VITAL SIGNS

Massachusetts Medical Society

Every physician matters, each patient counts.

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MMS Opens a New Chapter in GIC Advocacy

BY FRANK FORTIN

Three years after the MMS went to court to right the wrongs of the Group Insurance Commission's (GIC's) physician-tiering program, the Society's Board of Trustees and its physician co-plaintiffs have ended the lawsuit and moved into a new chapter in advocacy on physician tiering.

The action follows a ruling earlier this year by a state judge, who dismissed the GIC from the lawsuit. Judge Nancy Staffier Holtz ruled that the GIC has no direct commercial relationship with physicians. As a result, she stated, the Society could not bring a consumer protection violation claim against the GIC.

In voting to stop pursuing the case, the MMS trustees directed the Society to continue working to correct the tiering program by other means.

MMS Past President Bruce Auerbach, M.D., F.A.C.E.P., who led the Society's efforts on the litigation, said the tiering program still has "deep flaws," because it still rates the cost and quality records of individual physicians.

A study by RAND last year found that 22 percent of physicians were classified incorrectly by the GIC system. For some specialties, it was even worse. Fifty (50) percent of internists and 67 percent of cardiovascular surgeons who were rated as low-cost physicians actually had an average cost profile.

The GIC is the state agency that buys health insurance for 350,000 public employees in Massachusetts and their family members.

Dr. Auerbach said the Society will strive vigorously to fight to fix the tiering program's shortcomings. "We still have a lot of work to do," he said.

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How to Get There from Here: Conference Offers a Road Map to ACOs

BY VICKI RITTERBAND

Philip Gaziano, MD, has no trepidation about the arrival of the era of the accountable care organization (ACO). In fact, the new model — in all but name — is already firmly entrenched in the Springfield area, he said.

Dr. Gaziano, a practicing internist and geriatrician, is president of Accountable Care Associates (ACA), a medical service organization with more than 700 physicians in western Massachusetts. Its shared savings care model looks like an ACO and smells like one, with nurses keeping tabs on chronically ill patients, longer doctor appointments, patient phone and email reminders, an emphasis on preventive care, and an online data management system that keeps the whole thing purring.

Harold Miller: Small practices can be just as effective in ACOs as large practices.

"Our quality scores as well as our cost savings are tops in the state," said Dr. Gaziano, who is enrolled in one of the capitated plans himself. "The satisfaction levels of our members and their families, as well as the employers', are much higher than for our fee-for-service plans. Our physicians earn more money and seem more satisfied."

Creating the New Landscape

Noted ACO expert Harold Miller said doctors like Dr. Gaziano should lead the ACO charge. In the new landscape, hospitals will shrink as chronic disease is better managed, and regional health improvement collaboratives will coordinate the multiple moving parts needed to create these new entities, according to Miller.

Miller, executive director of the Center for Healthcare Quality and Payment Reform, was one of five speakers at the Society's recent educational conference "A Path to Accountable Care Organizations: How Do We Get There from Here?"

While some physicians fear that ACOs will lead to greater market consolidation, doctors do not have to give up their independence to embrace this new care model, according to Miller. "There are examples of small physician practices, working through IPAs, that are every bit as effective as being in large group practices," he said.

In an ACO world in which savings are shared, payers and providers will earn more thanks to fewer emergency room visits, adverse events, and readmissions, Miller said. Even if physician practices have to employ additional nurses to help with care coordination, they should still see significant increases in their net earnings. Health plans should give primary care providers up-front money to pay for these changes, and physicians must be given extra time for diagnosis, treatment planning, and follow up. However, if cost savings aren't realized, doctors should pay a penalty, said Miller.

Miller pointed to other ways to reduce unnecessary utilization and deliver better care, such as telemonitoring and greater use of specialist care for patients with chronic diseases, as a way to reduce hospitalizations. And specialists should get paid for this expanded role in care coordination, he added.

"We've had a taste of things like ACOs already with certain capitated plans, but it's been a small percentage of our patients," said John Dickason, MD, a Billerica internist who attended the program. "The conference highlighted that there are a lot of things that still haven't been defined, like how the shared savings will be divided."

Navigating Antitrust Compliance

While these increasingly collaborative arrangements may be a boon to patient care and providers' bottom lines, how do they avoid running afoul of antitrust laws? Patricia Wagner, JD, an attorney with Epstein Becker Green, said antitrust agencies have typically looked favorably on ventures in clinical integration when improved quality depends on joint pricing and certain other conditions have been met, including those that follow:

- Development of clinical protocols, standards, and performance monitoring
- Implementation of specific case and disease management programs

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PRESIDENT'S MESSAGE

Talking Business

It's traditional for MMS presidents to speak at our districts, specialty societies, hospitals, and medical staffs many times throughout the year.

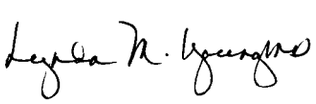
But sometimes it helps to go outside the health care community to see the broader picture.

Recently I spoke to an entirely different group of people: the subscribers of the *Boston Business Journal*. It was a breakfast symposium with co-speakers Lora Pellegrini of the Massachusetts Association of Health Plans and Rick Lord of Associated Industries of Massachusetts, a very influential trade association. We spoke about what employers should know about the changing health care system.

Business owners can be important partners in building a better health care system. They deserve lots of credit for supporting our health care system. They support their employees' health care far more generously than is common nationwide. They have been full partners in expanding access to care and improving affordability while preserving quality and access.

As the article on page 5 shows, physicians are effective advocates for our patients. With outside partners, we can be even more effective. The business community has already come up with many creative approaches to our problems, and they keep pushing for solutions. They're also willing partners on such issues as medical liability reform and administrative simplification. But they also insist that physicians join them in the effort to make health care more affordable. For the sake of our patients, we accept that challenge.

We have already learned a lot from each other, and we can learn a lot more. Let's keep this dialogue going.



– Lynda M. Young, M.D.

The ACO Road Map
continued from page 1

- Development of an integrated computer system to disseminate practice standards and enable communication among physicians caring for the same patients

A proposed statement issued in April by the Federal Trade Commission and the Department of Justice gave additional guidance about market share and provider exclusivity issues, with one underlying goal being to encourage ACO diversity, according to Wagner. "The Department of Justice and the Federal Trade Commission wanted to make sure that the dominating systems didn't lock up the independent doctors," she said. "They didn't want physicians to feel that if they didn't get into an ACO, they would be out in the cold. They wanted to ensure lots of different collaboratives [and] lots of different permutations on the theme."

Cutting Costs through Better Management and Reporting

Once the antitrust issues are addressed, it's time for the ACO to roll up its sleeves and get to work saving money. Conference speaker Susan Pantely, a principal and consulting actuary with Milliman, Inc., said ACOs should focus first on reducing "leakage" to hospitals and specialists who are not part of their organization as a way to better control costs and care for the patients they are responsible for.

Inpatient costs should be the first utilization target since they account for between 30 and 37 percent of total costs for commercially insured and Medicare patients, respectively. Providers should then focus on high-tech imaging, emergency room and specialist visits, and prescribing generic drugs.

"In most deals I see, utilization has to be reduced by 5 to 10 percent per member per month, which translates into a greater than 10 percent reduction in utilization of services because of the need to cover the cost of infrastructure," said Pantely. She also stressed the importance of regular reporting of utilization, cost, and quality data to make sure the ACO is on target for achieving its goals.

Conference attendee Stephen Heacox, MD, a Wareham orthopedic surgeon, worries that making the system work will require a whole new layer of bureaucracy. "We'll have to have our own cadre of managers and actuaries and quality care evaluation people, and that will add a lot more expense," said Dr. Heacox.

Adjusting for Risk, Acquiring the Right Technology Tools

Despite an ACO's best efforts at improving care management, severity of illness will always play a role in outcomes, which is where risk adjustment comes in. Error-free coding is one important way to ensure accurate risk adjustment and fair compensation under a global payment system, according to conference presenter Rong Yi, PhD, a senior consultant with Milliman.

While risk adjustment and the technology that enables it fall under the purview of payers, providers will need a variety of technology tools to guarantee their ACO's success, according to Marilyn Lamar, another speaker at the conference and an attorney with Liss & Lamar. Physicians will need electronic medical records as well as tools that provide clinical decision support, monitor patient compliance, and analyze outcomes data, among others. Additionally, patient tools must be user-friendly to encourage engagement and better data, said Lamar.

Dr. Heacox said he left the conference feeling that there's a lot more to learn. "There are no real rules or guidelines at this point," said Dr. Heacox. "While the mission is laudable in terms of becoming a more efficient health care system, the pathway remains somewhere in the clouds." VS

A New Chapter in GIC Advocacy
continued from page 1

Dr. Auerbach also said that despite the outcome of the litigation, it did bear some fruit.

He noted that health plans across the country have generally not adopted the GIC's practice of rating individual physicians. "It's far more common for physicians to be rated as part of their practice or group, where the data and ratings are much more reliable," he said.

"This is not the end of our efforts on tiering, but the beginning of a new chapter," Dr. Auerbach said. He also thanked the five physicians who agreed to be plaintiffs in the case. "They performed a great service to the profession and to the patients of Massachusetts," he said. VS

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

PRESIDENT: Lynda M. Young, M.D.
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Vital Signs is published monthly, with combined issues for June/July/August and December/January, by the Massachusetts Medical Society, 860 Winter Street, Waltham, MA 02451-1411. Circulation: controlled to MMS members. Address changes to MMS Dept. of Membership Services. Editorial correspondence to MMS Dept. of Communications. Telephone: (781) 434-7110; toll-free outside Massachusetts: (800) 322-2303; fax: (781) 642-0976; email: vitalsigns@mms.org.

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Emerging Health Tracking Applications: An Opportunity for Patient Engagement

We may be one step closer to answering the age-old question of how to enhance patient involvement and compliance with medical care.

The large-scale adoption of mobile technologies in the form of smartphones and tablet computers has sparked the development of mobile applications (commonly known as "apps") designed to enhance patient connectivity with health information and promote active health management around specific highly prevalent diseases and conditions.

A recent *New York Times* article cited emerging technologies such as a Wi-Fi enabled blood pressure cuff that a patient can use to take blood pressure and pulse readings, as well as connect to an iPhone, which synchronizes the data with records that are tracked online.

The data can be securely stored and updated as part of an online personal health record (PHR), many of which allow patients to share the information through a secure connection with their physicians.

Similarly, there are multiple applications currently in development for diabetic support, including a device that can measure blood glucose levels and, based on the reading, provide the user with advice on what to eat. Additionally, the app tracks blood glucose levels over time and can provide valuable feedback to the physician by monitoring changes in the patient's condition.

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Mobile technology is taking public health initiatives to the next level by encouraging individuals to become more actively engaged in managing their health. The American Diabetes Association, the Centers for Disease Control, the Health Resources and Service Administration, and innovative companies that develop mobile technology are teaming up to implement a highly visible public campaign that will focus on a new diabetes management initiative.

The goal is to use text messaging-based health risk assessments to focus on those individuals who may benefit from additional resources and health guidance.

While these applications may be classified as emerging, physician practices may begin seeing early adopter patients who come to the office with more knowledge about their conditions than they have in the past.

Physicians will have to consider how this data should be used in the clinical care of patients, the level of information they want patients to share, and how to converse with patients around this type of information. Regardless of the approach, the age of information technology will continue to provide endless opportunities for patient engagement well into the future. VS

– Kerry Ann Hayon

Gearing Up for ICD-10: The Importance of Testing Transactions in the New Version 5010 Format

The transition to ICD-10 will require system-wide changes in order to accommodate for the newly expanded code set.

While the compliance deadline may seem distant (October 1, 2013), practices should take the proper steps now to ensure a smooth transition.

Important steps include upgrading your system from the current Version 4010 to the new Version 5010 electronic transaction format and testing transactions in the new format.

On January 1, 2012, all health care providers that are covered entities under the Health Insurance Portability and Accountability Act (HIPAA) will be required to comply with Version 5010. As such, any electronic transaction that does not comply with the new Version 5010 (which recognizes ICD-10 codes) will be rejected after January 1. The switch to the 5010 platform is a necessary first step toward the ICD-10 conversion.

Once you are certain that you or your contracted billing provider has converted to the new HIPAA standard, it will be necessary to test transactions using the new version. Conducting internal testing will ensure that you are able to send and receive compliant transactions effectively.

Additionally, it will help you identify and address potential issues that may arise in advance of testing with external business partners. Taking these first steps toward ICD-10 compliance will best position you and your practice for future success.

To learn more about ICD-10, please visit **www.massmed.org/icd10**. VS

– Talia Goldsmith

LAW AND ETHICS

Credentialing for Telemedicine

In the November 2010 Law and Ethics column of *Vital Signs*, we highlighted a number of legal issues surrounding the practice of telemedicine.

Since then, one issue has been resolved: for the purpose of meeting Conditions of Participation (CoP) for Medicaid and Medicare, hospitals may, in some circumstances, rely upon the privileging and credentialing process of the facility where the physician is located (the "distant site").

If the distant site is a Medicare-certified hospital, there must be a written agreement between the hospital and the distant site stating that:

- The distant site is a Medicare-participating hospital
- The physician has privileges at the distant site
- The physician has a license recognized in the state in which the receiving hospital is located
- The receiving hospital reviews the physician's performance and reports adverse events and complaints to the distant site

If the distant site is not a Medicare-certified hospital, then the hospital and distant site must have a written agreement stating that the distant site provides services so as to meet certain regulatory credentialing requirements and applicable CoPs for the service being provided.

Even though the issue of hospital credentialing for telemedicine has been resolved, the issue of licensure for such practice has not. Thus, a Massachusetts physician contemplating practicing telemedicine should be familiar with the regulations of the state in which the patient is located and take care when seeking input from an out-of-state physician, as BRM regulations prohibit a physician from aiding an unlicensed individual to perform actions for which a license is required. VS

– Liz Rover Bailey, Esq.

The "Law and Ethics" column is provided for education purposes and should not be constituted as legal advice. Readers with specific legal questions should consult with a private attorney.

MMS Launches 17th Annual Anti-Tobacco Poster Contest

The MMS and MMS Alliance will mail Anti-Tobacco Poster Contest kits in early November to elementary schools, pediatricians, and family physicians throughout Massachusetts, coinciding with the Great American Smoke-out on November 17.

Now in its seventeenth year, the poster contest is open to children in grades one through six. Participation encourages children to avoid tobacco and to carry the anti-tobacco message to their friends and families.

In addition to information about how to participate in the contest, the contest kit includes a 2012 calendar featuring the 12 winning entries from last year's poster competition.

Entries must be received by February 10, 2012, and will be judged on originality, creativity, and adherence to the contest's themes. Children submitting the 12 winning posters will each 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.

For more information about the contest or to order 2012 Anti-Tobacco Poster Contest calendars, contact dph@mms.org or (800) 322-2303 ext. 7373. VS

MMS Joins Healthy Air Campaign

The MMS has joined a coalition of dozens of health organizations to fight efforts in Congress that would weaken emissions standards.

The Massachusetts Healthy Air Coalition includes the American Cancer Society, the Massachusetts Chapter of the American Academy of Pediatrics, the Massachusetts League of Community Health Centers, and the Massachusetts Public Health Council. This coalition, spearheaded by the American Lung Association of Massachusetts, is concerned about the impact that weakened emissions rules would have on the health of Massachusetts citizens.

"Spikes in pollution threaten the health and welfare of nearly every Bay State resident," said Megan Sandel, M.D., associate professor of pediatrics and public health at the Boston University Schools of Medicine and Public Health. "Reducing air quality protections is bad medicine."

The standards under attack regulate the power plant emissions of mercury and air toxins and health standards for ozone and particulate air pollution.

"Every dollar we spend on reducing emissions will result in a $30 reduction in health care costs by 2020," said Jonathan Levy, Ph.D., professor of environmental health at the Boston University School of Public Health.

Ozone pollution reacts in the pulmonary airways causing symptoms of chest pain, shortness of breath, cough, wheeze, increased susceptibility to infection, declines in lung function, increases in asthma attacks, increases in asthma medication use, and increased rates of emergency room visits for respiratory disease.

Those particularly vulnerable include children and teens, anyone 65 and older, people who work or exercise outdoors, people with existing lung diseases such as asthma and COPD, and otherwise healthy persons who for some reason react more strongly to ozone.

Nine Massachusetts counties received failing grades and two received D's for ozone levels in the American Lung Association "State of the Air 2011" report, which ranks the metropolitan areas based on ozone and particle pollution during 2007, 2008, and 2009.

Massachusetts Report Card for High Ozone Days (American Lung Association of Massachusetts)

County	Grade	Weighted Average
Barnstable	F	5.8
Berkshire	F	5.2
Bristol	D	2.7
Dukes	F	4.0
Essex	F	8.7
Hampden	F	10.0
Hampshire	F	10.0
Middlesex	F	5.7
Norfolk	F	7.0
Plymouth	DNC*	DNC*
Suffolk	D	3.0
Worcester	F	11.0

**No Data Collected*
Source: www.stateoftheair.org

Particulate air pollution is associated with increased cardiopulmonary symptoms, asthma attacks, days lost from work due to respiratory disease, ER visits, hospitalization rates, and mortality. Mercury pollution is associated with neurodevelopmental toxicity in children. VS

– Robyn Alie

MMS Advises Awareness of Gambling-Related Health Issues

Legislation authorizing three casinos and a slots-only gambling parlor, which the Massachusetts Legislature was still debating at press time, proposed to allocate millions of dollars to prevent, treat, and conduct research on gambling addiction.

In policies adopted in 2007, 2008, and 2010, the MMS has recognized the public health consequences of gambling and has recommended that revenues be dedicated, at adequate funding levels, for the treatment of public health problems that may be aggravated by the presence of casino gambling.

According to the Massachusetts Council on Compulsive Gambling (MCCG), based on national estimates and U.S. Census data, between 85,000 and 185,000 Massachusetts residents have experienced gambling problems during their lifetimes.

Negative consequences associated with gambling include family dysfunction and domestic violence, suicide and suicidal ideation, and significant financial problems directly resulting from gambling, prostitution, theft, drug trafficking, and homicide.

Like substance abuse, problem gambling involves a preoccupation with the activity, intense cravings, usage to medicate uncomfortable feelings, increased tolerance, continued usage despite negative consequences, and significant withdrawal symptoms. Problem gambling, however, doesn't have the visible signs, such as impaired motor skills, that are seen in substance abuse, making it harder to identify.

A 2008 national telephone survey on problem gambling and other disorders found that 75 percent of all pathological gamblers have had problems with alcohol, and 38 percent have had problems with other drugs. They are also much more likely to have mental health issues. Fifty (50) percent have had a mood disorder, 41 percent have had an anxiety disorder, and 61 percent have had a personality disorder in their lifetime.

The MCCG's 24-hour help line, (800) 426-1234, provides information and referrals for people with problem gambling and their families. More information, including trainings for clinicians to improve skills in clinical interventions, addiction treatment, and case management for people experiencing gambling disorders, is available through the MCCG website, **www.masscompulsivegambling.org**. VS

STATE UPDATE

MMS Makes a Difference on HIV Legislation — Thanks to Physician Advocacy

The value of physicians' direct involvement in legislative advocacy was highlighted recently by a coalition effort to oppose legislation that would change state law about HIV testing and treatment.

The legislation, "An Act to Increase Routine Screening for HIV," was touted in a public hearing as consensus language to promote routine screening. The bill was reported out favorably this spring with some amendments by the Joint Committee on Public Health and the Joint Committee on Health Care Financing, over the objections of the MMS — the sole initial opponent.

The bill would dictate the frequency and counseling requirements of testing, expand privacy standards from HIV testing to all HIV- and AIDS-related information, and prohibit the release of any information related to HIV testing or treatment without specific written informed consent of the patient for each release. Amendments did allow the sharing of information within a facility, which is a tremendous improvement but does not address care of the vast majority of HIV outpatients.

As practicing infectious-disease physicians learned details of the legislation and its progress toward enactment, a coalition of health care organizations and individual physicians who care for HIV and AIDS patients arose to oppose it.

Leaders of Fenway Health, the Massachusetts Hospital Association, the MMS, the Massachusetts Infectious Disease Society, and 120 physicians joined together in drafting and signing the letter, which said the 2 bills would be "directly harmful to those it seeks to protect — the patients of the Commonwealth."

"The proposed legislation," the letter states, "would close the clinical record to all related information and make comprehensive quality care for people living with HIV difficult if not impossible. A simple bill facilitating routine HIV testing with removal of written consent, so that people living with HIV can access life-saving treatment, is all that is needed."

The letter was sent to House and Senate leaders, Health and Human Services Secretary Judy-Ann Bigby, M.D., and Public Health Commissioner John Auerbach.

Shortly afterwards, the *Boston Globe* editorialized against the bill, saying there is "no need for special rules" about HIV testing. At press time, the legislation in its current form did not appear to have momentum for passage in the Senate.

The MMS is diligent in its efforts to monitor and track health care legislative and regulatory developments, and to help ensure the best outcome for our physician members and their patients. Frequent emails, mailings, and newsletters help keep our members current on issues important to them. But knowing what's happening is only one piece of the puzzle — physicians are the most important piece.

State legislators need to hear from their physician constituents. Until she heard our comments, Sen. Jehlen believed that she was supporting consensus legislation designed to simplify and improve HIV testing — a noble goal. Communication is critical to lawmakers' ability to understand the practice of medicine and the challenges you, as physicians, face daily.

As the HIV issue demonstrates, legislators who have regular contact with their physician constituents are better informed to make better health care policy decisions. VS

FEDERAL UPDATE

MMS, AMA Target SGR Repeal in Debt Talks

Physician advocates are again marshaling their forces to repeal the Medicare physician payment formula, hoping that Congress's deficit reduction debate will provide a new opportunity to make progress on an issue that has resisted resolution for a decade.

In September, MMS President Lynda M. Young, M.D., urged the Massachusetts congressional delegation to repeal the sustainable growth rate (SGR) formula within any deficit reduction package.

"Your advocacy to support the viability of physicians' practices and Medicare beneficiaries' access to care has been extremely important to our combined constituencies," Dr. Young wrote. "We believe the deficit reduction package provides the only viable opportunity to permanently solve this formidable and daunting problem."

Several members of the Massachusetts delegation will have a strong voice during the deliberations of the Joint Select Committee on Deficit Reduction. Sen. John Kerry is one of just twelve members of the so-called "super committee," while Rep. Richard Neal sits on the Ways and Means Committee, and Rep. Edward Markey is a senior member of the Energy and Commerce Committee. These committees exert a strong influence over federal spending priorities.

Dr. Young said repealing the SGR is consistent with budgeting the cost of Medicare honestly and containing long-term spending. She said that each year Congress defers action on the formula, the Medicare deficit increases. In 2005, the SGR could have been repealed for less than $50 billion. Today that number stands at just under $300 billion, and by 2016 the cost will grow to $600 billion, according to the AMA.

Dr. Young also said that Medicare cuts will exacerbate workforce shortages and impede access to care in Massachusetts. The most recent MMS workforce study (see *Vital Signs*, October 2011) reported that 8 of the 18 specialties that were studied met the criteria for severe labor market conditions.

A major cause for this is that Medicare physicians' payments have increased minimally over the past 10 years, while the cost of practicing medicine in Massachusetts has increased more than 30 percent.

Dr. Young concluded that deficit reduction should be undertaken with strategic and purposeful action rather than across the board cuts, since they would inflict disproportionate harm on Massachusetts. She also called on the delegation to include medical liability reforms in its deliberations.

At the same time Dr. Young was writing the delegation, the 20 district society presidents were individually writing members of the congressional delegation who represent the cities and towns within their districts. The district presidents also provided specific information about patient access to care within their respective counties, and the potential impact on that access if Congress fails to fix the SGR. Likewise, specialty society presidents in Massachusetts sent a joint letter to the delegation that urged the delegation to repeal the payment formula during debt-ceiling deliberations.

The MMS continues to undertake organizational and grassroots activities to drive home the need to fix the SGR before the impending 30 percent cut in Medicare physician fees that is scheduled to take place on January 1, 2012.

Watch for additional news and activities concerning the SGR and debt-ceiling talks in the email newsletter *Vital Signs This Week* and in MMS legislative email alerts. VS

Ethics Forum to Address Social Media

The 2011 MMS Interim Meeting will be held on Friday, December 2, at the MMS headquarters and Saturday, December 3, at the Westin Hotel in Waltham.

In addition to many informative business meetings and events, the Interim Meeting will feature the following presentations and programs:

Special Order of Business: "Current Issues in Massachusetts Medicine" Peter Paige, M.D., chair, Massachusetts BRM
Friday, December 2 (House of Delegates First Session begins at 9:00 a.m.)

Annual Oration: "Back to Basics — Improving Patient Outcomes by Improving the Patient/Physician Relationship" Sean Palfrey, M.D., F.A.A.P., professor of clinical pediatrics and public health, Boston University
Friday, December 2, 2:00 p.m.

Ethics Forum: "Social Media and Medicine: The Impact on Your Patients, Your Practice, and You" Arthur R. Derse, M.D., J.D., director of the Center for Bioethics and Medical Humanities at the Medical College of Wisconsin, and Kevin Pho, M.D., physician blogger and nationally recognized health care opinion-maker
Friday, December 2, 3:30 p.m. VS

For full details on these events and speakers, the complete Interim Meeting schedule, and online registration, visit **www.mms.org/interim2011.**

7th Annual Women's Cardiac Health Conference

Medical Management of Heart Disease

February 3, 2012
8:00 a.m. to 12:15 p.m.
MMS Headquarters, Waltham

For more information, go to **www.massmed.org/WCH2012**.
To register, call (781) 737-7413.

Go Red for women

PHYSICIAN HEALTH MATTERS

For Physicians in Retirement, Flexibility Is Essential

Physicians work extremely hard. They focus first on getting into medical school and then endure years of various training levels, moving on to the joy and stress of actively practicing medicine. For many physicians, the work fulfills a lifelong dream, and they get to do "what they wanted to when they grew up."

And then, assuming all goes well, one day it ends with retirement. This is an enormous change that, like most of life's issues, affects people differently. There can be relief, sadness, loss, anxiety, or happiness. It's usually a mixture of all of these. Simply the feeling of no longer interacting with the world as a doctor is a major change.

While there are administrative requirements for retirement such as notifying patients, notifying the Board of Registration in Medicine, making provisions for handling medical records, and transferring business, it's also critical to deal with the various feelings that arise.

The issue of "What now?" becomes paramount. Friends and patients may ask "What are you going to do?" Some people have an easy answer: write that book, take up sailing and go around the world, go do something for disadvantaged people, and so forth. For others, it will take time to decide what does and does not feel good, worthwhile, or fun.

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Most physicians have many things they've never had time to do before. Retirement is a chance to try new things — classes, art, sports, and/or volunteer work — Some people will continue to stay involved in medicine — serve on committees, teach, attend continuing medical education courses. For others, it is a time to look in new directions. There is no right way to do retirement and no protocol to follow, so flexibility is essential.

It may seem appealing to have time that is one's own to do with as you please. Certainly, sitting home with or without a spouse and doing nothing endlessly is a poor idea. For some doctors it may help to retire partially and start developing other interests before completely leaving medicine.

It's not easy to give up medicine. Being a physician is an enormous part of one's identity. Retirement is a time to be creative, reinvent oneself, and discover that there is a lot of life to live without practicing medicine.

If you are considering retirement and would like assistance with the transition, please feel free to contact Physician Health Services, Inc., at (781) 434-7404 for consultation on coaching and other options. The MMS has compiled a checklist to help sort through some of the issues that a retiring physician must face — please visit **www.massmed.org/physicians** and go to the Practice Management section. Also, consider serving on one of the Massachusetts Medical Society's committees or task forces. The AMA also offers resources to assist in closing a practice. VS

– Judith Eaton, M.D.
Associate Director Emeritus, Physician Health Services, Inc.

New Organization Joins the Ranks of Specialty Societies

The Massachusetts Chapter of the American Medical Directors Association (MAMDA) recently engaged the MMS for management services through MMS Specialty Management Services.

The MMS welcomes MAMDA as the newest organization to join the many associations that contract with the Society for management services. MAMDA is a professional association of medical directors, attending physicians, and others who practice in the long-term care continuum.

Specialty Management Services was established by the MMS in 1991, beginning with the Massachusetts Chapter of the American Academy of Pediatrics. It has continued to add organizations to its ranks over the years, including 3 regional New England associations, to bring the total to the 13 it currently serves. The regional associations are also accredited by the MMS to provide continuing medical education for their organizations.

The management services we provide include member recruitment and retention administration, assistance with the development and implementation of CME, building industry support, executive committee meeting oversight, and acting as the coordinators of medical education for accredited organizations. VS

For more information regarding specialty management, please contact Ginny DuLong at vdulong@mms.org, or (781) 434-7313.

Recruit Your Colleague Campaign

The most effective form of membership recruitment is peer to peer, and we've made it easy with the MMS Recruit Your Colleague Campaign. The campaign is simple — share the benefits of membership with your colleagues, invite them to join the Society, and direct them to **www.massmed.org/join**.

By participating in the Recruit Your Colleague Campaign, you can support the Society's advocacy efforts by building a greater voice, help ensure the continued growth of the MMS, earn rewards, and receive the recognition of your peers at the MMS Annual Meeting.

For 2012, we've simplified the Recruit Your Colleague Campaign. When you recruit a physician, you will receive a $100 reward. Recruit a group of five or more physicians and you will receive a $250 reward. Enjoy the reward yourself, share it with your staff, or we'll donate it to the MMS Alliance Charitable Foundation in your name. VS

To find out how you can help give the MMS a greater voice, contact our Member Information Center at info@massmed.org or (800) 322-2303, ext. 7311.

ACROSS THE COMMONWEALTH

District News and Events

Bristol South — **Fall Meeting.** Wed., Nov. 2, 6:00 p.m. Speaker: Lynda M. Young, M.D., MMS president. Location: Fall River Country Club. For more information, contact the Southeast Regional Office.

Charles River — **Delegates Meeting.** Wed., Nov. 16, 6:00 p.m. Location: MMS headquarters. For more information, contact the Northeast Regional Office.

Essex South/Essex North — **Joint Delegates Meeting.** Wed., Nov. 30, 6:00 p.m. Location: Beverly Depot. For more information, contact the Northeast Regional Office.

Hampshire/Franklin — **Fall Meeting.** Tues., Nov. 8, 6:00 p.m. Location: The Blue Heron, Sunderland. Speaker: Lynda M. Young, M.D. Title: "Charting the Course." For more information, contact the West Central Regional Office.

Hampden — **MMS Interim Delegate Caucus Meeting.** Tues., Nov. 29, 6:00 p.m. Location: HDMS, 1111 Elm St., Suite 22, W. Springfield. **Winter District Meeting.** Topic: Medical Legal Forum — Medical Legal Ramifications of EMR. Tues., Jan. 24. Max's Tavern, Basketball Hall of Fame, 1000 W. Columbus Blvd., Springfield. Registration: 6:00–6:30 p.m. Dinner: 6:30 p.m. Program: 7:00 p.m. Members: Free. Nonmembers: $37.50. For more information, please contact Suzanne Skibinski, executive director, at (413) 736-0661 or hdms@massmed.org.

Middlesex Central — **Holiday Party.** Sun., Dec. 4, 4:00 p.m. Location: Concord Country Club, Concord. For more information, contact Carol Marshall at cmarshall@emersonhosp.org.

Middlesex North – **Willie Nelson Concert.** Location: Lowell Memorial Auditorium, Tues., Nov. 1. Reception at 5:30 p.m., concert at 8:00 p.m. **Fall Meeting.** Wed., Nov. 29, 5:45 p.m. Location: Stonehedge Inn and Spa, Tyngsboro. Speaker: Rep. Steven Walsh. For more information, contact the Northeast Regional Office.

Middlesex West District — **Delegates Meeting.** Resolution Review. Tues., Nov. 29, 6:00 p.m. Location: MacPherson Hall, Framingham Union Hospital. For more information, contact the Northeast Regional Office.

Norfolk – **Delegates Meeting.** Thurs., Nov. 17, 6:00 p.m. Location: MMS headquarters. For more information, contact the Northeast Regional Office.

Norfolk South — **Women's Program.** Mon., Nov. 7, 6:00 p.m. Location: Abby Park, Milton. For more information, contact the Southeast Regional Office.

Southeast Caucus — Tues., Nov. 15. 6:00 p.m. Buffet dinner, followed by meeting. Location: LeBaron Hills Country Club, Lakeville. Review and discuss resolutions prior to the Interim Meeting of the House of Delegates. For more information, contact the Southeast Regional Office.

Suffolk District — **Delegates Meeting.** Resolution Review, Thurs., Nov. 17, 6:00 p.m. Location: East Garden Room, MGH. For more information, contact the Northeast Regional Office.

Worcester District — **The National Acrobats of the People's Republic of China.** Fri., Nov. 4. Reception: 7:00 p.m. Program: 8:00 p.m. Location: Mechanics Hall. **Fall Meeting.** Wed., Nov. 9, 5:30 p.m., Beechwood Hotel. 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 wdms@massmed.org, or visit **www.wdms.org**.

Worcester North — **Fall Meeting.** Thurs., Nov. 3, 6:00 p.m. Location: The Fay Club, Fitchburg. Speaker: Alex B. Calcagno, M.D. For more information, contact West Central Regional Office.

Statewide News and Events

Arts, History, Humanism, and Culture Member Interest Network — **Wreath Workshop.** Sat., Nov. 19, 12:00–2:00 p.m. Location: MMS headquarters, Waltham. **Birding Rehab.** Sat., Nov. 19, 10:00 a.m.–12:30 p.m. Location: Bernice Barbour Wildlife Clinic at Tufts University, Cummings School of Veterinary Medicine, North Grafton. **Executive Committee Meeting.** Wed., Nov. 30, 6:00 p.m. Location: Worcester Medical Society District Office. 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.

2012 *Member Benefits Guide*

The 2012 MMS *Member Benefits Guide* is now available and will be mailed to you, along with your membership card, as you renew your membership for 2012. First-time members will receive a copy of the guide along with their welcome packets.

The guide is your ultimate resource for learning about the publications, CME programs, practice management resources, and member discounts that are available to you. It's also your guide for discovering new ways you can become more involved with the Society. The 2012 guide has easy-to-spot contact information — websites, phone numbers, and emails — to direct you to the best place for more information about benefits. An interactive version of the guide can also be found at **www.massmed.org/benefits_guide**.

Renew for 2012, and watch your mailbox for your wallet card and 2012 *Member Benefits Guide*. If you have any questions about your benefits, contact the Member Information Center at (800) 322-2302, ext. 7311, or email info@massmed.org. VS

– Carolyn Maher

IN MEMORIAM

The following deaths of MMS members were reported to the Society in September 2011. We also note member deaths on the MMS website at **www.massmed.org/memoriam**.

Harry E. Ford III, M.D., 66; Boston, MA; Howard University College of Medicine, Washington, D.C., 1978; died May 23, 2011.

Robert A. Friberg, M.D., 96; West Yarmouth, MA; Middlesex University School of Medicine, Waltham, MA, 1938; died January 1, 2009.

James G. Manson, M.D., 78; Cambridge, MA; Cambridge University Medical School, Cambridge, England, 1957; died December 23, 2009.

Frederick P. Murphy, M.D., 70; Ellicott City, MD; State University of New York, Syracuse, NY, 1966; died August 1, 2011.

Addressing the Business Community

Left to right: MMS President Lynda M. Young, M.D., Lora Pellegrini, president of the Massachusetts Association of Health Plans, and Rick Lord, president of Associated Industries of Massachusetts, address a breakfast symposium on health care for the business community sponsored by the *Boston Business Journal*. For more, see page 2.

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Massachusetts Medical Society

VITAL SIGNS

VOLUME 16, ISSUE 9, NOVEMBER 2011

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Go to **www.massmed.org/cme/events**. Unless otherwise noted, event location is MMS headquarters, Waltham.

Implementation of Clinician Support Programs Following Adverse Events
Jointly Sponsored with Medically Induced Trauma Support Services. **Tues., Nov. 1**, 1:00–4:30 p.m.

Managing Workplace Conflict — Improving Personal Effectiveness
Jointly Sponsored by the MMS and Physician Health Services, Inc. **Thurs., Nov. 17**, 8:00 a.m.–4:00 p.m., and **Fri., Nov. 18**, 8:00 a.m.–3:00 p.m.

2011 Annual Directors of Medical Education Conference — CME: Driving Performance and Quality Improvement Initiatives
Fri., Nov. 18, 8:00 a.m.–2:30 p.m.

Annual Oration at the MMS Interim Meeting — Back to Basics: Improving Patient Outcomes by Improving the Patient/Physician Relationship
Fri., Dec. 2, 2:00–3:00 p.m.

Ethics Forum at the MMS Interim Meeting — Social Media and Medicine: The Impact on Your Patients, Your Practice, and You
Fri., Dec. 2, 3:30–5:30 p.m.

Massachusetts Medical Orders for Life Sustaining Treatment (MOLST) Webinar
Tues., Dec. 8, 12:00–1:00 p.m.

SAVE THE DATE
Fri., Feb. 3, 2012
7th Annual Women's Cardiac Health Conference

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

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