

VITAL SIGNS



- 2 **PRESIDENT'S MESSAGE** Changes Are Everywhere
- 3 **YOUR PRACTICE** ACOs: Three Questions • Preparations for ICD-10
- 4 **THE PUBLIC'S HEALTH** Expedited Partner Therapy for Chlamydia • Vaccinate Your Patients Against the Flu • Tornado Response — One Physician's Story
- 5 **GOVERNMENT AFFAIRS** Federal: The Fall of Our Discontent
- 6 **PROFESSIONAL MATTERS** NE Medical Association to Serve Physicians of Color • Practicing Modern Professionalism • Pri-Med East • Research Poster Symposium
- 7 **INSIDE MMS** Interim Meeting Resolution Deadline • IMGs: From Training to Green Cards • Across the Commonwealth • In Memoriam
- 8 **MMS EDUCATION PROGRAMS**

VOLUME 16, ISSUE 8, OCTOBER 2011

Workforce Study Highlights Ongoing Shortages, Changing Environment

BY DEBRA BEAULIEU

Denise Mills, M.D., a solo family physician in Dra-cut, is not afraid of swimming against the tide. As one of the dwindling number of family doctors who continues to provide obstetrical care and visit her patients in the hospital, Mills gave up a position in a larger practice at a time when doctors were jumping in droves onto lifeboats offered by hospitals and other big organizations.

"If I had stayed with that group I'd be making a lot more than I am now, but that's not why I did it," said Dr. Mills, immediate past president of the Middlesex North District Medical Society. Rather, Dr. Mills said, she made a personal decision to set up a practice that allows her to work with her patients to determine what's in their best interest without getting caught up in bureaucracy.

That decision hasn't been without consequence. Although Dr. Mills had another physician with which to share the load for three years, she's spent the past two and a half years being on call 24 hours a day, 7 days a week.

Her recruitment efforts have been unsuccessful thus far, Dr. Mills said, because low reimbursement rates in Middlesex County make it difficult for her to compete for candidates in short supply. "The doctors that come out now want significantly more money than I am paying myself," she said, adding that very few prospects are interested in the demanding lifestyle of obstetrics. "They want to know about their

bonuses; they want to know about partnership opportunities; they want to be employed and maybe on phone call coverage only every couple of weeks."

For all the traits that make Dr. Mills unique, her concerns speak to many of those revealed by the 2011 *MMS Physician Workforce Study*, which highlights ongoing

Specialties in Short Supply	
Critical	Severe
Family Medicine	Dermatology
Internal Medicine	General Surgery
Psychiatry	Neurosurgery
Urology	Orthopedics

Source: 2011 MMS Physician Workforce Study

physician shortages in Massachusetts as well as significant challenges faced by small practices in an increasingly "go-big" world.

Physicians and Payment Reform

When it comes to payment reform, which the survey asked about for the first time this year, physicians across the board reported reluctance to jump on board with new models. Overall, more than half of the physicians surveyed said they are unlikely to participate voluntarily in global payment programs or ACOs.

In particular, of the 57% of respondents who said they were familiar with global payment systems, 55% said they were not very or not at all likely to participate in a voluntary global payment system. The smaller the practice size, the less likely physicians are to participate in global payments: 62% of physicians in a practice of one to ten physicians were not very or not at all likely to participate in a global payment system.

These relative differences in interest make sense, given that procedure-oriented specialists may have a hard time envisioning where they might fit in a global payment system or primary care-based ACO. And while employed physicians are in many ways already involved in variations of these models by virtue of being

salaried, self-employed physicians are understandably concerned about the impact of such dramatic changes to the way they are compensated, according to MMS President Lynda Young, M.D. "I'm in a small practice, and I could see how we could fit in, but it would be a big change," said Dr. Young, a practicing pediatrician. "And I don't think it's such a bad thing. The small practice can do this, but they're going to have to integrate with a larger system." Of course, doing so comes with the tradeoff of losing some independence, she said.

Stephen Johnson, M.D., president of the Massachusetts Neurological Society, agrees that payment reform will pose a sea change for some private practice physicians. "What will happen, as best as I can tell, is that surgeons will have to be contracted entities," said Dr. Johnson, who is on staff at South Shore and Brigham and Women's Hospitals in addition to practicing at his own office in Weymouth.

Doctors Want More Details about Global Payments and ACOs

That "best I can tell" part, coming from a physician so highly involved in these issues at the state



Photo by Lloyd Resnick

Insurance Commissioner Joseph G. Murphy

State's Insurance Chief Tackles Cost Control

BY FRANK FORTIN

Joseph G. Murphy is at the forefront of the Massachusetts health reform debate. As commissioner of the state Division of Insurance for the last 19 months, Murphy has used his leverage with health plans to control health care costs. Under payment reform legislation proposed by Gov. Patrick, Murphy's office could play an even more important role.

Vital Signs recently sat down with Murphy to discuss cost control, payment reform, and the role insurance regulators will play in the future.

Controlling Health Care Costs

Murphy said Gov. Patrick heard from many small business owners that health care costs were one of the major barriers to their growth in this difficult economy. He said that new powers granted to the Division of Insurance by executive order gave his staff the ability to reject about 230 of 275 contracts with small businesses.

"There were ensuing administrative hearings as well as litigation. The result was that there were settlements with all but one carrier, saving consumers significant sums of money. Since that time, we have worked with the carriers as they

continued on page 2

continued on page 5

PRESIDENT'S MESSAGE



Changes Are Everywhere

Based on my recent meetings with medical staff throughout the state, physician reaction to the prospects of ACOs and payment reform run the gamut from fear and loathing to "this isn't so different from what I've been doing in the last couple of years anyway."

The concern I hear most from the fear-and-loathing group, typically comprised of doctors in their 50s and 60s, is that global payment is capitation all over again. I believe there's a commitment among all stakeholders to avoid "capitation redux" by ensuring that sensible risk adjustment and risk controls are built into any and all alternative payment systems. But that means physicians must play a major role in determining how risk will work in a new payment environment so our patients and practices are protected from interests that care more about financials than optimum health.

One physician I met with recently said, "No matter what the MMS does, the government calls the shots." That's only partly true. This Society's active participation in state and federal discussions about health care has never been greater than it is now. And we're not only at the table — we're being listened to. Gov. Patrick's proposed payment-reform legislation does not call for mandatory physician participation, and it includes meaningful malpractice reform in almost the exact language the MMS recommended.

We are one of many stakeholders at the health care negotiating table. Now is not the time to bang our shoe on that table or walk away from it. It's time to listen, share our ideas, and respond clearly to preserve the best of what our health care system currently offers — to ensure that any changes make the best even better.

Lynda M. Young

— Lynda M. Young, M.D.

Workforce Study

continued from page 1

level and beyond (he's also an officer of the New England Neurosurgical Society and a delegate to the congress of state neurological societies), points to another major reason for physicians' guarded enthusiasm about payment reform.

"Despite a structure and plan for ACOs having come out at the national level, the ability for any physician group to really wrap their minds around what it means for them and the way they practice medicine makes it difficult to commit to the concept of the ACO," said Dr. Mills. In other words, it's not the idea of payment reform that's being met with resistance, but the lack of clear methodologies for determining payments.

Massachusetts Psychiatric Society President Donald Condie, M.D., echoed this concern. "I've testified in front of the Legislature about the governor's proposal for global payments, which contains only a single paragraph about behavioral health. It gives no specifics except that the nine-member commission will figure it all out," he said. "The position of the Massachusetts Psychiatric Society is that psychiatry should be integrated into the rest of medical care as much as possible... but it's certainly not clear how anything other than the fee-for-service model would reward specialists."

As mentioned previously, more PCPs seem to have a positive outlook toward global payments, depending on how the specifics unfold.

"I don't have anything against global payments per se," noted Cape Cod internist Cormac Coyle, M.D. "The place I diverge and will not do it is if the payment system is structured in a

way that I feel it's going to impinge on the doctor-patient relationship. If I think that the incentive is to deny care, that I can't and won't do."

Physician Leadership Crucial

Despite concern over the uncertainty, Dr. Mills said there's no question that something needs to be done to slow the growing cost of health care. "The system really is broken in terms of payment and health care dollars," she said. "I would love physicians to have an active role in trying to make it better."

Thomas Hines, M.D., president of the Massachusetts Academy of Family Physicians, agreed. "If ACOs are really going to provide the kind of results that people are hoping they will, that is going to require that they be directed by physicians, ideally primary care physicians," he said.

Physicians need more than just being asked for their input, they must be sitting at the table where decisions are made. "They need to be in a leadership position within whatever model it is that they are going to be a part of," Dr. Young said. "Not just 'What do you think, doctor?' but 'I want to be on the board.' It's crucial that a physician or physicians be in those positions."

More Unhappy Docs Becoming Satisfied

Even while confronting all of these issues, roughly four out of five of the practicing Massachusetts physicians still find their careers to be rewarding, according to the survey. However, with regard to satisfaction with their current medical practice environment, physicians' level of satisfaction depends on whom you ask.

While the percentage of physicians who say they are either very satisfied/satisfied or very dissatisfied/dissatisfied with the current practice environment has been converging since 2006, this marks the first year that the two groups are equal in size, at 42%.

A major driver of dissatisfaction among physicians is the amount they're forced to spend on administrative tasks rather than seeing patients. On average, physicians reported that they spent 21% of their time on administrative work. Yet in six specialties — cardiology, emergency medicine, family medicine, internal medicine, psychiatry, and vascular surgery — tasks such as dealing with paperwork and health plans took up a whopping 40% of their time. The study concluded that administrative simplification through standardization will be essential in order to ease the burden on physician hours and bend the curve on the rising cost of overhead. However, Dr. Young noted that the dismaying amount of administrative burden shouldered by physicians is a national problem.

Despite the troubling rate of Massachusetts physicians who say they're not happy, it's worth noting that this convergence has come about solely as previously dissatisfied physicians shifted their views to become more satisfied with the practice environment, according to the study.

Perhaps Dr. Mills sums up the findings best by explaining: "The practice of medicine I'm satisfied with; I'm dissatisfied with the fact that I'm less and less able to actually engage in it."

To read the complete workforce study, visit www.massmed.org/workforce.

VITAL SIGNS is the member publication of the Massachusetts Medical Society.

STAFF WRITERS: Deb Beaulieu, Vicki Ritterband

EDITORIAL STAFF: Charles Alagero, Office of General Counsel; Robyn Alie, Public Health; Lori DiChiara, Government Relations; Kerry Ann Hayon, 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: Lynda M. Young, M.D.

EXECUTIVE VICE PRESIDENT: Corinne Broderick

DIRECTOR OF COMMUNICATIONS: Frank Fortin

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.

Vital Signs lists external websites for information only. The MMS is not responsible for their content and does not recommend, endorse, or sponsor any product, service, advice, or point of view that may be offered. The MMS expressly disclaims any representations as to the accuracy or suitability for any purpose of the websites' content.

©2011 Massachusetts Medical Society. All Rights Reserved.

Accountable Care Models: Three Questions for Consideration

No magic bullet exists when it comes to succeeding in a health care payment reform environment. This is especially fitting for accountable care delivery models, because there is no “one-size-fits-all” format.

As practice owners consider where their particular entity might fit into the accountable care mix and how prepared they are to engage in an accountable care organization (ACO) or new payment reform model, it's important to consider the true capabilities of one's practice.

Understanding a practice's ability to tolerate and adapt to change is critically important, regardless of the type of accountable care model a practice might pursue. Three questions can help you in considering where your practice stands:

1) Do you have electronic health records (EHRs), and if so, are you able to extrapolate data from the system? Using the EHR system for metrics capture and reporting is a huge opportunity for timesaving reporting. Unfortunately, many practices do not have adequate support or reporting capabilities to mine the data in a meaningful manner based

on the structure that is in place today. It's important to do a system assessment to understand the reporting capabilities that currently exist and the additional capabilities that are needed to be successful in an accountable care model.

2) Do you have the ability to engage patients in care management? Truly engaging patients in care management is challenging, yet in an accountable care model,



© 2011 Thinkstock

patients play a central role in their own care. Does your practice have the necessary support in place to facilitate this model of care delivery? Evaluating the current processes for interacting with and supporting patients with chronic disease in your practice is important. Identifying what opportunities exist to streamline communication with patients —

while providing an additional level of patient engagement, disease surveillance, and education — is necessary.

3) Do you possess the capability to be a learning organization?

A learning organization as defined by Peter Senge is “an organization where people continually expand their capacity to create the results they truly desire... and where people are continually learning to see the whole together.” The ability to

implement mid-course corrections will be a must for any practice engaging in an accountable care or new payment model. An ACO today will not be the same ACO a year from now. Practices engaging in these entities must be comfortable with and have the capacity for adapting and changing in order to further the goal of improving quality and reducing cost, while meeting the needs of an increasingly engaged patient population. **VS**

To learn more about ACOs and the steps your practice can take to prepare for becoming an ACO, visit the Accountable Care Solution Center at www.massmed.org/acsc.



David Blumenthal, M.D., M.P.P.

Former Health IT Czar to Deliver Garland Lecture at HMS

David Blumenthal, M.D., M.P.P., the former leader of President Obama's health information technology program, will speak on “Bringing Health Information to Life” at the 36th Annual Joseph Garland Lecture on Tuesday, October 25, sponsored by the Boston Medical Library.

Dr. Blumenthal was national coordinator for health information technology through April 2011, after launching the federal government's meaningful use incentive program for electronic health records.

The lecture will be held at the Armenise Building at the Harvard Medical School, 210 Longwood Ave, starting at 5:30 p.m. **VS**

To register, contact Roz Vogel of the Boston Medical Library at roz_vogel@hms.harvard.edu or (617) 432-4807.

Preparations for ICD-10 Are Underway

The transition to ICD-10 is gathering momentum following the CMS's National 5010 Testing Week in August. This opportunity for trading partners to come together and test systematic improvements that are the new standard for electronic health care transactions is the first of many efforts to seamlessly transition the health care system to the ICD-10 platform.

The differences between ICD-9 and ICD-10 are significant and should not be left to last minute consideration, especially given the fast approaching October 1, 2013, compliance deadline. Physicians and practice managers should familiarize themselves as these changes will ultimately have system-wide impact.

Key Differences Between ICD-9 and ICD-10	
ICD-9-CM	ICD-10-CM
Diagnosis codes are 3 to 5 digits in length and total over 14,000	Diagnosis codes are 3 to 7 characters in length and total 68,000
ICD-9-CM procedure codes are only 3 to 4 numbers in length and total approximately 4,000 codes	ICD-10-PCS (procedure codes) are alphanumeric, 7 characters in length, and total approximately 87,000
Utilizes HIPAA transaction standards version 4010, which will be discontinued as of January 1, 2012, in order to accommodate use of the ICD-10 codes	Requires new version of HIPAA transaction standards, known as 5010

Source: American Medical Association

To start, physicians and practice staff should become more familiar with the key differences that exist between ICD-9 and ICD-10.

There are several measures that can be taken now to ensure a smooth transition to ICD-10.

Start by speaking with your practice management or software vendor to determine whether necessary software updates will be installed to accommodate for the version 5010 HIPAA transactions.

Next, contact your clearinghouses, billing service, and payers

to be sure that their systems are compatible as well.

This is an important first step in the process, and you will want to test your billing transactions once all entities have completed their upgrades.

The switch to ICD-10 will require changes to your practice processes, including changing super bills to accommodate for the new code set.

Additionally, you will want to assess the training needs of your staff and identify educational opportunities.

The Massachusetts Medical Society will continue to provide information and services in support of the upcoming ICD-10 implementation. Visit www.massmed.org/PPRC for more information. **VS**

State Approves Expedited Partner Therapy

In August, the state's Public Health Council voted to approve regulations for expedited partner therapy (EPT) for chlamydia infection. The regulations allow a clinician to write a prescription for a patient's partner without personal assessment by the clinician. Clinician provision of the EPT prescription is voluntary.

Chlamydia is the most commonly reported sexually transmitted infection in the United States. In Massachusetts, 21,236 cases were reported in 2010, more than double the number reported 10 years earlier. Most individuals with chlamydia are asymptomatic, may not independently seek treatment, and may reinfect their partner(s). The regulations aim to reduce the incidence of chlamydia in the population and reinfection of the individual patient.

"EPT helps prevent reinfection by increasing the likelihood that sex partners are effectively treated, even if they are unwilling or unable to seek medical care on their own," said Katherine Hsu, M.D., M.P.H., medical director of the division of STD Prevention at the Massachusetts Department of Public Health.

Therapy is not contingent on clinical or laboratory examination and is presumptive with respect to known exposure to the sexually transmitted infection (STI), according to CDC treatment guidelines published in 2010 (www.cdc.gov/std/treatment). Under the regulations, a written prescription with EPT written in place of the patient name and address will be valid. For chlamydia, standard treatment is one oral dose of 1 g of azithromycin.

The Department of Public Health is developing fact sheets for clinicians to provide with EPT prescriptions, including encouragement for patients' partners to follow up with their clinicians. "Optimally, both partners will see their physicians for evaluation," said Hsu. The clinical encounter is an opportunity to test the patients for other STIs and discuss appropriate prevention and treatment. **VS**

For more information, including patient info sheets and instructions for e-prescribing, visit www.mass.gov/dph/cdc/std.

Vaccinate Your Patients against Flu

Did you know that 55 percent of high-risk adults in Massachusetts did not receive flu vaccine last flu season? Studies have shown that a physician's recommendation is the most important determinant of whether or not a person gets vaccinated. And, offering the vaccine to your patients is even more effective than just recommending it.

A study published in the August 19, 2011, *MMWR* reported that 71 percent of pregnant women who were offered flu vaccination by their health care provider (HCP) last flu season got the vaccination, compared to 14 percent whose HCPs did not offer them the vaccine. The former group was also more likely to

have positive attitudes about the effectiveness and safety of flu vaccination during pregnancy.

This year, local health departments expect to vaccinate significantly fewer adults; due to budget cuts, the state is supplying half as much vaccine to local health departments and community health centers as last year. Physicians, both specialists and primary care, should consider every patient visit between August 2011 and March 2012 an opportunity to offer flu vaccine.

Not set up for flu vaccination in your office? An Adult Vaccination Guide, available at www.immunize.org/guide, provides step-by-step instructions for planning, purchasing, handling, storing,

administering, and paying for vaccine. To find vaccine manufacturers and distributors, visit www.preventinfluenza.org/ivats. Insurance will reimburse for the cost of the vaccine and the administration.

— Allison Hackbarth
and Donna Lazorik, R.N., M.S.
Massachusetts Department
of Public Health

If you have questions about flu vaccine, please call the Massachusetts Department of Public Health Division of Epidemiology and Immunization at (617) 983-6800.

For links to information about the flu vaccine and high-risk populations, visit www.massmed.org/flu.

Tornado Response — One Physician's Experience

On June 1, tornadoes struck western Massachusetts, uprooting trees, homes, and buildings. Ardis Fisch, M.D., a solo practitioner in Lee, Massachusetts, who responded to the disaster, shares her experience.

I heard about the tornado in a store, when a woman got a phone call and learned that her house was gone. I joined the Berkshire Medical Reserve Corps six years ago and was able to respond right away.

My first day was Saturday, three days after the tornado. The shelter was at a high school in Springfield. Right as I got there, someone was having chest pains, which turned out to be an anxiety attack. There were a variety of medical issues that day — one guy had been crushed by a wall, a woman had end-stage renal failure, a girl presented with abdominal pain. I saw a lot of chest pain (mostly anxiety), a lot of diabetics, and a lot of blood sugar checks.

People who lost their homes also lost prescriptions and CPAP machines. We gave them prescriptions to tide them over and spent a lot of time making phone calls. There was a Somali family that no one could communicate with. We called the translation line through the hospital, and were able to figure out what they



Ardis Fisch, M.D., (back row, second from left) at Springfield High School with members of Southern Berkshire Medical Reserve Corps, the medical team who cared for victims of the tornadoes that hit western Massachusetts in June.

needed, including a place for the father to pray privately.

By Sunday, there was already a lot less going on. One guy flipped out and I had to keep the MPs from arresting him; he had psychiatric diagnoses and was unable to tolerate being surrounded by so many people.

On Wednesday, I was at the shelter in the arena building downtown where people were much calmer, not as isolated as they were at the high school.

It was a learning experience. The cots in the shelter were from the army and designed for people 150 pounds or less. Since many people were overweight, the cots kept breaking. The dinner consisted of three kinds of pasta, two kinds of rolls, and salad. Unfortu-

nately, cheap food tends to be laden with carbohydrates, so we'd check blood sugars and send diabetic patients off for a breakfast of donuts or bagels.

It was a sobering experience. These were people who didn't have much to start with and had nowhere else to go — one was a single mom with four kids who just needed to sit in a room and cry. It's one of those things that makes you stop and think, when you go home and still have your house and all your things.

The volunteers were great, knew what they were doing, and were enthusiastic and energetic. The patients seemed to appreciate having a physician present and were so appreciative of the work we were doing.

FEDERAL UPDATE

The Fall of Our Discontent

As *Vital Signs* goes to press, the nation and presumably many members of Congress are still reeling from the rancor and distaste from the first debt ceiling debate.

The fall legislative agenda may prove to be even more onerous as Congress attempts to deal with the debt ceiling legislation and the budget for 2012. Cuts to Medicare, Medicaid, and the future of the Sustainable Growth Rate (SGR) will be central to both.

Sen. John Kerry is one of the six members of the Senate Joint Select Committee on Deficit Reduction that is charged with making recommendations to Congress by November 23 for \$1.5 trillion in cuts over 10 years.

If Congress fails to act, a 2 percent across-the-board cut will be enacted. As a long-time member

of the Senate Finance Committee, Sen. Kerry has a long history of advocating for Massachusetts patients, physicians, and health care.

The AMA is working with the MMS and other state and national medical societies to strongly urge the Joint Select Committee to include a provision to permanently reform the Medicare physician payment system. Key points include:

- Any serious proposal to confront the fiscal challenges facing our nation — the Medicare program in particular — must address the massive shortfall in funding for Medicare payments for physician services. The current SGR formula calls for cuts of 29.5 percent on January 1, 2012. There is unanimous agreement

that cuts of this magnitude will result in massive disruptions for the nation's elderly and disabled populations.

- Failure to act now will dramatically increase the cost of necessary action in the future. Had Congress acted as recently as 2005, the 10-year cost of preventing future cuts would have been \$48 billion. Today, it's estimated that averting currently scheduled cuts would cost nearly \$300 billion over the next 10 years. If Congress were to wait until 2016 to eliminate the SGR, the combined score for providing temporary patches through 2016 and then eliminating the SGR would approach an estimated \$600 billion.

- Continued short-term interventions are creating instability in physician practices and are jeopardizing seniors' access to care. Eliminating the SGR is an essential element of any effort to reform Medicare.

- A credible deficit/debt agreement should not include a Medicare budget baseline that assumes draconian physician payment cuts of almost \$300 billion.

While it would be premature to predict the outcome of this debate, it is clear that the ongoing fight over the debt ceiling and the budget will dominate the remainder of the legislative session. For physicians and their patients who rely on Medicare and Medicaid, the outcome will be historic. **VS**

Murphy

continued from page 1

made their quarterly rate filings, and the increases this year were under 6 percent. We estimate that saved consumers at least \$125 million since we changed the way we reviewed those rates."

Legislation passed last year further empowered the Division of Insurance by granting it the ability to "presumptively" deny rate increases if medical-loss ratios, administrative expenses, and surpluses didn't meet specific targets. Under the Governor's bill, the Division would also get additional powers to reject premium increases based on the insurers' contracts with providers.

"I imagine that we would be doing that the way we have been doing things, through an open, transparent process," he said. "We call them special sessions, where we bring in everyone to make sure we do things in a thoughtful way. We don't want to disrupt the apple cart too much, as we try to move away from a fee-for-service based system to a global system."

When asked whether he's seen any trends in health care costs, he

noted that utilization seems to have modestly lowered, but in his opinion, provider price disparities continue to drive higher health care prices.

He said, "There's no silver bullet to cost containment. It's a combination of those factors. The most recent filings were under 5.9 or 6 percent, so we are seeing somewhat of a slowdown from where we were a year ago."

ACO Development and the State Bureaucracy

Murphy said on a number of occasions that he doesn't want the state oversight process to be overly burdensome to providers. "It would not be our intention to create a new bureaucracy," he said. "We would be using the existing structure, although there is the creation of oversight councils. We would be utilizing Division of Health Care Finance and Policy data; we would not be requiring you to file 160,000 different contracts with the Division for review."

Murphy sought to allay concerns that the accountable care organization (ACO) oversight process will be burdensome. "Our hope is to come up with an approach that's somewhat streamlined so that we wouldn't have duplication. We want providers and insurers to get back to the business at

hand — providing care to folks who need it and quality care at an affordable cost so we are extremely sensitive to the issue of over-regulation."

However, Murphy left no doubt that his agency would carefully review the risk-based contracts of ACOs to ensure financial solvency.

"The Governor's legislation gives a very clear role to the Division, as well as to others. There needs to be solvency monitoring if you're taking on risk," he said. "We are adamant that entities that take on risk meet certain financial standards, with continued financial monitoring, to ensure that, at the end of the day, they're able to meet their obligations."

At the same time, he acknowledged that provider organizations should be treated somewhat differently from traditional insurance companies and that his staff is reviewing model regulations from the National Association of Insurance Commissioners to monitor ACO solvency.

He noted that some provider groups have publicly speculated about contracting directly with employers (without the benefit of an insurer acting as the intermediary), and if this becomes more common, his staff will be active.

"We want to make sure that folks know what the rules are today, what's proposed, and that those rules are consistently applied going forward," he said.

"But we're certainly sensitive to the impediments that regulations can bring to physicians who are trying to organize an ACO moving forward. All of this will be done through an open, transparent process, as we've done before. There will be plenty of opportunity for folks to weigh in," he said.

Provider Price Disparities

Murphy echoed the opinion of others within the Patrick administration that price differences among provider groups are a significant cause of rising health care premiums — though not the only cause. He said payment reform must not turn a blind eye to that issue.

"The Governor's legislation was carefully crafted," he said. "We want to be careful that whatever system we move to, that we don't bake into that system existing inequities that are in the current system. That is why the legislation includes a provision where the Division will set maximum allowable increase that a carrier can enter into with a given provider." **VS**

New England Medical Association to Serve Physicians of Color

For the past year, the Society has been engaged in efforts to help reactivate the New England Medical Association (NEMA, formerly the New England Medical Society). The Society has successfully helped NEMA obtain its articles of organization in Massachusetts and continues to support the organization's future endeavors.

NEMA represents the interests of physicians practicing or residing in the New England area who are of color or care for minority patients. NEMA advocates for, educates, and mentors physicians, enhancing practice viability and

sustainability. NEMA seeks to help the underserved to assure equity in the delivery of health care by promoting health care literacy and patient empowerment.

NEMA is an official state society of the National Medical Association (NMA), which is the nation's oldest and largest organization representing minority physicians and health professionals in the United States. Please contact Dr. Karen Winkfield, president of NEMA, for more information about NEMA at kwinkfield@partners.org. **VS**

Pri-Med East Returns to Boston

The MMS is a partnering organization for Pri-Med East, a comprehensive medical conference that provides extensive continuing medical education opportunities. The event will be held at the Boston Convention and Exhibition Center, Thursday, October 27, through Sunday, October 30.

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 exhibition area will provide opportunities to review the latest in pharmaceuticals, medical devices, and technologies. **VS**

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

Research Poster Symposium

Friday, December 2, 2011 • 12:00 to 3:00 p.m.
MMS Headquarters, Waltham

Submission deadline for abstracts: Monday, October 3, 2011

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

Practicing Modern Professionalism

The complex requirements of professionalism in medicine challenge practitioners to look beyond simple statements of rules and responsibilities. "Do no harm," "respect the patient," and "be truthful" are all guides that may seem simple at first glance, yet they are grounded in important philosophical movements that range from the ancient Greeks to the post-modernists. They are foundations that are not always familiar to practitioners who must spend their time working with patients rather than exploring the ethics of their forebears.

The good news is that physicians need not be philosophers to be ethical practitioners. Professionalism is not generally put into practice by studying the old philosophers, but through honing the ethical habits and skills that are emphasized in training. Whether it is in the patience of a senior attending who recognizes the patient's vulnerability when receiving bad news, or the self-reflection of a student who recognizes the difficulty he has when working with terminal illness, these habits and skills are found commonly in the daily work of physicians.

Habits such as practicing openness and collaboration when working with colleagues or striving for objectivity in the interpretation of clinical data are all part of the armamentarium of those who practice a robust medical professionalism. They are part of a vision of professional duty that underlies many current developments in medicine, from patient-centered practice and quality assurance to civility in the workplace.

Behaviors are a reliable indicator of these ethical habits. Do practitioners recognize the limits of their knowledge? Do they educate themselves and keep up with the literature? Do they consult regularly with others when they are in doubt? Self-assessment, education, and consultation are easily recognizable habits of the ethical practitioner — ones that can be taught, recognized, and reinforced.

Psychological habits are part of this repertoire. Self-reflection

and self-awareness may be useful in monitoring personal bias or processing difficult emotions. Managing one's emotions and reactions to patient behaviors are important in seeing the patient as a whole person, rather than just as a diagnosis or intervention (e.g., the classic "gall bladder in Room 6"). Accepting feedback on one's blind spots or reflecting on them in retrospect makes one a better colleague and practitioner at the same time.

Recognizing the vulnerability of patients to the power and knowledge differential with physicians deserves recognition as its own ethical skill. Ethical problems arise at the outset of all relationships of unequal power. If the purpose of medical discussions is for patients to be empowered to exercise their autonomy — free from the coercion of the situation, their condition, and the complexity of clinical language — physicians will practice this skill so that patients can truly participate in the process of informed consent.

Routine discussions of patient values over the course of the clinical relationship are critical to effective patient-physician collaboration. Addressing potential clinical outcomes in the context of patient values are an aspect of medical professionalism often raised in discussions of advance-care planning or end-of-life decision-making. Yet they are a vital component of the ongoing relationship with the patient across all stages of life.

Practicing openness with patients, being sensitive to their vulnerability, identifying one's own limitations, educating oneself, maintaining collegial relations, and monitoring one's responses are all habits and skills of an ethical practitioner. They are critical pieces of a robust and modern medical professionalism. **VS**

— Philip J. Candilis, M.D., D.F.A.P.A.

Dr. Candilis is an associate director of Physician Health Services and an associate professor of psychiatry at the University of Massachusetts Medical School.

IMGs: From Training to Green Cards

J-1 Waivers, Work Visas, and Immigration Card Options

Featuring Two Prominent Immigration Attorneys:
Roy Watson, Esq., and Greg Siskind, Esq.

Join us for dinner and an informative session addressing issues such as:

- Screening job opportunities
- Navigating the H-1B quota
- J-1 Waivers: Conrad and other federal waiver options involving shortage areas and other types of waivers
- Green card options: the end game
- An update on new federal legislation that will be introduced in the next session

Wednesday, October 12, 2011
Dinner and presentation
6:30 to 8:30 p.m.

Massachusetts Medical Society
(FREE Parking), Waltham, MA

- MMS Members: \$20
- Nonmembers: \$40

Nonmember Special Offer!

Join the MMS for \$100 and attend this program for FREE **VS**

To register, visit www.massmed.org/IMG_Event.

Interim Meeting Resolution Deadline: October 18

The 2011 MMS Interim Meeting of the House of Delegates will be held on Friday and Saturday, December 2 and 3.

The deadline for submitting resolutions is October 18. Members can submit resolutions online at www.massmed.org/resolutions or via email to resolutions@mms.org.

For the first time, members have the option to post and share their draft resolutions online with colleagues for feedback prior to the deadline. Visit community.massmed.org for more details.

The deadline for reservations at the Westin Hotel is October 21. Please call (781) 290-5600 to make reservations directly with the hotel.

Visit www.massmed.org/interim2011 for more details about the 2011 Interim Meeting and to register online.

ACROSS THE COMMONWEALTH

District News and Events

Barnstable/Bristol North — Joint Family Event.

Sun., Oct. 2, self-guided tours (optional) beginning at 10:00 a.m. until closing, noontime luncheon. Location: Heritage Museum and Gardens, Sandwich. For more information, contact the Southeast Regional Office.

Berkshire — Fall Meeting. Thurs., Oct. 20, 6:00 p.m. Location: Zucchini's Restaurant, Pittsfield. Speakers: Theresa Zink, M.D., and Richard Berlin, M.D. Title: "Who Is the Modern Country Doctor? The Journey of Defining Him/Her." For more information, contact the West Central Regional Office.

Essex South — Fall Meeting. Tues., Oct. 18, 6:00 p.m. Location: Peabody Marriott, Peabody. Guest Speaker: Rep. Steven Walsh. For more information, contact the Northeast Regional Office.

Hampden — MMS Interim Delegate Caucus Meeting. Tues, Nov. 29, 6:00 p.m. Location: HDMS, 1111 Elm Street, Suite 22, West Springfield. **Winter District Meeting.** Medical Legal Forum: Medical Legal Ramifications of EMR. Tues., Jan. 24. Location: Max's Tavern, Basketball Hall of Fame, 1000 West Columbus Blvd, Springfield. Registration: 6:00 p.m. Dinner: 6:30 p.m. Program: 7:00 p.m. Member: No charge, Nonmember fee: \$37.50. For more information contact Suzanne Skibinski, executive director, at (413) 736-0661 or hdms@massmed.org.

Middlesex West — Fall Meeting. Wed., Oct. 19, 6:00 p.m. Location: Aegean Restaurant, Framingham. Guest Speaker: George Santos, M.D. "Medicinal Plants in Literature, Art, History, and Geopolitics." For more information, contact the Northeast Regional Office.

Norfolk South — Family Event. Sun. Oct. 9, 1:00 p.m. Location: Luncheon aboard the Pilgrim Belle, Plymouth. For more information, contact the Southeast Regional Office.

Plymouth — District Meeting. Tues. Oct. 18, 6:00 p.m. Location: Stoneforge Tavern, Raynham. Guest speaker: Lynda Young, M.D., MMS president. For more information, contact the Southeast Regional Office.

Suffolk — Fall Meeting. Thurs., Oct. 20, 6:00 p.m. Location: Massachusetts General Hospital, East Garden Room. For more information, contact the Northeast Regional Office.

Worcester — WDMS Forum. Thurs., Oct. 13, 5:30 p.m. Location: Beechwood Hotel. Financial Planning Seminar for Young Physicians, Residents, and Students. Sponsored by the WDMS Alliance, WDMS Public Relations Committee, and PIAM Financial Services. **Medical Education Program.** Wed., Oct. 19, 5:30 p.m. Location: Beechwood Hotel. Topic: "Charting the Course: Health Care in the Post-Reform Era." Speaker: Lynda Young, M.D., MMS president. This live risk management program is supported by a grant from Guenter Spanknebel, M.D., given to him by the Health Foundation upon his retirement from service as a founding director of the foundation. For more information, contact Joyce Cariglia at (508) 753-1579 or wdms@massmed.org.

Statewide News and Events

Arts, History, Humanism, and Culture Member Interest Network — Bird Banding. Sat., Oct. 1, 9:00 a.m.–12:00 p.m. Location: Joppa Flats Educational Center, Newburyport. **Music and Medicine Program.** Sat., Oct. 15, 6:00–9:00 p.m. Location: Tower Hill, 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 2011. We also note member deaths on the MMS website at www.massmed.org/memoriam.

Paul M. Burke, M.D., 87; Peabody, MA; Boston University School of Medicine, 1949; died June 24, 2011.

Stanley H. Cath, M.D., 90; San Francisco, CA; Boston University School of Medicine, 1946; died June 24, 2011.

Robert F. Curran, M.D., 79; North Andover, MA; Tufts University School of Medicine, 1961; died August 21, 2011.

George T. Hamm, M.D., 91; Wildwood, GA; Loma Linda University School of Medicine, 1951; died August 1, 2011.

Leston L. Havens, M.D., 86; Cambridge, MA; Cornell University Medical College, 1952; died July 29, 2011.

Harold J. Kosasky, M.D., 83; Chestnut Hill, MA; University of Manitoba Faculty of Medicine, 1953; died July 21, 2011.

Elliott M. Marcus, M.D., 78; Key Biscayne, FL; Tufts University School of Medicine, 1958; died July 25, 2011.

George S. Richardson, M.D., 89; Nahant, MA; Harvard Medical School, 1946; died July 1, 2011.

Robert N. Semine, M.D., 88; Weston, MA; Faculty of Medicine, Alexandria University, Alexandria, Egypt, 1949; died June 15, 2011.

Wilhelmina M. Van Dyke, M.D., 97; San Diego, CA; University of Michigan Medical School, 1938; died March 12, 2011.

Richard V. Wilson, 89; Laconia, NH; University of Cincinnati College of Medicine, 1922; died August 1, 2011.



MMS MEMBERSHIP

PROVIDING VALUE

- Continuing Medical Education
- Practice Management Tools
- Online Resources
- Advocacy


It's Time to Renew

Renew online at www.massmed.org/renew.

Or watch for your membership renewal notice in the mail.

(800) 322-2303, ext. 7311 | info@massmed.org

Thank you for your loyalty. Renew today!



INSIDE ▶

- ▶ **Workforce Shortages and Changing Environment Page 1**
- ▶ **Preparing for ICD-10 Page 3**
- ▶ **Tornado Response — One Physician's Experience Page 4**



MASSACHUSETTS
MEDICAL SOCIETY

860 Winter Street,
Waltham, MA 02451-1411

VITALSIGNS

VOLUME 16, ISSUE 8, OCTOBER 2011

NONPROFIT
U.S. POSTAGE
PAID
BOSTON, MA
PERMIT 59673

MMS SPONSORED AND JOINTLY SPONSORED CME ACTIVITIES

LIVE CME ACTIVITIES

Go to www.massmed.org/cme/events or call (800) 843-6356. Unless otherwise noted, event location is MMS headquarters, Waltham.

CME Accreditation Orientation
Wed., Oct. 5, 8:00–11:45 a.m.

Caring for the Caregivers VIII: Meeting Changes and Challenges

Jointly Sponsored by the MMS and Physician Health Services, Inc. Fri., Oct. 14, 8:00 a.m.–5:00 p.m.

Federal Funding Opportunities

Jointly Sponsored by the MMS and the Biomedical Science Careers Program. Thurs., Oct. 20, 3:00–7:00 p.m. Harvard Medical School, Boston, MA

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.

SAVE THE DATE

Friday, November 18

2011 Annual Directors of Medical Education Conference

ONLINE CME ACTIVITIES

Go to www.massmed.org/cme.

Massachusetts Medical Law Report Risk Management CME Series

- **NEW** Medical Mistakes: Learning to Steer Clear of the Common Ones
- Managing Risk When Prescribing Narcotic Painkillers for Patients*
- The Importance of Discussing End-of-Life Care with Patients*
- Managing the Risks of Practicing Telemedicine*
- A Primer for Accountable Care Organizations*
- Avoiding Failure to Diagnose Suits*
- Getting It on Record and Getting It Right*
- Physician Practices Scramble to Comply with New Privacy Reg*
- Dealing with the Changing Dynamic of the Medical Staff*
- Health Providers Facing Stiff HIPAA Regulations
- Health Care Providers Brace for Medicare Audits*
- Social Networking 101 for Physicians*

**Also available in print. Call (800) 322-2303, ext. 7306.*

The Legal Advisor Risk Management CME Series

- Terminating the Doctor-Patient Relationship
- Advance Directives
- Boundary Issues in the Physician-Patient Relationship
- Public Health
- **NEW** MA Responds Orientation Course
- 5th Annual Public Health Leadership Forum — Violence: Implications for Health

TO REGISTER FOR ANY OF THESE ACTIVITIES, CALL (800) 843-6356.

CME CREDIT: These activities have been approved for AMA PRA Category 1 Credit™.

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



Risk Management
massmed.org/cme

100% Relevant Content

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