

VITAL SIGNS



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VOLUME 15, ISSUE 8, OCTOBER 2010

Help Is Out There for Achieving Meaningful Use of EHRs

BY TOM WALSH

When Bart Alfano, M.D., first looked at what health information technology might mean for the future of his Framingham primary care practice, he initially felt that it was not for him. "I was pushing 65 years old, and after 35 years in practice I didn't really want to do this," he recalled. "I was hoping to sneak by into retirement."

However, as president of the 200-physician MetroWest IPA, Dr. Alfano also recognized that his organization needed him to take a broader view of issues such as electronic health records (EHRs). "I realized that things were moving in such a way that you couldn't avoid it and still be successful," he said.

So despite being comfortable with what he calls a "very efficient paper system," Dr. Alfano forged ahead with a new EHR system last fall with the help of a grant from Blue Cross Blue Shield of Massachusetts. "When suddenly the price was so low, it became a great opportunity," he said. "It has grown in leaps and bounds this past year."

Requirements Spelled Out

Like it or not, for all of the nation's practicing physicians, EHRs and their "meaningful use" became a top-tier issue in July when the federal Centers for Medicare and Medicaid Services (CMS) unveiled its final regulations and timeframes for implementation.

Physicians are not legally required to adopt EHRs, but they face monetary penalties in the form of Medicare fee reductions starting in 2015 if they have not installed an EHR system and are

not using it in a meaningful way as required by CMS regulations.

Thanks to federal stimulus legislation, over five years, individual physicians could get as much as \$44,000 through Medicare and \$63,750 through Medicaid to defray the cost of adopting EHRs. But experts estimate that installation costs alone may range from \$25,000 to \$100,000 per doctor.

Moreover, to get the back-end subsidies, physicians must prove meaningful use of EHRs. Among other things, the CMS regulations require that, by January 1, 2011, and through the end of 2012, physicians use EHRs for 15 "core" objectives (such as patients' smoking status, demographics, and vital signs) and 5 of 10 additional "menu" items that include implementing drug formulary checks and generating condition-specific patient lists for use in quality improvement, reducing disparities, research, or outreach.

Physicians "All Over the Map"

There is little data on how many Massachusetts physician practices have already adopted electronic health records. Several knowledgeable sources interviewed for this story suggested that about 40 percent of physicians — more in the eastern part of the state and in large practices — have them.

"The physician mindset is all over the map on this," said David Szabo, a Boston attorney with numerous physicians and other health care clients. "There is enormous variation."

MMS President Alice Coombs, M.D., said she is concerned that the CMS timeline may be too rigorous for many of the state's physicians. Because MMS members represent a wide range of practice situations, "as an organization, the MMS is supporting

doctors, whatever their circumstances, as they try to address this issue," Dr. Coombs said.

Six-Month Break-In Period

Everyone agrees that there is more to this transition than computer hardware and software. "There will be a major transformation of the way the delivery system handles clinical activity in the next three to five years," said Ray Campbell, CEO of the Massachusetts Health Data Consortium (MHDC). "It will be very disruptive to all participants in the system. Doctors in the smallest

practices will have the hardest time of all."

There is also agreement that it takes about six months for practices to get comfortable and efficient with a new EHR system. Practices must adopt new work flows to use the technology efficiently. It can also impact the way physicians interact with patients. Dr. Alfano said at this point using electronic records takes him more time than paper documentation.

Dr. Coombs said she is concerned that the disruptiveness of adapting to EHRs will cost the

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Bridgewater Pediatrician Makes the Most of His EHR

BY LLOYD RESNICK

Bridgewater pediatrician Fred Kern, M.D., is an unabashed booster of electronic health records (EHRs). "It has helped make me a better doctor and transformed my practice," he said. His fellow providers and office staff are happier, his patients are more satisfied, and his greatest initial concern — problems with

security and confidentiality of patient data — never materialized.

Dr. Kern is cognizant, however, of the challenges involved in succeeding with EHRs. He credits the infrastructural, financial, and consulting help his small practice received as keys to its success. As a member of the Pediatric Physicians of Children's organization, his e-Clinical

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Fred Kern, M.D., of Bridgewater Pediatrics says it takes three to six months to learn to use an EHR efficiently.

PRESIDENT'S MESSAGE



In It from Start to Finish

The state Legislature did not introduce a payment reform bill during the past session, but the issue is still front and center. The Society continues to work on it internally with members and leaders, and externally with lawmakers and state officials. Physicians must remain in these discussions from start to finish.

The MMS is committed to *designing out* of any reform plan the concerns raised this summer in member focus groups — a return to “capitation,” loss of small-practice autonomy in accountable care organizations (ACOs), and power struggles between primary care and other specialties.

When I met with Health and Human Services Secretary JudyAnn Bigby, M.D., recently, I emphasized the risks of pushing payment reform too hard and too fast. I think she gets it. Secretary Bigby also has a broad vision of ACOs, ranging from large hospital-centric models to amalgamations of 5 to 10 smaller practices without a specific hospital affiliation. Secretary Bigby is forming a working group to develop feasible models for ACOs, and the MMS will recommend three physicians to serve on that panel.

In addition, the Society will continuously advocate with all lawmaking and regulatory bodies. We'll also research our members' readiness to make changes and support physicians who want to get started. And we'll educate and communicate with districts, specialty societies, hospital medical staffs, and the public.

We will talk and we will listen. Together, we can ensure that payment reform and ACOs are implemented only with the best interests of patients and their physicians in mind.

— Alice T. Coombs, M.D.

Meaningful Use

continued from page 1

state's physicians money they cannot afford to lose in difficult economic times. “I've heard doctors say they've had to schedule fewer patients while they're learning to use an EHR,” she said. “When you cut down the number of patients you see, your bottom line goes down.”

Help at Hand

The same sources that estimate 40 percent of Massachusetts doctors have EHRs say that between 25 and 50 percent of those who have tried to embrace EHR technology may have failed. “We've seen high failure rates among early adopters,” said MHDC's Ray Campbell. Going forward, he cautioned, failure rates could remain high without ample support.

Thankfully, such support is now available from several quarters, including the state government, as Health and Human Services Secretary JudyAnn Bigby, M.D., reminded physicians in a September 9 open letter (go to www.massmed.org/bigbyletter).

Rick Shoup directs the Massachusetts e-Health Institute, the organization that has been designated by the federal government as the state's regional extension center (REC) to help doctors cope with EHR requirements.

Shoup's organization has \$12.4 million in stimulus money to eventually provide additional services to primary care physicians who commit to achieving meaningful-use standards. “Primary care providers, group practices with 10 or less physicians are the folks we want to get to,” he said. One of his goals is to create an online community of EHR users “with access to best practices from around the country.”

The Massachusetts eHealth Collaborative will be working with the state's REC as an implementation optimization organization (IOO). Mickey Tripathi, president and CEO of the collaborative, said his organization subcontracts with Shoup's organization to help physicians “get the job done.” Tripathi believes some of the meaningful-use requirements will be difficult for some doctors to achieve. “But overall I like stretch goals because that's the only way you can really change things,” he said.

As MMS President Dr. Coombs pledged, the Society will also play a leading role in helping doctors deal with these new challenges. Leon Barzin, an MMS IT director, has worked closely with the Society's Information Technology Committee to get the word out on these issues. Barzin also writes and edits a free electronic newsletter, the MMS *ARRA Advisor*, that reports extensively on EHR developments. To sign up for the *ARRA Advisor*, go to www.massmed.org/newsletters.

The MMS will also update the EHR section of its website with resources and other information to help physicians on their implementation journey. The Society is also planning to produce live and on-line educational programs to help physicians learn what they need to know.

Finally, Szabo, the Boston health care attorney, offered some perspective on the disruptive effects of health IT. At a recent meeting about this topic, he said, a doctor stood up and showed the group a dog-eared, decades-old copy of the *Journal of the American Medical Association*. Featured in it was an article about a development that promised to transform physician practices. Doctors were quoted in the story expressing concerns about how they would pay for it.

The development? The advent of the automobile in America. **VS**

Changes Coming to the MMS Website

Within a few weeks, a new system will be installed on the MMS website to process course registrations, dues renewals, and other member transactions more efficiently. We will also improve the site's calendar functions.

In order to complete this installation, online registrations, online payments, and access to members-only content must be shut down for a limited period of time. During this hiatus, instructions on the website will offer alternative methods to register for courses, pay dues, and conduct any other website transactions. When the installation is

complete, most regular website users who conduct MMS business online should experience no changes.

However, to protect members' financial security, website users who currently share the same e-mail address with another MMS member, an Alliance member, or any other registered MMS website user will be required to provide a unique e-mail address. Users in this category who need help making this change will be offered assistance on the website, as well as from customer service representatives.

More details on these changes will be provided on the MMS website. **VS**

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Evaluating the Costs and Benefits of Health-Plan Incentive Programs

For years, medical practices have endured a cascade of health-plan administrative burdens, with constantly shifting rules and requirements. The most obvious of these include processes such as prior authorizations and insurance-eligibility checks. One subset of administrative burdens is the reporting requirements necessary to qualify for health-plan incentive programs.

Regardless of the plan or the program, the practice's initial reporting results in a report back on the practice's performance according to whatever measures the program uses. This is often followed by an appeals period, during which the practice tries to correct erroneous data processed by the plans or provide supplemental documentation in support of the work performed.

Given the complexity of medical practice itself and the administrative layers heaped upon it, there are many reasons for conflicting versions of work performed, billed for, or documented. The bottom line is that practices

should evaluate the work necessary to meet the criteria for each plan's incentive program and perform a cost-benefit analysis to determine the advantages of participating.

There are fringe benefits to completing such analyses. Evaluating each plan's incentive programs may provide a path to streamlining reporting across

plans. And even when analysis reveals a clear practice advantage to participating in the program, establishing a benchmark cost-benefit analysis could make it easier to assess the impact of any future reimbursement reform efforts on the practice's revenue cycle. **VS**

—Adam Shlager



Ricardo Lewitus, M.D., a Marlboro pediatrician, responds to many health-plan requests for more information, some of them irrelevant to providing quality patient care.

MMS White Papers Keep Tabs on What Health Care Reform Might Mean to You

Massachusetts and the country are in earnest debate about what the future of health care will look like. These discussions generally revolve around how the health care delivery system will change, how health insurance coverage will change, and how provider reimbursement systems will change.

A plethora of other related topics tangentially associated with those questions includes scope of practice, income distribution, cost-attribution methodologies, and affiliation concerns.

Involvement in and education about health care reform are necessary for physicians. But fully understanding any one of these topic areas involves copious research. Such investigation might be less overwhelming if there

were some standards or metrics in place to evaluate these change proposals. But a review of current literature reveals a broad swath of theories and applications in place using similar terms and definitions in very different manners.

To help MMS members make sense of all this, the Health Policy and Health Systems Department reviews current literature at regular intervals and creates accurate and concise explanatory documents that are available online.

The most recent white papers, "Global Payments and Accountable Care Organizations: Understanding the Concepts, Their Relationship, and Their Potential Impact on Your Practice" and "Common Elements of Health Systems Using Global and

Episodic Payment Models" present systematic and readable overviews of these hot topics.

These MMS white papers incorporate information from other states as well as from successful models here in Massachusetts. The comprehensive nature of this material allows physicians to sift through other models for elements that may be applicable to the patient-centered practice of medicine in Massachusetts.

As national reform efforts progress and the direction of reform in Massachusetts is refined, we will continue to disseminate information useful to physicians in the Commonwealth. **VS**

—Adam Shlager

Understanding PECOS Particulars

In late 2008 and early 2009, the Centers for Medicare and Medicaid Services (CMS) launched the long-awaited Internet-based version of its Provider Enrollment, Chain and Ownership System (PECOS). Internet-based PECOS enables individual practitioners to complete their Medicare provider enrollment application online.

Practitioners use their national provider identifier and password to access Internet-based PECOS. CMS recommends that individuals reset their user IDs and passwords before accessing Internet-based PECOS, and then reset them at least once a year. The agency also suggests that practitioners not share this information with others, including billing services, consultants, and practice staff. Instead, CMS recommends that individual practitioners use the system to enroll and/or update their own information.

CMS delayed implementation of the second phase of modifications to PECOS until January 3, 2011. These requirements relate to ordering/referring providers and stipulate the following:

- All Medicare providers who order or refer for non-durable medical equipment (DME) items or services must be enrolled in PECOS or in the Medicare carrier's or Part B administrative contractor's claims system
- Medicare providers who order or refer DME claims must be enrolled in PECOS

Providers who enrolled in Medicare prior to 2003 but have not completed a revalidation process are not included in PECOS. CMS will reject claims from and deny payment to such providers.

Prior to the January 3, 2011, implementation date, CMS will continue to place warnings on claims for which the ordering/referring provider is not enrolled in PECOS. It will also remind providers who enrolled in Medicare prior to 2003 but who have not completed the revalidation process to submit a new enrollment application either on paper or by using Internet-based PECOS.

The bottom line: check your status in PECOS to prevent any interruption in Medicare payments. **VS**

New State Law Requires Concussion-Safety Education

This past summer, Gov. Deval Patrick signed a law relative to safety regulations for school athletic programs. Under the new law, now in effect, all physicians and nurses who work or volunteer at a Massachusetts Interscholastic Athletic Association (MIAA) member school must participate in a concussion awareness program. The law also requires that nonclinical staff, volunteers, and parents of children who participate in an extracurricular athletic activity at those schools receive head-injury education.

The MMS, the MIAA, the state chapter of the American Association of Pediatrics, and the Brain Injury Association of Massachusetts are working with the state Department of Public Health to develop an interscholastic athletic head-injury safety training program.

In the meantime, pediatricians, family practitioners, emergency medicine physicians, and neuropsychiatrists can participate in an online training program developed and currently in use by the National Federation of State High School Associations. This free course, available at www.nfhslearn.com/electiveDetail.aspx?courseID=15000, satisfies the educational training component of the new law.

Additionally, the MMS Committee on Student Health and Sports Medicine recently updated its brochure and wallet cards about concussion. *Concussion: A Coach's Guide for Sideline Evaluation* has been distributed to MIAA-member school principals, physicians, nurses, athletic trainers, and other health care providers. You can also download the brochure at www.massmed.org/concussion or request one or more copies by e-mailing dph@mms.org. **VS**

— Candace Savage



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Physicians Should Help Patients Understand Fire Risk of Home Oxygen Use

Do you have patients who use home oxygen? If so, they are at increased risk of fire and burns, according to State Fire Marshal Stephen Coan. Working with the state Task Force on Home Oxygen Safety, Coan's office launched a campaign to educate patients, families, caregivers, and physicians about these dangers.

What Are the Risks?

Home oxygen adds oxygen to the ambient air, making any fire that erupts burn faster and hotter. Furniture, clothes, bedding, and hair absorb the supplemental oxygen and can catch fire more easily.

"Tragic blazes such as the Lynn fire this past February and the Quincy fire in December 2009 highlight the risks associated with home oxygen use," Coan said. Since 1997, home oxygen has been involved in more than 72 identifiable incidents in Massachusetts, including 27 fatalities and more than 53 serious injuries.

"As the baby boomer generation ages, more and more patients will be treated in their homes with portable medical oxygen," said Colleen Ryan, M.D., staff surgeon at the Sumner Redstone Burn Center at Massachusetts General Hospital. "It's crucial that patients, their families, physicians, and other caregivers

are aware of and understand the fire risks associated with home oxygen use."

Safe Oxygen Use

Patients using home oxygen should be reminded to keep 10 feet away from any flame or heat source such as electric razors, gas stoves, heaters, hair dryers, or candles. They should also avoid using petroleum-based personal products such as certain lip balms and lotions, which can

"It's crucial that everyone understand the fire risks associated with home oxygen use."

— Colleen Ryan, M.D.
Sumner Redstone Burn Center

easily ignite. All smoke alarms should be working, and the family should have — and practice — a home escape plan with a meeting place outside and clear pathways to the exits.

Of course, patients who use oxygen should not smoke, and no one should smoke around them. Physicians should encourage and help patients to quit smoking.

But until patients quit, physicians should advise them to disconnect the oxygen and wait 10 minutes before going outside to smoke. This gives the oxygen



time to evaporate from hair and clothes, lessening — but not eliminating — the danger. Simply turning off the oxygen supply is not an adequate safety measure.

The task force is asking physicians to place informational posters and brochures in their waiting rooms and to talk with patients about the fire risks of home oxygen. **VS**

— Robyn Alie

To order copies of the poster or brochure or for more information, call the Department of Fire Services at (978) 567-3380.

Clinician's Guide to Partner Violence Updated

The MMS and MMS Alliance Campaign Against Violence have released the fifth edition of *Intimate Partner Violence: The Clinician's Guide to Identification, Assessment, Intervention, and Prevention*. The latest edition of this guidebook includes four major new sections, including "The Adult Health Effects of Traumatic Exposures during Childhood," "Trauma-Sensitive Care," and "Assessment for Abuse from a Life-span Perspective." The online

edition, available at www.massmed.org/partnerviolence, is customizable to geographic areas nationwide and includes links to many Web-based resources.

"Because physicians are often the first and sometimes the only professionals survivors of violence encounter, they can play a crucial role in breaking the cycle of violence and working toward prevention," said Elaine Alpert, M.D., M.P.H., an editor and author of the guidebook.

The guidebook, formerly known as *Partner Violence: How to Recognize and Treat Victims of Abuse — A Guide for Physicians and Other Health Care Professionals* and first published in 1992, has been adapted with permission for use in multiple states, including New York, Arizona, and Illinois.

A limited number of print copies of the guidebook are available by e-mailing dph@mms.org. **VS**

STATE UPDATE

All in All, State Legislation Good for Physicians and Patients

Looking back, the formal 2009–2010 state legislative session was distinctive in what lawmakers did — and did not do.

Instead of sweeping yet untested health care payment reform legislation, lawmakers passed a more limited bill (Chapter 288) focused on reducing the cost of health insurance for small businesses. The decision to table payment reform was in no small part influenced by vocal concerns expressed by virtually every health care entity in the Commonwealth, including the MMS.

The most significant provision of Chapter 288, the so-called small-business relief bill, allows insurers to sell lower-cost products that either limit provider networks or charge higher patient copays as determined by tiered provider networks. Providers cannot be forced to participate in these limited networks, nor can providers force insurers to include them.

Chapter 288 also gives the state insurance commissioner broad rights to reject rates that are deemed “excessive, inadequate, or unreasonable.” It also permits small businesses to form group purchasing cooperatives.

The law also requires several mechanisms to reduce physicians’ administrative hassles and costs, including standardization of health plan credentialing, patient eligibility determinations, and prior-authorization processes.

Additionally, the MMS has seats on several new study commissions established by Chapter 288, including one whose objective is to “recommend policies aimed at enhancing competition, fairness, and cost effectiveness... through the reduction of reimbursement disparities.”

A potential downside for physicians is a host of new reporting requirements, including one requiring physicians to track and report quality data to the state annually.

New Laws Benefit Public’s Health

While payment reform and cost containment occupied much of the MMS advocacy agenda in 2010, the Society was also actively involved in

the passage of several other laws that will benefit physicians and their patients, among them the following:

- Banning texting while driving and creating a new reporting system to improve detection of “impaired drivers” (Chapter 155)
- Improving nutritional standards in schools (Chapter 197)
- Expanding the Prescription Drug Monitoring Program to address prescription drug abuse (Chapter 283)
- Increasing penalties for assaulting a health care provider while he or she is providing treatment (Chapter 151)
- Establishing an organ and tissue donor registration fund (Chapter 190)

For a complete list of all health care laws passed in the 2009–2010 state legislative session, including links to the full text, go to www.massmed.org/legislative/summary.

Success in legislative advocacy is sometimes measured in terms of bills that *didn’t* pass. The MMS actively opposes any legislation that would compromise the quality of health care and jeopardize patient safety. Such was the case this past session with legislation to increase the scope of practice for lay midwives, podiatrists, and optometrists. MMS advocacy was largely responsible for the defeat of these bills during this legislative session.

What Will November Bring?

The upcoming November elections are expected to bring significant changes to membership of the House, Senate, and quite possibly the governor’s office. There are currently 8 open seats in the Senate and 26 in the House, with an unprecedented number of hotly contested races. While House Speaker Robert DeLeo (D-Winthrop) and Senate President Therese Murray (D-Plymouth) will undoubtedly be re-elected to their leadership positions, a high turnover in House and Senate membership will likely translate into changes in other leadership positions and committee chairmanships and assignments.

— Ronna Wallace

Making the Most of EHRs

continued from page 1

Works EHR benefits from a robust network infrastructure maintained by Children’s.

Just as important, Dr. Kern’s practice was part of the Greater Brockton eCare Alliance, a group comprising nearly 400 physicians that began receiving financial and technical assistance from the Massachusetts eHealth Collaborative five years ago. With the financial and learning-curve burdens eased significantly, Dr. Kern was able to make the most of the three- to six-month period most people say it takes to efficiently use an EHR once the hardware and software are installed.

Dr. Kern strongly encourages any practice with an EHR to establish “templates” for the most common

types of patient encounters they experience. He personally created about 150 templates for various types of well-child visits and for the most common pediatric diagnoses. “If you’re willing to do the initial work to set up these standardized electronic charts, it comes back to you many times in terms of efficiency,” he said.

The EHR was the driving force behind the practice’s streamlined and now-paperless workflows. All front-end work, chart entry, billing, referrals, and prescription writing are done electronically. “My patients really appreciate the e-prescribing aspect of the system,” said Dr. Kern. “Their prescription is at the pharmacy before they even leave the office.” His patients and their parents also like how the EHR simplifies all those school and camp forms pediatric practices have to process.

Dr. Kern personally appreciates the improved communication with subspecialists that the EHR has facilitated. “Any information coming from another physician immediately

“The EHR has helped make me a better doctor and transformed my practice.”

— Fred Kern, M.D.
Bridgewater Pediatrician

becomes a part of the patient’s electronic record,” he said. Dr. Kern also relies on his EHR-powered laptop for daily reminders, including appointment schedules, phone calls to make and return, and lab results to review.

His EHR also produces reminders to patients for yearly flu shots and other

important wellness activities. “The patient reminders go out via e-mail, text message, or phone call, whichever form of communication the patient prefers,” said Dr. Kern.

Dr. Kern’s experience suggests that it is possible to reap advantages from EHRs that outweigh the challenges encountered along the way. To avoid the relatively high failure rates associated with first-time EHR installations (see related article on page 1), small practices like his benefit from partnering with other entities — hospital systems, health plans, or government agencies — for funding and procedural assistance.

“If you do your homework, get educated, and embrace the challenge, you and your patients will reap the rewards,” he concluded. **VS**

Veteran Physicians to Share Career Experience with Medical Students

On October 18, the MMS Committee on Women in Medicine will host its fourth annual mentoring night for medical students.

This event will allow medical students to hear experiences from physicians who encompass a broad range of backgrounds and work specialties. Speakers will share with students their insights into the current practice environment, including information about part-time careers, different work settings, and balancing professional and personal goals. Kristen Robson, M.D., a member of the Committee on Women in Medicine, will moderate the program.

A short meeting of the MMS Medical Student Section will precede the program.

To join the Society or register for the program, contact Erin Tally at (800) 322-2303, ext. 7413, or etally@mms.org.

Mentoring Night for Medical Students

October 18 • 7:30 to 8:30 p.m.
MMS headquarters, Waltham

Research Poster Symposium

December 13, 12:30 to 4:00 p.m.
MMS headquarters, Waltham

Submission deadline for abstracts:
October 18, 2010

Cash prizes will be awarded in four categories:

- Basic Research
- Clinical Research
- Clinical Vignettes
- Health Policy/Medical Education

Residents, fellows, and medical students are eligible to submit posters.

For more details, go to www.massmed.org/postersymposium.

PHYSICIAN HEALTH MATTERS

Pay Attention to Prescribing Parameters

Many physicians believe that maintaining an active Drug Enforcement Administration registration and valid Massachusetts prescribing privileges allows them the unrestricted ability to prescribe medications. However, there are some important parameters on prescribing medications of which all physicians should be aware.

Generally, all prescriptions must be for a legitimate medical purpose and must be written within a physician's usual course of professional practice (see Massachusetts General Laws, Chapter 94C, Section 19a). Occasionally prescriptions may be written quickly, limiting the amount of documentation needed to confirm that all the basic requirements have been met.

Prescribing for Family Members

For example, some physicians write prescriptions for family members, primarily out of convenience and a desire to be helpful. While prescribing to family members is only strictly prohibited for Schedule II controlled substances, doing so is seldom advisable.

One reason is that many physicians are reluctant to perform a complete physical on a family member. But prescribing medications without an examination creates significant risk for oversight in making accurate diagnoses and formulating appropriate medication plans. Also, when a physician prescribes for a family member, he or she may not review other medications being prescribed for the patient by other sources. This could lead to negative drug interactions or even overdoses. Finally, physicians who prescribe for family members may not keep complete records of the medications that have been given, or their personal notes might fail to become part of the patient's permanent record. The potential then exists for subsequent providers to overprescribe or to prescribe medications that could cause adverse drug reactions.

Prescribing for Colleagues

Similar risks are present when a physician prescribes for a colleague. These "curbside consults" may lack complete physical examinations, proper documentation, or complete consideration of medical history. Moreover, the prescribing doctor may be reluctant to ask questions that, while relevant in the context of providing medical care, might seem too sensitive or personal to pose to a peer.

Prescribing Within the Scope of Practice

Although medications are not typically restricted by practice specialty, this is a factor regulators might consider if there are concerns that a physician is pre-

scribing outside of the usual course of practice. For example, if an allergist prescribes large amounts of narcotics, regulators are more likely to question the prescriptions. Similarly, concerns might arise if a physician who is primarily hospital based starts writing numerous prescriptions using a personal prescription pad. Physicians who find themselves writing prescriptions that are not clearly within the scope of their professional practice should carefully document the basis for the prescriptions in the patients' medical records.



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New Prescription Monitoring Program

Also, under a revised state prescription monitoring program that starts next

year, doctors will be required to alert the state when they prescribe not only narcotics but also a broader roster of medications that includes pain-relievers such as Vicodin and Darvon, as well as steroids. For more information about the prescription monitoring program, go to www.mass.gov and enter "prescription monitoring program" in the search box. **VS**

For more information about Physician Health Services, call (781) 434-7404 or go to www.physicianhealth.org.

SAVE THE DATE

7th Annual Free Health Care Forum

Wednesday, November 3, 6:00 to 8:30 p.m. — MMS headquarters, Waltham

Sponsored by the MMS Committee on Senior Volunteer Physicians

For more information, contact Carolyn Maher at (781) 434-7311 or cmaher@mms.org.

ACROSS THE COMMONWEALTH

District News and Events

Barnstable — Family Event. Sun., Oct. 3, 2:00 p.m. tours, 5:00 p.m. reception and clambake. Location: Plimoth Plantation, Plymouth. For more information, contact the Southeast Regional Office.

Berkshire — Family Event. Sun., Oct. 24, 1:30 p.m. reception, 3:00 p.m. show. Location: Mahaiwe Theatre, Great Barrington. Show: Mummenschanz. **Fall District Meeting.** Wed., Oct. 27, 6:00 p.m. Location: Jae's Spice, Pittsfield. Topic: Vitamin D — What Clinicians Need to Know. Speaker: Jeffrey Perkins, M.D., Comprehensive Internal and Preventative Medicine, Albany, NY. For more information, contact the West Central Regional Office.

Charles River — Family Event. Sun., Oct. 24, 11:00 a.m. Location: Belkin Family Lookout Farm, South Natick. District members and their families are invited to attend a barbecue and fruit picking. For more information, contact the Northeast Regional Office.

Essex South — Membership Meeting. Wed., Oct. 13, 6:00 p.m. Location: Peabody Marriott, Peabody. Speaker: Gubernatorial candidate Jill Stein, M.D. For more information, contact the Northeast Regional Office.

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

Hampshire/Franklin — Fall District Meeting. Wed., Oct. 13, 6:00 p.m. Location: Blue Heron, Sunderland. Speaker: Alex. Calcagno, MMS director of federal relations. Topic: "Health Care Reform: Where Do We Go from Here?" For more information, contact the West Central Regional Office.

Middlesex Central — Annual Breakfast. Fri., Oct. 15, 7:30 a.m. Location: Emerson Hospital, Concord. Speaker: JudyAnn Bigby, M.D., secretary of health and human services. For more information, contact the Northeast Regional Office.

Middlesex West — Membership Meeting. Wed., Oct. 27, 6:00 p.m. Location: Wayside Inn, Sudbury. For more information, contact the Northeast Regional Office.

Suffolk — Membership Meeting. Thurs., Oct. 28, 6:00 p.m. For more information, contact the Northeast Regional Office.

Worcester — Medical Education Program. Wed., Oct. 6, 5:30 p.m. Location: Beechwood Hotel, Worcester. Topic: "The Cornerstones of Health

Reform: What Patients and Physicians Need." Speaker: Lynda Young, M.D., MMS president-elect. **Third Annual Health Care Forum.** Wed., Oct. 27, 5:30 p.m. Location: Mechanics Hall, Worcester. Topic: "Making Your EHR Work for Your Office." Speaker: Denise Scott of Masspro. For more information, contact Joyce Cariglia at (508) 753-1579.

Statewide News and Events

Arts, History, Humanism, and Culture Member Interest Network — Tower Hill Music and Medicine Program. Sat., Oct. 16, 6:00 to 9:00 p.m. Location: Tower Hill Botanic Garden, Boylston. 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.

IN MEMORIAM

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

Harry E. Braconier, M.D., 100; Weston, MA; Tufts University School of Medicine, 1941; died August 29, 2010.

Howard R. Crawford, M.D., age unknown; Stow, VT; University of Cincinnati College of Medicine, 1945; date of death unknown.

Frederick G. Doran, M.D., 83; Vero Beach, FL; Boston University School of Medicine, 1955; died October 12, 2009.

Robert Ferguson, M.D., 87; Wellesley, MA; Queen's University Faculty of Medicine, Ontario, 1959; died February 1, 2010.

Ann E. Frodey, M.D., 55; Pittsfield, MA; University of Massachusetts Medical School, 1985; died June 6, 2010.

William E. Hennessey, M.D., 76; West Springfield, MA; New York Medical College, 1960; died September 2, 2010.

Selwyn A. Kanosky, M.D., 81; Marblehead, MA; Tufts University School of Medicine, 1954; died July 11, 2010.

John J. Massarelli Jr., M.D., 82; Worcester, MA; Georgetown University School of Medicine, 1950; died August 22, 2010.

David S. Newcombe, M.D., 80; Weston, MA; McGill University Faculty of Medicine, Montreal, 1956; died June 11, 2010.

Thomas C. Peebles, M.D., 89; Port Charlotte, FL; Harvard Medical School, 1951; died July 8, 2010.

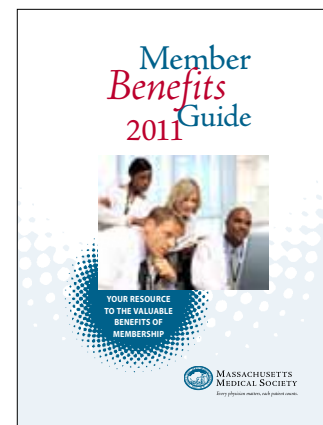
Jean M. Porwoll, M.D., 60; Monson, MA; University of Minnesota Medical School, 1976; died August 3, 2010.

Louis D. Savage, M.D., age unknown; Gloucester, MA; Harvard Medical School, 1946; date of death unknown.

Joseph C. Tarantino, M.D., 83; Northampton, MA; Tufts University School of Medicine, 1948; died August 27, 2005.

Irving N. Wolfson, M.D., 90; Worcester, MA; Yale University School of Medicine, 1942; died July 8, 2010.

2011 Member Benefits Guide Now Available



The 2011 MMS *Member Benefits Guide* is your source for information on publications, educational programs, practice management resources, patient education materials, engagement opportunities, and special discounts available exclusively to MMS members.

In keeping with our efforts to conserve resources, we will send a copy of the guide to any renewing member who requests one. Similar information is also available via interactive PDF in the member benefits and services section of the MMS website (www.massmed.org).

To request a print copy of the guide, e-mail info@massmed.org, or call (800) 322-2303, ext. 7311. **VS**

Interim Meeting Resolution Deadline: October 19

The 2010 MMS Interim Meeting of the House of Delegates will be held on Friday and Saturday, December 3 and 4, 2010.

The deadline for submitting resolutions for the Interim Meeting is October 19. Members can submit resolutions online at www.massmed.org/resolutions or via e-mail to resolutions@mms.org.

The deadline for hotel reservations at the Westin Hotel is October 29. Please call (781) 290-5600 to make reservations directly with the hotel.

Visit www.massmed.org/interim2010 for more details about the 2010 Interim Meeting and to register online. **VS**

MMS President Addresses Tufts Medical Students



Photo by Colleen Hennessey

Alice T. Coombs, M.D., MMS president, welcomed students at Tufts University School of Medicine in September.

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MASSACHUSETTS
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VITALSIGNS

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Live CME Activities — Go to www.massmed.org/cme/events.

Federal Funding Opportunities

October 13, 3:00–6:00 p.m. Harvard School of Dental Medicine, Boston. 3.0 Credits

Integrative Medicine 101: Practical Approaches for Primary Care Providers

October 28, 8:00 a.m.–4:30 p.m. MMS headquarters, Waltham. 7.25 Credits

The Effects of Alcohol on Women

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

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

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