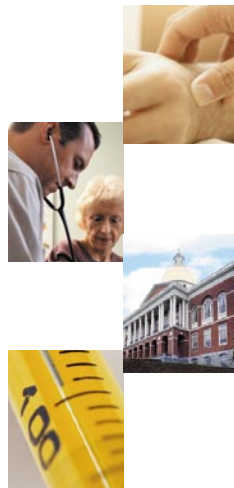




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Medical Home Model Could Resuscitate Primary Care

BY TOM WALSH

Reformers in Massachusetts and nationwide are planning pilot projects to test new models of primary care practice and payment. Responding to what many are calling a crisis in primary care, these reformers are promoting redesigned primary care practices and alternatives to the current visit-based system of payment.

In Massachusetts, wait times for visits to primary care practices have lengthened considerably, many practices have stopped accepting new patients, and the number of new physicians choosing primary care as a career continues to plummet. "If your primary care physician retired or cut back tomorrow, you would face serious trouble getting a new one," said Allan H. Goroll, M.D., a Boston internist, immediate past governor of the Massachusetts chapter of the American College of Physicians (ACP), and past president of the MMS. Dr. Goroll has written and spoken widely about primary care reform. "The bad news is that we've let this become a crisis; the good news is that having a crisis means the problem will now get the attention it requires."

The worsening primary care environment was underscored with the recent release of the 2007 MMS Physician Workforce Study (see *Vital Signs*, August, page 1). This year's study showed continuing erosion in the ranks of physicians engaged in primary care.

"The [primary care] system right now is broken," observed Barry Z. Izenstein, M.D., an internal medicine practitioner in Springfield and current governor of the Massachusetts ACP.

While many health care leaders cite a dysfunctional payment system as the central cause of the crisis, they also recognize the need for more accessible, patient-centered care that is affordable, cost-effective, evidence-based, and safe. Primary care specialties have responded by designing a new model of practice referred to as the "medical home." Key features include a physician-led multidisciplinary team, an electronic health record infrastructure with decision support, 24/7 accessibility, and payment reform.

What and Where Should "Home" Be?

The national ACP, whose immediate past president, Lynne M. Kirk, M.D., described the medical home at the MMS Annual Meeting in May, adopted the following principles to guide the concept:

- Patients should have a personal physician.
- The practice or medical home should be physician-directed.
- Patient care should be "whole-person" oriented.
- All care must be coordinated.
- Quality and safety must always be paramount.
- Reimbursement must be adequate to support the concept.

In May, Dr. Kirk told the MMS, "the goal [of the medical home] is not to

restrict access to specialists, but to facilitate and integrate care with the whole-person perspective of the patient's personal physician."

"Primary care specialties believe that the primary care practice should be the patient's medical home," Dr. Goroll said. "It's your medical base, the place that provides you with personalized care and advocates on your behalf. This concept was the standard of care for years before the pressures of dysfunctional payment systems caused care to decline."

Team Approach

Medical home practices would use an expanded team approach supported by

information technology to improve access. A physician-led multidisciplinary team might include nurse practitioners, physician assistants, health educators, dietitians, mental health professionals, social workers, and expanded support staff. The workflow among the team would be organized to improve access, efficiency, and patient responsiveness while holding down costs.

While the medical home concept is sometimes mentioned as part of a strategy to contain spiraling health care costs, Dr. Goroll said, "This is not predominantly about saving money; it's about

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Fewer Administrative Hassles Seen as Biggest Win in National Blue Cross Settlement

BY TOM WALSH

For some Massachusetts physicians, settlement of a national class-action lawsuit against the Blue Cross Blue Shield plans may mean a modest financial gain. But for doctors who treat patients covered by Blue Cross Blue Shield of Massachusetts (BCBSMA), it will mean fewer administrative hassles.

According to Stuart B. Mushlin, M.D., chair of the MMS Committee on the Quality of Medical Practice. "The settlement recognizes that business as usual during the last 20 years is unacceptable."

Administrative Concessions Key

MMS analysts believe the settlement's greatest significance for physicians lies in the administrative concessions agreed to by BCBSMA and each of the other 25 plans included in the nationwide

agreement (see box on page 2). "Obviously this part of it is very important, especially around transparency," said Elaine Kirshenbaum, MMS vice president for policy, planning, and member services.

Blue Cross of Massachusetts declined to discuss settlement specifics with *Vital Signs*. However, Christopher Murphy, a BCBSMA spokesman, said, "In general, the reason we participated in the settlement was because it was in the best interest of our relationship with the physicians who provide care for our members." The Blue Cross settlement is the latest in a series of similar outcomes involving class-action suits against other national health plans.

Lawyers who handled the suit, which was tried in a Miami federal court, called the settlement historic. They added in a

continued on page 2

PRESIDENT'S MESSAGE



The Healthy-Weight Challenge

Everywhere we look — from our own *New England Journal of Medicine* to the nightly news

on TV — evidence of the serious consequences of the overweight/obesity problem is overwhelming.

We physicians must come up with non-threatening, effective ways to talk about achieving — and maintaining — healthy weight. Conversations about diet and exercise are not easy, but they must take place, one on one with our patients, with policymakers and legislators, and in the community at large.

Everyone recognizes how difficult it is to change. Knowing what we should do to get our body mass index or blood pressure where it belongs is an essential but only modest beginning. Implementing the changes is everything.

Our patients spend most of their time outside our offices — at home, school, on the job, and in the community. Nearly everything about those environments — longer work hours, the dearth of safe places to walk, supersized restaurant portions, cutbacks in school physical education — is conducive to making us fatter.

Consequently, as physicians, we have to take the healthy-weight message beyond the walls of our offices. The Medical Society is looking for partners to collaborate with on this important effort. I'm impressed and fully supportive of the MMS and Worcester Alliance's pedometer projects to promote exercise

in Worcester's inner-city schools. And I hope our public health education campaign promoting healthy weight is having a community-wide impact in Boston, Springfield, and Worcester, where we concentrated those multimedia messages. I'm inspired by what's happening in Somerville, where the city's "Shape Up" initiative has prompted healthy improvements in school lunches and restaurant fare. I hope to see healthy weight embedded in upcoming MMS-sponsored policy and educational events, including the 2008 Annual Meeting. Finally, we have requested that the MMS caterers list nutritional information with meals served at the Society.

On a more personal note, I have a family history of high blood pressure and cholesterol, so when I see those numbers go up, I adjust my diet and increase my activity, and the numbers go back down. Here are some simple tactics that have worked for me:

- Skip dessert
- Substitute steamed veggies for less healthy side dishes.
- Don't eat everything on your plate.
- Walk up and down stairs instead of using escalators and elevators.

We need to make individual and community-wide commitments to healthy weight and fitness. So let's get moving!

— B. Dale Magee, M.D.

Medical Home Model

continued from page 1

improving the quality, safety, efficiency, and patient-centeredness of care."

Payment Reform a Must

Implementing the medical home model will require investment in primary care practices, noted Dr. Goroll. "A new social contract is being proposed," he said. "In return for accepting responsibility for higher health system performance, primary care physicians are demanding new net investment in primary care practices." Dr. Goroll and his colleagues propose replacing the current visit-based, relative-value system of payment for primary care with a risk-adjusted comprehensive payment plan. Other ideas include adding a management fee to current visit-based payment formulas.

Dr. Goroll estimates that the net investment required to reform primary care would be readily offset by reductions in wasteful spending, medical errors, and delays in care.

Fewer Administrative Hassles

continued from page 1

news release that they believe it includes "important and valuable business practice changes" that will streamline the way Blue Cross plans interact with doctors and, ultimately, achieve substantial health care cost savings.

Settlement Timeliness

Notices of the approved settlement were mailed nationwide on July 27 to the estimated 900,000 affected physicians. Doctors have until October 19 to file claims following the procedures outlined in the notices.

The plans have been assessed a total of \$131,209,507 in monetary damages, according to court documents. Of this total, the BCBSMA assessment is \$7,739,271. Claims may amount up to \$1,000 per doctor, depending on how many doctors file claims under the settlement, which covers the years 2004 through 2006.

Doctors may opt out of the settlement and thereby preserve their right to sue plans as individuals. However, they must opt out by September 14, or they automatically become part of the class-action settlement.

Due to the complexity of the claims process, the MMS entered into an agreement with Managed Care Advisory Group, LLC, (MCAG) to assist Society members with claims. For more information about the settlement and MCAG services, visit www.massmed.org/bcbs_settlement. VS

The MMS supports the medical home concept. "It will enhance our ability to coordinate care, increase the capacity of the average primary care office, and lead to better care for more patients," said MMS President B. Dale Magee, M.D.

Autumn Summit Eyed

Sometime this fall, Drs. Goroll, Izenstein, and others will convene a meeting of the state's health care leaders to discuss a collaborative effort to pilot medical home demonstration projects in conjunction with payment reform. Similar projects are springing up across the country. In Rhode Island, a program will begin soon, and the state's insurers plan to finance the demonstrations. Eventually, Dr. Goroll said, federal legislation may be needed to turn the medical home concept into widespread reality. The Massachusetts pilots will likely run through 2009 and may help inform policy formulation in Congress. VS

Blue Cross Settlement Summary

The following changes imposed on the Blues by the class-action settlement require BCBS plans to:

- Define "medical necessity" so that patients are entitled to receive medically necessary care as determined by a physician
- Use clinical guidelines based on credible scientific evidence
- Provide an independent medical necessity review process
- Establish an independent external review board for resolving common billing disputes
- Pay for recommended vaccines
- *Not* automatically reduce the intensity coding of evaluation and management codes
- Ensure payment of valid, clean claims within 15 days (electronic claims) and 30 days (paper claims)
- Provide fee schedules to physicians
- Establish a dispute mechanism to address issues concerning plan compliance with the settlement
- Establish or maintain physician advisory committees
- Provide 90 days notice of any change in practices, policies, or fee schedules

NOTE: Massachusetts law has already addressed some of these requirements.

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

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

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LAW AND ETHICS

Medical Peer-Review Privilege Pierced in Federal Discrimination Case

The medical peer-review privilege protects certain materials from discovery and disclosure during legal processes. This privilege is unique. Unlike the doctor-patient privilege, for example, where only the patient can waive the privilege, no one involved in the peer-review process can waive the privilege. Proponents argue that the peer-review privilege promotes candor essential to ensuring quality health care and patient safety. Opponents contend that misuse blocks disinfecting sunlight from shining on the legal process.

This summer, the protections associated with medical peer review were weakened. The U.S. Court of Appeals for the Eleventh Circuit held in *Adkins v. Christie, et al.*, that the Georgia peer-review law does not apply in federal civil rights cases. The Eleventh Circuit joined the Fourth Circuit (in a 1981 federal antitrust action) and the Seventh Circuit (in a 2001 federal discrimination case) in declining to recognize the peer-review privilege in federal court when a countervailing and compelling government interest is at stake.

Dr. Adkins filed a federal civil rights lawsuit claiming that his hospital's suspension of his medical privileges was racially motivated. After limiting the scope of discovery, the trial court found no evidence of racial discrimination. Dr. Adkins appealed.

On appeal, the Eleventh Circuit balanced "the interest to be derived from the privilege against the interest of furthering discovery of probative and relevant evidence to root out invidious discrimination." The Eleventh Circuit found

that, on balance, the interests in facilitating the eradication of employment discrimination prevailed and that the medical peer-review process "does not warrant the extraordinary protection of an evidentiary privilege in federal civil rights cases." Accordingly, the Eleventh Circuit held that the trial court erred in "denying [Dr. Adkins] the opportunity to compel discovery of a wider range of documents," and the trial court's judgment was vacated. The case was remanded back to trial court for further discovery.

The *Adkins* decision highlights that the peer-review protections afforded by state courts under state law will likely be unavailable in federal courts, at least in civil rights cases. The Eleventh Circuit, however, "recognize[d] that health care providers ... have a legitimate interest in keeping peer-review documents confidential and in protecting them from widespread dissemination In the absence of the privilege, the [trial] court retains its authority to protect [the hospital's] interests through other established means such as protective orders, confidentiality agreements, and when appropriate, by disclosure only after in-camera review." Therefore, this decision does not mean that peer-review materials have lost all protection from compromise by wayward hands. **VS**

— Sarah Elisabeth Curi, J.D., M.P.H.

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

New PPRC Resources Helps Physicians with Business Plans and Practice Valuation

The Physician Practice Resource Center (PPRC) developed two new tools to help physicians manage key business aspects of their practices.

A Guide to Developing and Writing a Basic Business Plan for Your Practice

Creating a business plan is a critical piece of owning and running a practice. A basic business plan should give the practice owner(s) a set of data that provide detail into the structure and thought process behind the practice.

For already-established practices, a business plan is a great way to determine if the goals of the practice are being met.

The guide offers a template that helps physicians establish their baseline expectations and provides examples of the types of information needed to expand the basic business plan "shell."

A Guide to Establishing a Baseline Value for Your Practice

Practice valuations are applied in a variety of circumstances. Performing one

How to Respond to a Medical Records Audit

It's no secret that payers — including Medicare, private insurance companies, and HMOs — have substantially increased their oversight of physician practices, leading to a growing number of medical records audits. From the targeted physician's perspective, such audits begin with a request for patient records. That request may be for a random sample of patient records, or it may identify specific procedural or diagnostic codes. The request may be for certain patients' complete medical files or for specific dates of service. Responding carefully to such requests can help you sidestep significant downstream hassles.

While some audits truly are random, most are planned in advance. The prudent provider should assume that there is some common denominator among the records that are selected or a pattern to the billing or other practices that the auditing agency considers suspect.

Not responding to an audit is not an option. Failure to respond is likely to result in a withholding of future payments, disenrollment/debarment from the provider network, or in the case of Medicare, a subpoena for the requested records (and probably additional records, as well).

Completeness Is Key

The first task in responding is to ensure that the records are complete. Each medical record should be compared to its corresponding billing record. Before sending any records in response to an audit request, use the following questions as a checklist for completeness:

- Is there a note for each visit?
- If a lab test or x-ray was ordered, is the report in the chart?
- If a consult was billed, is there a report to the referring physician?
- If a referral was made, is there an entry documenting it?

Two notes of caution when compiling records in response to an audit: first, never fabricate or alter a missing or wanting entry or document. Nothing will

lead more quickly to a fraud prosecution than producing records that have been tampered with. If records are incomplete, include a cover letter that provides the missing information. If such an addendum is necessary, seek the advice and/or assistance of legal counsel.

Second, the current trend in audit requests is for particular dates of service rather than complete medical files. Such requests can be traps for the unwary. This is not a situation where less is best, and here's why:

Medical records — and a physician's knowledge of his or her patient — are cumulative by nature. Isolated date-of-service entries are often inadequate to reflect the complexity of both the patient's medical history and the physician's medical decision-making. Since those are two key components in determining the appropriate evaluation and management (E/M) service level to be billed, if you don't provide sufficient documentation to support those decisions, the auditor may down-code — or disallow — the level of service billed. "Recoupments" add up fast, especially when auditors use the sample as a basis to extrapolate a larger overpayment.

In addition, isolated service date information may not include related test results, x-ray reports, or consultations (each of which often contributes to the E/M coding decision). Include all this collateral information with your response to the original request. Although most insurers have post-audit appeals procedures, the after-the-fact submission of additional materials may be viewed with a jaundiced eye.

Lastly, unless the auditors specifically request it, do not submit original records. For your records, be sure to make at least one complete copy of the records you submit, and number the pages. **VS**

— Paul Cirel, partner
Dwyer & Collora

For more information, contact Steve Quigley at (781) 944-3636 or stevequigley@comcast.net.

can be a complex process that may involve numerous other professionals, so physicians should understand the elements of a valuation and the thought processes behind it. This document gives physicians a look at some of the more common considerations entailed in practice valuation, including the rationale for various processes that the guide illustrates.

You can obtain these resources by visiting the MMS website and clicking on the "Physician Practice Resources" tab, or by contacting the PPRC at (781) 434-7702 or ashlager@mms.org. **VS**

— Adam Shlager,
Practice Management Consultant

Boosting Vaccination Rates Drives New ACIP Flu Shot Recommendations

On July 13, the Advisory Committee on Immunization Practices (ACIP) released updated recommendations regarding the prevention and control of influenza. The changes are aimed primarily at improving vaccination rates.

Estimated vaccination rates are less than 50 percent among certain groups for whom routine annual vaccination is recommended, including young children and adults with risk factors for influenza complications, health care personnel, and pregnant women.

"The challenge is a large population and a relatively narrow window of time to provide vaccination," said Edward Nalband, M.D., medical director of South Shore Medical Center, a multispecialty practice of more than 40 physicians.

In previous years, South Shore Medical Center set up flu clinics, bringing in existing staff at specified times to vaccinate large numbers of patients. Dr. Nalband found the approach efficient but a burden on the staff. Two years ago, South Shore Medical Center contracted with Maxim Health Systems, which set up and staffed the clinic and provided the vaccine. Physicians refer patients to the clinic but still administer flu shots during regular patient visits to those for whom getting to the clinic would be difficult. Contracting out the clinics frees up staff to provide other care to patients, said Dr. Nalband, who received his vaccination through the clinic.

Dr. Nalband commended the local hospital for further improving vaccination rates by offering flu and pneumococcal vaccinations to all eligible patients. Dr.

Nalband also noted a growing interest among patients in getting the flu shot.

Summary of ACIP Recommendations

The ACIP recommendations re-emphasize the importance of administering two doses of vaccine to all children six months to eight years of age who have not been vaccinated previously. Children in that age range who received only one dose in their first year of vaccination should receive two doses the following year.

To avoid missed opportunities for vaccination, the ACIP recommends that providers offer influenza vaccine during routine health care visits or during hospitalizations whenever vaccine is available. Providers should also schedule immunization clinics throughout the influenza season, because vaccine administered in December or later is likely to be beneficial, even if influenza activity has already begun.

The ACIP also advises health care facilities to offer influenza vaccinations to all health care personnel, particularly workers who provide direct care for persons at high risk for influenza complications. To further raise vaccination rates among health care personnel, the ACIP recommends that administrators include the level of staff vaccination coverage as part of patient safety quality programs and regularly measure and report vaccination rates.

To keep abreast of information about influenza activity and vaccine supply throughout the flu season, sign up for the MMS Flu Advisory Listserv. Visit www.massmed.org/conv/listservweb. VS

Physicians Step Up for Weight Loss

On Saturday, September 29, physicians in central Massachusetts will lead their patients on a three-mile walk to promote the importance of maintaining an active lifestyle. The second annual "Step Up for Weight Loss" walk and health fair is an effort of the Central Massachusetts Independent Physician Association (CMIPA).

"We want to get the message out about obesity, nutrition, and diet so people will understand the importance of these issues," said Wayne Glazier, M.D., a Worcester urologist and member of the CMIPA and the MMS.

Obesity is associated with a range of health concerns including heart disease, stroke, certain types of cancer, type 2 diabetes, osteoarthritis, respiratory disease, reproductive problems, and depression.

As part of the Step Up for Weight Loss effort, CMIPA is asking physicians to talk to their patients about obesity and physical activity — and to

ask patients to join them at the walk. "There's no better way for physicians to set examples for patients, and show they are committed to physical activity and improvement in overall health," said Dr. Glazier. "Getting people into the pre-

ventive mode will improve longevity, quality of life, and work to combat health care costs."

The event includes a health fair promoting awareness of the role of diet and nutrition in relation to good health. The health fair will include free screenings, consultations, and educational information about health issues such as cholesterol, blood pressure, skin care, and eye care. VS

— Robyn Alie



Photo by Beth Spray

Worcester District Medical Society members George Abraham, M.D. and Leonard Morse, M.D. set a positive example during the first annual Step Up for Weight Loss walk last year.

For more information about the CMIPA walk, call (508) 754-2273 or visit www.cmipa.com.

To get involved in or for more information about MMS efforts to promote physical activity and

healthy weight, contact ralie@mms.org or visit www.massmed.org/yourhealthfirst.

IHS Grant Applications Due Sept. 15

The MMS and Alliance Charitable Foundation awards \$750 International Health Studies (IHS) grants annually to medical student and resident members of the MMS.

The grants are intended to encourage international education, with a focus on underserved populations, by helping to defray the cost of pursuing medical studies in another country.

Applications for the next round of grants are due September 15.

The Foundation has awarded 26 IHS grants since the program was established six years ago. The Foundation's mission is

to support the charitable and educational activities of the Society and Alliance and to address issues affecting the health, benefit, and welfare of the community.

Since its inception in 2000, the Foundation has distributed more than \$1,127,000 in grants to programs addressing issues such as homelessness, sexual abuse and domestic violence, shaken baby syndrome,

hunger, and health care for the uninsured and underinsured.

For more information about the MMS and Alliance Charitable Foundation and the IHS grants, go to www.mmsfoundation.org. VS



Photo courtesy of Kim-Ngan Pham Fellman

IHS grant recipient Kim-Ngan Pham Fellman (back row, right) at an orphanage near Ho Chi Minh City, Vietnam

WEBSITE OF THE MONTH

Poison Control and Prevention

In Massachusetts and Rhode Island, more than 65,000 poisonings occur each year. Approximately 90 percent of these poisonings occur in the home, and many are easily preventable.

The Regional Center for Poison Control and Prevention provides emergency assistance and poison prevention information to the people of Massachusetts and Rhode Island. The organization's website, www.maripoisoncenter.com, provides answers in English and Spanish to patient questions about the toxicity of medications, household products, and other potentially dangerous substances. The center also publishes *Clinical Toxicology Reviews*, which contains information on the pharmacology, management, and antidotes for nearly 300 toxic substances. Physicians can access the entire catalogue of reviews online.

For questions and concerns about poisoning, the experts at the center are available 24 hours a day, 7 days a week at (800) 222-1222.

STATE UPDATE

Table Is Set for State House Action in the Fall

Under the rules of the Legislature, every bill must get a hearing, and hearings were plentiful at the State House earlier this spring and summer. As this issue of *Vital Signs* went to press, the MMS had testified before 15 different legislative joint committees and offered its opinion on more than 100 bills. However, most of these bills have yet to be acted upon, setting the stage for a busy fall.

Nonetheless, two of the bills filed by the MMS have already cleared the first hurdle and have been referred to the Joint Committee on Health Care Financing:

- Senate Bill 1213, "Resolve Establishing a Special Commission to Study Physician Recruitment and Workforce Development in Massachusetts," was reported favorably by the Joint Committee on Public Health. The measure would establish a broad-based commission to investigate physician workforce issues and make recommendations to increase the recruitment and retention of physicians. The commission

would look at the disincentives to practice in Massachusetts, including existing laws, regulations, and contracting and reimbursement practices. The commission would also review possible incentives to encourage new physicians to come to Massachusetts and current physicians to maintain their practices here. The initiative was sponsored by Sen. Stephen Buoniconti (D-West Springfield) and Rep. Sean Curran (D-Springfield).

- House Bill 4145, "An Act Relative to the Physician Credentialing Process," was reported favorably by the Joint Committee on Financial Services. This bill is a redrafted version of legislation filed on behalf of the MMS by Rep. Ronald Mariano (D-Quincy) and Sen. Susan Tucker (D-Andover). It would streamline the physician credentialing process by establishing standard credentialing and re-credentialing forms and requiring that credentialing occur in a timely manner. The MMS has worked closely with the Massachu-

setts Hospital Association, the Massachusetts Association of Health Plans, and Blue Cross Blue Shield to draft the measure.

When the formal sessions begin again after Labor Day, bills that have been heard will be reported out of committee with greater rapidity, and the hearing season will come to an end. At that time, the MMS will have a better sense of which measures will go forward into the next year and which will be referred to "study" and not be heard from again.

Also, we anticipate hearings on key issues such as professional liability reform and "fair contracting" between insurers and physicians. In addition, we also anticipate hearings on MMS-filed bills that would protect physicians and nurses from civil suits when they volunteer or are called upon to assist during a health emergency, and that would prohibit the sharing of physician-specific prescribing information with parties who use the data for business purposes. **VS**

— Steve Shestakofsky

FEDERAL UPDATE

House Passes CHAMP, Senate Passes SCHIP, But Future Unclear

Just prior to the August recess, the U.S. House of Representatives passed HR 3126, the Children's Health and Medicare Protection Act (CHAMP). All members of the Massachusetts congressional delegation voted in favor of the legislation, which addresses the health care needs of low-income children and seniors and stops Medicare physician payment cuts for at least the next two years.

Meanwhile, by a veto-proof margin, the Senate passed a bill that reauthorizes the State Child Health Insurance Program (SCHIP). Sens. Edward Kennedy and John Kerry were very involved in the legislation, and both voted for it.

However, the differences between the bills, both in terms of substance and political dynamics, are vast and will need to be resolved in a Conference Committee. Furthermore, President Bush said he will veto any proposal that he believes inappropriately expands SCHIP, increases tobacco taxes, or cuts Medicare Advantage plans.

As one might expect, the comprehensive CHAMP bill contains both positive

aspects and contentious portions that will need to be resolved. HR 3162 would reauthorize SCHIP at \$50 billion, continuing coverage for millions of children and strengthening outreach to others who are eligible but not enrolled. The bill would also stop the pending 15 percent 2008 and 2009 Medicare physician payment cuts and give physicians a 0.5 percent increase. CHAMP would establish new Medicare pay-for-performance bonus payments and, in 2010, would put in place six spending targets to replace the much-maligned sustainable growth rate method of paying physicians.

Some Controversial Provisions

Controversially, the bill's proposed physician payment formula could pit one physician specialty against another, and it includes a 50 percent reduction in 2008 for the technical component of imaging services. The bill would also ban self-referrals by physicians who have more than 40 percent ownership in a hospital and impose significant cuts to home health care.

The CHAMP bill would be funded through an increase in the federal tobacco tax and by phasing down payments to Medicare Advantage plans by 2011 to be consistent with fee for service.

In his letter thanking the Massachusetts congressional delegation for its support, MMS President B. Dale Magee, M.D., stated, "We recognize that you and your colleagues were required to make very difficult choices to pass this signature legislation. We applaud your leadership in reauthorizing a strong State Child Health Insurance Program and creating a process to reform the Medicare physician payment formula.... We look forward to working with you on these and other issues yet to be resolved." The MMS worked with the New England Alliance for Children's Health and the AMA through the Congressional deliberations.

In the Senate, the stand-alone SCHIP bill reauthorizes the program at \$35 billion and is funded exclusively through increased tobacco taxes.

Detailed summaries of CHAMP and the Senate SCHIP bill are available at www.massmed.org/medicare_childhealth. **VS**

— Alex. Calcagno

LEGISLATOR OF THE MONTH

Representative Mary Rogeness (R)

District: East Longmeadow (part), Hampden, Longmeadow, Monson, Springfield (part)

Committees: Assistant Minority Leader; Children, Families & Persons with Disabilities, Election Laws



QUOTE: High quality, affordable, and universally accessible. Those three ingredients define the health care goal of society. A friend gave me this summary some time ago, and it has stayed with me as the Legislature works to improve the health care system in Massachusetts.

Two out of three ingredients always seem within reach, but capturing all three presents a serious, historically unmet challenge. Last year's health insurance system overhaul is our state's latest attempt to reach the goal. Can we do it?

We have several things going for us: we began with a high number of insured residents and are building on that number each month. The Connector is working through growing pains to link individuals with health plans. And the threat of a tax penalty should bring more people into compliance in 2008.

We will have to guard against the legislative tendency to add new benefits, since each new mandate increases costs. We must confront the challenges of recruiting and retaining qualified professionals, a particular concern in my part of the state. Losing talented physicians to other states threatens both the quality and accessibility of medical services.

Can we do it? Yes, we can.

Four Years Later — Re-examining Resident Work-Hour Reform

As residents and program directors reflect upon the Accreditation Council for Graduate Medical Education (ACGME) duty hour requirements implemented in 2003, there is growing evidence suggesting further reforms are needed.

Neeral Shah, M.D., chair of the MMS Resident and Fellow Section and a gastroenterology fellow at Lahey Clinic, said, “We have made initial steps toward the problem of resident work hours, but we need more data to validate that the ACGME regulations are effective and training better doctors.”

Existing Guidelines

The ACGME is currently reviewing the standards and intends to make further changes with feedback provided from programs. The ACGME’s current common duty hour standards stipulate the following:

- Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period.
- Adequate time for rest and personal activities should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

The MMS and the AMA Resident and Fellow Sections (RFS) are assessing the progress and impact of the ACGME re-

forms, and they will be discussed at the AMA-RFS Interim Meeting in November.

Concerned with Continuity of Care

Meanwhile, continuity of care remains one of the biggest concerns. When residents work a shorter shift, they must ensure that patient-care information is passed off appropriately through an effective sign-out process. “There are issues of patient ownership and the transfer of information,” noted Dr. Shah. “With electronic medical records, information can be easier to access, but without proper sign-outs, there are still details that can slip through the cracks.”

Adam Levine, M.D., an emergency medicine resident at Massachusetts General Hospital, and member of the MMS-RFS Governing Council, is part of the national effort researching resident

work-hour reforms. He agrees with Dr. Shah. “I think the key to making a shift-work system function involves teaching residents how to give high-quality sign-out on their patients, as well as how to work effectively as part of a larger team,” he said. Dr. Levine also believes it is important to examine the effects of reducing extended work shifts versus decreasing overall work hours.

Dr. Levine added that overall, research has shown that residents are happier and better rested, while clinical care and education have changed little, if at all. “The system is not perfect,” he concluded, “but it has been a substantial improvement over the prior system.” **VS**

— Emily Richardson

“More data is needed to determine how effective the ACGME regulations are.”

2008 Physician Workforce Study — Call for Participation

Each year the Society surveys practicing physicians, medical directors of medical groups, program directors of residency programs, department chiefs at teaching hospitals, and medical staff presidents at community hospitals to gather important data for our annual Physician Workforce Study. Our study has been instrumental in formulating strategies that benefit the specialties under the most critical or severe stress.

Surveys will be mailed during the last week of September. **Your responses are crucial to helping us advocate for physicians in Massachusetts and improve the practice environment.** If you receive a survey, please complete it and return it to the Society as soon as possible.

If you have any questions about the surveys or the Physician Workforce Study, contact the Health Policy and Systems Department at (800) 322-2303, ext. 7222. **VS**

PHYSICIAN HEALTH MATTERS

Choose Your PCP Wisely

Not all physicians receive regular health care. When care is needed, many physicians treat themselves, especially when their ailment may lead to shame or embarrassment. Other reasons for self-treatment range from physicians feeling too busy to schedule outside appointments, to physicians feeling that they have the skill and knowledge to address their own medical care without having to consult professional colleagues.

Objectivity Needed

The best way for a physician to feel confident and comfortable about seeking outside care for an illness — mental or physical — or regular, preventive medical care is to carefully choose a primary-care physician (PCP). The physician you choose should be someone you can trust, but who can also be unbiased and honest with you. Your PCP should be someone you feel comfortable sharing personal information with and who you know will treat you respectfully but objectively as the patient.

You may also want to determine whether a prospective PCP is easy to reach, what the office hours are, what his or her communication style is, as well as the prospect’s general approach to treatment and referrals. The latter characteristic is especially important if you have a chronic condition or disability.

Physicians selecting a PCP may want to avoid coworkers, friends, or colleagues — or even physicians in the same hospital or group. Some physicians may not treat another physician’s concerns in the same way as they would a “regular” patient. To reduce the risk of this, you might want to choose a primary care physician who does

not know you in your professional role. You need to feel confident that your treating physician will care for you fully by discouraging you from ordering your own tests and writing your own prescriptions. You also need to feel certain that confidentiality will be maintained so you do not need to censure your interactions for fear they will be discussed in your professional setting.

Word of mouth is a common and effective way to find a physician. You can get referrals from friends, neighbors, state medical associations, a previous provider, or other health professionals who have forged a successful relationship with a PCP. Your health insurance plan may also be of assistance in finding a qualified physician for your specific needs.

Seek Wellness Care

Once you have chosen a PCP, see him or her on a regular basis. Make sure your PCP knows your family and medical history, lifestyle, and habits. Your doctor can help you coordinate needed care and develop and carry out a personal health maintenance and improvement program.

Establish your relationship with a PCP when you are healthy. You will be in a better position to choose a PCP when you are well than when you are sick or injured and need medical care quickly.

Selecting and utilizing the right PCP can ensure that you receive the same quality of care that you provide to your own patients. **VS**

For more information, contact Physician Health Services at (781) 434-7404 or www.physicianhealth.org.

Career Day/Job Fair Slated for February 2

Mark your calendars! On February 2, 2008, all residents and early career physicians in Massachusetts are invited to attend our 16th Annual Career Day/Job Fair. It will be a great opportunity to:

- Discuss career opportunities with hiring representatives
- Receive a critique of your CV
- Network with your peers



Last year’s Career Day/Job Fair drew many interested attendees.

This event is co-sponsored by the MMS Resident and Fellow Section, and the Committees on Young Physicians and Diversity in Medicine.

Registration information will be distributed in October. For more information about the MMS Career Day/Job Fair — or to register early — e-mail etally@mms.org, or call Erin Tally at (800) 322-2303, ext. 7413. **VS**

ACROSS THE COMMONWEALTH

District News and Events

Berkshire – Legislative Breakfast. Fri., Sept. 21, 7:30 to 9 a.m. Location: Berkshire Medical Center. For more information, contact the West Central Regional Office.

Charles River – Executive Committee Meeting. Tues., Sept. 11, 6 p.m. Location: MMS Headquarters, Waltham. **Delegates Meeting.** Tues., Sept. 25, 6 p.m. Location: MMS Headquarters, Waltham. For more information, contact the Northeast Regional Office.

Essex South – Clambake. Sat., Sept., 8, 1 p.m. (Rain date Sun., Sept. 9). Location: Coffin/Wingaersheek Beach, Gloucester. Pre-registration required. For more information, contact the Northeast Regional Office.

Hampshire/Franklin – Joint Fall District Meeting. Wed., Sept. 12, 6 p.m. Location: Blue Heron Restaurant, Sunderland. For more information, contact the West Central Regional Office.

Middlesex North – Fall Outing. Wed., Sept. 26, 1 p.m. golf; 3 p.m. tennis; 6 p.m. clambake. Location: Vesper Country Club, Tyngsboro.

Norfolk South – Executive Committee Meeting. Tues., Sept. 18, 6:30 p.m. Location: Reggio Ristorante, Weymouth. For more information, contact the Southeast Regional Office.

Plymouth – Family Event. Sat., Sept. 8, 2 p.m. Location: Plimoth Plantation, Plymouth. For more information, contact the Southeast Regional Office. Congratulations to **B. Hoagland Rosania, M.D.**, Plymouth District president, on being the first recipient of a newly created award from the Massachusetts Orthopaedic Association recognizing outstanding contributions to the orthopaedic community.

Worcester – 16th Annual Women in Medicine Breakfast. Fri., Sept. 21, 7:30 a.m. Location: Beechwood Hotel, Worcester. Speaker: Alex Calcagno, director of federal and community relations for the Massachusetts Medical Society. For more information, contact Joyce Cariglia at (508) 753-1579.

Statewide News and Events

Arts, History, Humanism & Culture MIN – Tower Hill Event. Sat., Sept. 29, 6 p.m. Location: Tower Hill Botanical Gardens, Boylston. For more information, contact the West Central Regional Office.

If you have news for Across the Commonwealth, contact Florence Keefe, Northeast Regional Office, at (800) 944-5562 or fkeefe@mms.org; Linda Howard, Southeast Regional Office, at (800) 322-3301 or lhoward@mms.org; or Cathy Salas, West Central Regional Office, at (800) 522-3112 or csalas@mms.org.

In Memoriam

The following deaths of MMS members were reported to the Society in July and August 2007. We also note member deaths on the MMS website at www.massmed.org/memoriam.

Daniel S. Bernstein, M.D., 80; Cambridge, MA; Johns Hopkins University School of Medicine, 1953; died July 25, 2007.

Leonard M. Bornstein, M.D., 73; Scituate, MA; Tufts University School of Medicine, 1958; died July 25, 2007.

Gilbert M. Cogan, M.D., 84; Westford, MA; Tufts University School of Medicine, 1946; died June 6, 2007.

Walter G. Leonard Jr., M.D., 85; Saugus, MA; Boston University School of Medicine, 1946; died August 1, 2007.

Roy W. Nelson, M.D., 95; Attleboro, MA; Boston University School of Medicine, 1938; died July 25, 2007.

Frederick G. Whoriskey, M.D., 86; Newton, MA; Tufts University School of Medicine, 1946; died July 20, 2007.

Membership Options Mean Savings

Since the 2005 introduction of our multiyear and group-enrollment pilot programs, the number of MMS members who have taken advantage of our cost-saving enrollment options has continually grown. Participating members find that along with saving money, the programs offer convenience as well.

Multiyear Savings

For solo practitioners, or physicians in groups of fewer than five, two- and five-year multiyear discount plans offer a 5 percent and 20 percent reduction in state dues, respectively. Both plans alleviate the need to process MMS membership information on an annual basis.

Group Discounts

Groups of five or more physicians can realize either 20 percent off the total state dues (if 100 percent of the group participates), or 5 percent off the total state dues (if at least 80 percent of the group participates). Although group members are extremely pleased with the savings, the most positive feedback we receive comes from group administrators, who praise the program's practice-management advantages, which include:

- A single dues invoice, with discount savings displayed for each member

- A roster of the group's complete enrollment available via e-mail
- User-friendly application packets for physicians joining the MMS for the first time
- Centralized communications with the MMS, including the group's dues status

New Residency Program

The MMS is now collaborating with academia and physician training programs on a dues-exempt enrollment option for residents and fellows. When all the residents and fellows within an accredited residency training program enroll, the program members become MMS members *free of charge*.

In addition to the programs above, physicians who are active in the military can become MMS members free of charge, as can members who qualify for "Senior" or "Emeritus" status.

To enroll a group or to find out more about any of these membership options, contact MMS Membership Services at (800) 322-2303, ext. 7311, or e-mail info@massmed.org. **VS**

– George Dudley

What's that Adage about Apples and Doctors?

Please join the MMS at Honey-Pot Hill Orchards in Stow for an afternoon of apple picking and fall fun on Saturday, September 15 from 12 to 4 p.m.

The event is sponsored by the MMS Committee on Young Physicians.

The 200-plus acre orchard expects to have a variety of apples (Macintosh, Cortland, Royal Gala, and Golden Supreme) and some pears to pick. Relax under the tent with a boxed lunch, apple cider, cider donuts, and caramel apples. Or explore the hedge maze and ride on a hay wagon.

Pre-registration is required, and space is limited (see fees below). To register with a credit card, call Emily Richardson at (800) 322-2303, ext. 7315. **VS**

MMS Members: \$10
One guest of an MMS member: \$10
Nonmembers: \$20
Children ages 4 through 12: \$5
Children under age 4: Free

Resolution Deadline for MMS Interim Meeting Is Sept. 18

The 2007 Interim Meeting of the House of Delegates will be held on Friday and Saturday, November 2 and 3, 2007. Day one will be held at MMS Headquarters in Waltham, and day two will take place at the Westin Hotel in Waltham.

The deadline for submitting resolutions for the Interim Meeting is September 18. The deadline for late resolutions

and reports 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 4. Please call (781) 290-5600 to make reservations directly with the hotel. **VS**



Photo by Rick Gulla

MMS Thanks HCAM-TV

To celebrate their collaboration on the *Physician Focus* TV show, the MMS honored HCAM-TV in Hopkinton. Shown (left to right) are Jim Cozzens, HCAM station manager; Mike Preite, HCAM president; MMS President B. Dale Magee, M.D., and principal *Physician Focus* host Bruce Karlin, M.D.



MASSACHUSETTS MEDICAL SOCIETY

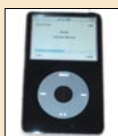
EVERY PHYSICIAN MATTERS, EACH PATIENT COUNTS.

WHAT'S ON THE WEB?



▶ Recorded Webinar on Blue Cross Settlement

This recent MMS webinar offers information about how physicians can collect on the recent \$128 million settlement of litigation against the Blue Cross Blue Shield health plans. Go to www.massmed.org/bcbs_settlement.



▶ Podcast on Tiering with MMS President

The Group Insurance Commission's tiering program has been controversial since the start. Go to www.massmed.org/podcast_tiering for a podcast from MMS President Dale Magee, M.D., who explains what the Society has been doing in response to the GIC plan.



▶ Health Care Reform Help for Employers

This guide (www.massmed.org/healthcare_reform_guide) explains important features of the state's health reform law and what employers need to do to comply.

WWW.MASSMED.ORG

MMS Sponsored & Jointly Sponsored CME Activities

To register for any of these activities, call (800) 843-6356. For additional information, contact the Department of Continuing Education and Certification at (800) 322-2303, ext. 7306, or go to www.massmed.org/cmecenter. CME CREDIT: Unless otherwise noted, each activity is designated for AMA PRA Category 1 Credits.™

Live CME Activities

Go to www.massmed.org/cme/events

Who Pays the Price? The Influence of Medical Liability on Women's Access to Health Care

Sept. 26, 6:30–8:00 p.m. MMS Headquarters, Waltham.

Sponsored by the MMS and its Committee on Women in Medicine. 1.5 Credits (RM)

Unmasking Depression in Primary Care Practice

Sept. 28, 8:15 a.m.–12:30 p.m. MMS Headquarters, Waltham.

Sponsored by the MMS in collaboration with the MHQP and Massachusetts Psychiatric Society. 4.0 Credits (RM)

Regional CME Accreditation Workshops

1:00–3:30 p.m.

Sept. 25 — MMS Headquarters.

Oct. 10 — Cooley Dickinson Hospital, Northampton.

Oct. 15 — Caritas Good Samaritan Hospital, Brockton.

Oct. 25 — Lowell General Hospital. Sponsored by the MMS and its Committee on Accreditation Review. 2.5 Credits

Federal Funding Opportunities

Oct. 11, 3:00–6:00 p.m. Gordon Hall, Harvard Medical School, Boston. Sponsored by the MMS and the Biomedical Science Careers Program. 2.75 Credits

8th Annual State of the State's Health Care Leadership Forum

Oct. 18, 8:00 a.m.–12:00 noon MMS Headquarters, Waltham. 4.0 Credits (RM)

Managing Holiday Stress for Optimal Mind/Body Health

Nov. 7, 5:45–8:00 p.m. MMS Headquarters, Waltham. Sponsored by the MMS and its Committee on Women in Medicine. 1.5 Credits

2007 DME Conference & Ralph Monroe, MD Lecture

Nov. 15, 8:00 a.m.–3:00 p.m.

MMS Headquarters, Waltham.

Sponsored by the MMS in collaboration with the Rhode Island Medical Society. 6.0 Credits

Caring for the Caregivers VI: Helping Ourselves, Our Colleagues & Our Patients

Nov. 30, 8:00 a.m.–4:00 p.m.

MMS Headquarters, Waltham.

Jointly sponsored with Physician Health Services.

6.5 Credits (RM)

Managing Workplace Conflict: Improving Personal Effectiveness

Dec. 13, 8:00 a.m.–4:00 p.m.

Dec. 14, 8:00 a.m.–3:00 p.m.

MMS Headquarters, Waltham.

Jointly sponsored with Physician Health Services.

12.5 Credits (RM)

Online CME Activities

Go to www.massmed.org/cme

NEW Recognizing and Preventing Youth Violence

2 Credits (RM)

NEW Audio & PowerPoint

Cost Performance Ratings: What You Need to Know about Episode Treatment Groups (ETGs)

2.5 Credits (RM)

The following online activities are co-developed with Adler, Cohen, Harvey, Wakeman & Guekguezian, LLP. Each activity is designated as 1 Credit (RM)

NEW Hearing Impaired Patients and the Americans with Disabilities Act

NEW New Guidance: Patients with Limited English Proficiency

NEW Mandatory Reporting