim Cahill



Jai Stein



Charlie Baker

Photos by Frank Fortin

Go to www.massmed.org/governor for short video interviews in which the four Massachusetts gubernatorial candidates explain their stances on health care.

INSIDE ▶

- ▶ Dr. Bigby on ACO Flexibility **Page 1**
- ▶ Legal Issues in Telemedicine **Page 3**
- ▶ Geographic Conflicts with Medicare Payment **Page 5**



MASSACHUSETTS
MEDICAL SOCIETY

VITALSIGNS

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MMS Sponsored and 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.

The Effects of Alcohol on Women

November 2, 8:00 a.m.–12:00 p.m. MMS headquarters, Waltham.
3.75 Credits

Breast Cancer in 2010: The Road toward Personalized Cancer Care

November 4, 5:30–8:30 p.m. MMS headquarters, Waltham.
1.5 Credits

Pregnancy and Addiction

November 18, 5:45–8:30 p.m. MMS headquarters, Waltham.
1.5 Credits

Managing Workplace Conflict

November 18, 8:00 a.m.–4:00 p.m. and November 19,
8:00 a.m.–3:00 p.m. MMS headquarters, Waltham.
12.5 Credits (RM)

MMS Interim Meeting Live CME Activities

All three events at MMS headquarters, Waltham.
Go to www.massmed.org/interim2010.

**Joint Commission Guidelines on Hospital Visitation Rights:
Removing Barriers to Quality Health Care for LGBT Patients**
December 2, 6:30–8:00 p.m. 1.25 Credits (RM)

Annual Oration — Conflict Violence against Women: Moral and Ethical Obligations of Physicians

December 3, 2:00–3:00 p.m.
1.0 Credit (RM)

Ethics Forum — End-of-Life Choices: Patient Autonomy, Palliative Care, and Death with Dignity

December 3, 3:30–5:30 p.m. 2.0 Credits (RM)

Online CME Activities — Go to www.massmed.org/cme.

Health and Wellness Courses

NEW Early Recognition of Dementia: A Phase Change in Primary Care
1.5 Credits (RM)

Pandemic Flu

2.0 Credits (RM)

The Legal Advisor Risk Management CME series.

Each course is 1.0 Credit (RM).

NEW Terminating the Doctor-Patient Relationship

Advance Directives

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.