

# VITAL SIGNS



- 2 **PRESIDENT'S MESSAGE** Fighting for Stronger Primary Care
- 3 **YOUR PRACTICE** Health Plan Expertise • Meaningful Use Workshops • Urgent Care
- 4 **THE PUBLIC'S HEALTH** Managing Autism Spectrum Disorders • International Health Studies Grants • Anti-Tobacco Poster Contest Winners
- 5 **GOVERNMENT AFFAIRS** State: New Safe-Driving Law
- 6 **PROFESSIONAL MATTERS** Stimulant Misuse a Growing Concern • Mentorship Program for LGBT Medical Students • Reaching Out by E-mail
- 7 **INSIDE MMS** Rundown of Discounted Enrollment Options • Interim Meeting Resolution Deadline Is Oct. 19 • Poster Abstracts Due Oct. 18 • Across the Commonwealth • In Memoriam
- 8 **MMS EDUCATION PROGRAMS**

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## AMA and 47 States Pressure Health Plans to Prove Tiering Is Accurate

BY LLOYD RESNICK

Following additional research by the RAND Corp. showing that physician tiering programs are seriously flawed and "not ready for prime time," the American Medical Association, the MMS, and 46 other state medical societies called on 45 health plans nationwide to "formally reevaluate physician rating program(s) and demonstrate that they are reliable, accurate, and valid."

RAND's findings are based on a series of studies into physician profiling programs that have been initiated by health plans across the country, particularly in Massachusetts.

### Rampant Misclassification

A RAND study published in the March 18 *New England Journal of Medicine* found that claims-based physician ratings by health insurers can be wrong up to two-thirds of the time for certain specialists. Under the best circumstances, the study found, nearly one-quarter of all physicians were assigned to the wrong cost category. Among internists, 41 percent were misclassified as lower cost when they actually were not.

A second RAND study, published in the May 18 *Annals of Internal Medicine*, found that how and to whom health plans assign costs (so-called "attribution rules") strongly affect a physician's cost profile in a three-tiered (low-, average-, and high-cost) system.

For example, health plans have to decide if a profiling program should allocate costs based on individual patient transactions or so-called episodes of care. In addition, because

*continued on page 5*

## Payment Reform Prerequisites Looming Large for Many Physicians

BY TOM WALSH

With health care payment reform legislation shelved for 2010, the path to achieving a global payment system recommended last year by a state panel seems strewn with potholes and barriers.

In July, Senate President Therese Murray told *The Boston Globe* that the "logistical and political complexity" of changing the current decades-old system led her to abandon a payment reform bill for the formal session of the Legislature. Sen. Murray said she thinks Senate leaders, the Patrick administration, and many health care providers agree that the current system is broken. She said she hoped to reach a consensus on legislation for 2011.

"Everyone has to come together to work it out," said Sen. Murray.

But the question remains: what are the obstacles to working it out?

### Preparatory Steps

From the MMS perspective, any successful legislative transition to a global payment system must acknowledge that the state's physician community varies greatly in its readiness for such a drastic change in business model. "The move to global payment needs to happen slowly," said Alice Coombs, M.D., MMS

president. "There are a lot of preparatory things that must be addressed."

Dr. Coombs said these include the following:

- Rebuilding the state's depleted roster of primary care physicians
- Enacting significant professional liability and antitrust reforms
- Addressing the needs of physician practices that cannot afford the information technology (IT) upgrades vital to a new payment system
- Receiving valid, useful data from payers to help physicians manage their patients and practices
- Transparency across entities
- Educating physicians and patients about all aspects of payment reform
- Devising a workable system of risk adjustment for physicians

"Providers have to share some of the risk," Dr. Coombs said. "But that has to be performance risk, not insurance risk."

### 2009 Report Backed Global Payments

A report issued in July 2009 by the state's Special Commission on the Health Care Payment System advocates a global payment system that would be risk-adjusted to reflect patients' health status to ensure doctors are not penalized financially for taking care of sicker patients (see *Vital Signs*, September 2009, page 1). The report also supports coordinated care delivered through accountable care organizations (ACOs), which would funnel global payments to their physician members.

A series of summertime MMS-sponsored focus groups with doctors from varying practice settings across the state uncovered widespread uncertainty and concerns about many aspects of the proposal. Generally, physicians practicing solo or in small practices expressed strong reservations about global payments and the ACO concept. They said they would be unable to afford needed IT upgrades without investment help, and several expressed concern about losing physician-patient autonomy in an ACO framework.

"Doctors believe strongly that they'll need the right foundation to do this," said Elaine Kirshenbaum, MMS vice president of policy, planning, and mem-

*continued on page 2*



Photo by Therese Fitzgerald

When it comes to payment reform, Springfield Internist Barry Izenstein, M.D., says, "Legislators have to realize this is not something that can happen overnight."

## PRESIDENT'S MESSAGE



### Fighting for a Stronger Primary Care System

I am a critical care physician and anesthesiologist, but my colleagues in primary care have helped me understand their daily struggles.

I recently attended a state hearing where it was estimated that the Massachusetts health care system could save \$1.15 billion each year if avoidable and preventable rehospitalizations and emergency department (ED) visits were eliminated.

Here's the connection: we could virtually eliminate those avoidable events by improving access to timely primary care. In 2009, new patients had to wait 44 days on average to get a doctor's appointment for non-urgent care. In Essex County, the average wait time was 119 days! In addition, the proportion of family medicine and internal medicine offices accepting new patients keeps declining.

Many cases that end up as emergent ED visits and hospitalizations could be avoided with a more robust primary care system focused on prevention and chronic-disease management.

One-third of all ED visits occurred during regular physician office hours. True emergencies can occur at any time, of course, but this statistic suggests that there are too many people in our system who are unable to access a primary care doctor.

Bolstering primary care — and the delivery of it via innovations such as medical homes and open-access scheduling — will yield multiple benefits.

Massachusetts has done a great job ensuring health coverage for more than 97 percent of its citizens. The MMS is committed to helping ensure that everyone has a primary place to go to receive prompt, high-quality care. In so doing, we'll substantially reduce the cost burden throughout the system.

— Alice T. Coombs, M.D.

## Payment Reform Prerequisites

*continued from page 1*

ber services. "They believe the needed initial infrastructure has to come from the government and the payer worlds."

Physicians from larger independent practices already involved with data collection, financial risk management, and IT implementation tended to be wary but less daunted by issues such as ACOs. Meanwhile, physicians employed by large groups or health systems seemed much more open to the concepts of global payment and ACOs.

Doctors generally said they found risk adjustment issues confusing, want any new system to be transparent, and that further education overall is important. Some feared that "global payment" might be code for a return to failed capitation payment systems. There was a general consensus that the special commission's recommendations would take years to fully achieve.

### Strategies Still Theoretical

"Massachusetts hasn't figured anything out yet," said Barry Izenstein, M.D., who practices endocrinology and internal medicine in a three-physician office in Springfield. "ACOs and bulk payments are still just theoretical. Nobody has proved they will work here."

At the same time, Dr. Izenstein does not advocate the status quo. "The volume-generated system we have is broken and illogical," he said. "We clearly need a system that pays for the delivery of good care." He said the patient-centered medical home concept, now in pilot stages in Massachusetts and elsewhere, moves in that direction. "But it's not easy to do," Dr. Izenstein said.

Dr. Izenstein agrees with Dr. Coombs that the state's primary care physician shortage is an impediment to reform. "Residents are not going into primary care," he said. "When my generation retires, there will be a real crisis. From our perspective, you've got to pay primary care physicians more in order to attract residents into primary care." He concurred also that professional liability is a lingering barrier to payment reform. "There has got to be some liability reform so doctors do not feel compelled to order all those tests," he said.

Dr. Izenstein believes payment reform can be achieved through legislation, "but legislators have to realize that this is not something that can happen overnight," he said.

### Doctors Need Help With Infrastructure

Ronald Dunlap, M.D., part of a seven-physician cardiology practice in South Weymouth, said IT is

a formidable barrier to payment reform that will take several years to overcome. "No one has provided doctors with the technological infrastructure to do this," said Dr. Dunlap. "Our medical record systems do not communicate with one another, and no one has demonstrated they can provide the data doctors need to do quality management."

Further, he said, obtaining hardware and software is not enough. "There are wide regional differences in the state among patients and the physicians who serve them," he said. Without "care maps" of each area, it will be difficult to accurately assess risk regionally. "Doctors are being asked to get out front and do this before we have the systems to get it done," Dr. Dunlap said, adding that smaller practices such as his simply do not have the resources of larger organizations that have already made strides with IT.

### Physician Community Not "Homogeneous"

Even among leaders of large physician organizations, there is uncertainty.

"I'm not sure where it will all end up," said Barbara Spivak, M.D., president of the Mount Auburn Cambridge Independent Practice Association (MACIPA), with about 500 physician members. She said an important unresolved issue is how quality should be measured. "If the state wants to reward people for quality, it will have to determine how to measure it," she said. "Everyone seems to have a different approach to that."

Dr. Spivak conceded it will take years before the payment reform job is finished, "and it's going to require a lot of patient education," she added.

H. Eugene Lindsey, M.D., the president and CEO of Atrius Health and its more than 800 doctors and 700,000 patients, said, "The biggest barrier is that the medical community is not homogeneous. There are many different types of doctors practicing in different environments."

Dr. Lindsey thinks the "focus should not be on what works for doctors, but on what supports the needs of the broadest number of patients and goes furthest to reduce waste throughout the system... All of us will experience some downward adjustment to revenue."

That downward pressure on revenue is what drives most organizations to eliminate waste in their work processes. "Almost every industry has learned this," Dr. Lindsey concluded. "We look for reasons why these rules don't apply to us, but they do." **VS**

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## MMS Resources Help Mitigate Health System Hassles



Tracy Ledin

Physicians struggle daily with constantly shifting demands from the health care systems with which they interact. Keeping a medical practice running efficiently demands up-to-date knowledge of changing requirements in administrative processes, quality reporting, and reimbursement and coding standards.

The MMS Health Systems Department works to gather this information, track changes, and keep MMS members informed.

A key player in this process is Tracy Ledin, a health systems analyst in the department who brings more than 10 years of physician advocacy experience in the Massachusetts managed-care environment to the

MMS. She has extensive experience on the payer side of the health care system and many years of experience resolving physician issues with a local health plan.

Since joining the MMS, Tracy has worked to map out Massachusetts health plan administrative requirements to help physician practices navigate their complexities (go to [www.massmed.org/healthplanguide](http://www.massmed.org/healthplanguide)). Tracy regularly works with practices to assist them with specific payer issues and to address larger concerns affecting specific specialties or regions in the state.

If you have concerns about a health plan policy or would like assistance pursuing a claim or appeal issue, contact Tracy directly at (781) 434-7218 or [tleidin@mms.org](mailto:tleidin@mms.org). **VS**

— Adam Shlager

## Urgent Care Expansion May Help Solve Patient Access Problems

Urgent care is reemerging as a way for patients to access medical care when they don't need emergency services but can't wait for a standard appointment. Urgent care centers are different than mid-level provider offices in retail stores because they are usually staffed by physicians, physician assistants, and nurse practitioners who have specific training in either emergency or urgent care medicine.

### Is It Covered?

For most Massachusetts HMO members, no referral is needed if the covering urgent care physician is within that member's local care unit. Payment for services rendered to PPO members is typically based on whether the treating physician is in or out of network, and according to stated member benefits for urgent care services.

The number of people visiting hospital emergency departments (EDs) continues to rise in Massachusetts. According to state data released in July, emergency room visits rose by 9 percent from 2004 to 2008. Data from the Division of Health Care Finance and Policy show that the cost of treating a patient in an ED for any given condition is significantly higher than in a physician's office, due partly to diagnostic testing that is sometimes ordered because medical records are not rapidly obtainable.

Urgent care centers could address this significant cost and access issue. Compass Medical is part of the reemergence of urgent care centers, with one existing urgent care site in East Bridgewater and a second that recently opened in Easton. Compass Medical also announced plans to include urgent care services in a facility planned for the previous location of St. Luke's Hospital in Middleboro.

George Clairmont, M.D., president of Compass Medical, said, "We are very aware of the higher costs for care in ERs along with longer wait times. This is coupled with increasing problems of access to primary care for routine visits."

Compass Medical utilizes an EHR system to streamline the patient process. Dr. Clairmont says EHRs are necessary for a successful urgent care center because they facilitate access to a patient's medical record and prescription history from primary care and specialty physicians.

Expansion of urgent care holds the potential to meet unfilled patient needs and reduce overall health system costs. But the success of the urgent care business model will depend largely on changed patient behavior patterns. **VS**

— Tracy Ledin

### ACHIEVING MEANINGFUL USE: REGIONAL EXTENSION CENTER CAN HELP

The Massachusetts eHealth Institute is the Massachusetts Regional Extension Center established to help providers obtain federal incentives for implementing electronic health records (EHRs).

The institute is offering workshops in September, October, and November at the locations below to help doctors and their office staffs select and implement EHRs that meet federal criteria for meaningful use.

**September 15 — Berkshire Medical Center (Hillcrest Campus), Pittsfield**

**October 7 — Good Samaritan Medical Center, Brockton**

**October 25 — Northern Essex Community College, Haverhill**

**November 3 — Fitchburg State College, Fitchburg**

For more details, go to [www.maehi.org/2010ebcasts/070210ebcast.html](http://www.maehi.org/2010ebcasts/070210ebcast.html).

### LAW AND ETHICS

## Stiffer State Privacy Regulation Applies to Physician Practices

Effective March 1, Massachusetts stiffened standards for the protection of personal information of Massachusetts residents. This regulation applies to any organization — including physician practices — that collects and retains personal information from Massachusetts residents in connection with commerce.

The regulation defines "personal information" as a Massachusetts resident's first name or first initial and last name in combination with any one of the following:

- Social Security number
- Driver's license number or state-issued ID number
- Financial account number, credit or debit card number, access code, or personal financial account identification number or password

Under this regulation, physician practices must develop, implement, maintain, and monitor a comprehensive written information security program (WISP) that contains "administrative, technical, and physical safeguards to ensure the security and confidentiality" of personal information. The practice must also train employees on the program and certify compliance of all outside service providers.

Penalties amount to \$100 per Massachusetts resident affected by a breach, up to a maximum penalty of \$50,000 per violation. To guard against this potential liability, physician practices should engage both an attorney and an IT consultant to get the practice into compliance.

MMS members can find guidance on meeting this regulation at [www.massmed.org/wispguidance](http://www.massmed.org/wispguidance). For background information, go to [www.mass.gov/?pageID=ocatoptic&L=3&L0=Home&L1=Business&L2=Identity+Theft&sid=Eoca](http://www.mass.gov/?pageID=ocatoptic&L=3&L0=Home&L1=Business&L2=Identity+Theft&sid=Eoca). **VS**

— William Frank, Esq.

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.



## Physicians Play Pivotal Role in Managing Autism Spectrum

A 2007 study by the Centers for Disease Control and Prevention revealed that 1 in 150 eight-year-olds in the U.S. had an Autism Spectrum Disorder (ASD). ASD is a spectrum of developmental disorders that impairs a child's thinking, feeling, social interactions, and ability to learn. According to the National Institute for Mental Health, the spectrum includes autism, pervasive development disorder, Asperger syndrome, Rett syndrome, and childhood disintegrative disorder.

Identifying the signs and symptoms during a developmental screening test or a routine interaction with the child usually doesn't present a great challenge to physicians. A bigger challenge is deter-

mining the best course of action once an initial diagnosis is made.

Each child meeting the diagnostic criteria for any ASD re-

### New Law Requires Insurers to Cover Autism Services

On August 3, Governor Patrick signed a bill making essential tests, medical treatment, and services for people with autism spectrum disorders more affordable. The law will require health insurers to provide coverage for early and intensive interventions. It also prevents insurers from setting limits on visits to autism services providers.

The law goes into effect January 1, 2011.

quires an individualized, multidisciplinary approach. An immediate referral should be made to state, school, and private programs for further evaluation — ideally a comprehensive examination by a developmental pediatrician or psychologist specializing in ASDs.

Thanks to the Individuals with Disabilities Education Act, every child diagnosed with a learning deficit is guaranteed an appropriate public education and related services at no cost to parents. An official diagnosis is imperative because the provision of services hinges upon it. Intensive multidisciplinary intervention is deemed to be most effective when started early, so encourage parents to utilize whatever resources are available as soon as possible.

Sometimes the diagnosis of autism is unnecessarily delayed due to parents' reluctance to seek help — or to realize that there is a problem. Parents often attribute a child's lack of communication or stereotypical movements to other causes as they wait for the child to "catch up" or "outgrow" troubling behaviors. In such cases, the clinician's ability to guide and educate parents is crucial. Physicians should extend support and recommendations for counseling to parents, as well, because a diagnosis of ASD can be stressful, and it can affect the entire family.

The role of the physician in the multidisciplinary team managing the child's care tends to center around the crucial initial diagnosis and subsequent referrals for testing and treatment. But the clinician also needs to consider the special challenges of providing medical care to a child with autism, especially if the child's communication skills are highly impaired or if the child has significant behavioral issues.

Often, these challenges can be overcome or at least lessened by collaborating with the other members of the multidisciplinary team and the child's family to come up with effective, tailor-made solutions.

— *Albertina Lopes, M.D.*  
*May Institute, Inc.*

For more resources and information, go to [www.massmed.org/autism](http://www.massmed.org/autism).

## Legislators Honor 2010 Anti-Tobacco Poster Contest Winners

On May 27, the MMS and Alliance honored the 2010 Anti-Tobacco Poster Contest winners with an event hosted by Sen. Richard Moore (D-Uxbridge) at the Massachusetts State House. MMS President Alice T. Coombs, M.D., a long-time proponent of smoking prevention and cessation, presented the awards. She was assisted by MMS Alliance President Marie-Christine Reti and Alan Ashare, M.D., chair of

the MMS Committee on Student Health and Sports Medicine.

The 12 winning posters will become the basis for a 2011 calendar, which will be distributed to Massachusetts schools, pediatricians, and family practitioners in November.

Winners from grades 1 and 2 were Jack Albert of Canton, Emily Gervais of Weymouth, Emily Pimentel of Weymouth, and Liam Nestor of Reading.

Grade 3 and 4 winners were Robert Sullivan of Canton, Madison Ahern of Cohasset, Delilah DaSilveria of Malden, and Cynthia Fraine of Reading.

Winners from grades 5 and 6 were Jacqueline Williams of Northboro, Minhthuy Huynh of Lawrence, Kate Yuan of Natick, and Samuel Johnson of Natick.

To view the winning entries, visit [www.massmed.org/AntiTobacco2010](http://www.massmed.org/AntiTobacco2010). VS

— *Jill Cricones*



Photo by Jill Cricones

Front row: Samuel Johnson, Liam Nestor, Delilah DaSilveria, Jacqueline Williams, Madison Ahern, Emily Pimentel, Emily Gervais, Cynthia Fraine, Robert Sullivan, and Jack Albert. Back row: Kate Yuan, Minhthuy Huynh, Marie-Christine Reti, Alan Ashare, M.D., and Alice Coombs, M.D.

### International Health Studies Grant Applications Due Sept. 15

The MMS and Alliance Charitable Foundation annually awards International Health Studies grants to support medical study in developing nations.

The 2010 grant application deadline is September 15.

Visit [www.mmsfoundation.org](http://www.mmsfoundation.org) for more information on how to apply.

## STATE UPDATE

## New Safe-Driving Law Includes Immunity from Liability for Doctors

In July, Gov. Patrick signed a new law with multiple provisions designed to enhance driving safety. All drivers older than 75 years of age must now renew their licenses in person at a Registry of Motor Vehicles office. No person under 18 is permitted to use a cell phone or other electronic device while operating a motor vehicle. Adults must have at least one hand on the wheel when using cell phones for calls, and texting while driving is banned altogether.

Achieving political balance in this legislation was difficult. Section 10 of the law addresses the issue of reporting patients to the registry who have medical issues that impair their ability to drive. Some thought the responsibility for making the decision regarding competence to drive should rest solely with the driver's physician. As a result, some debate ensued regarding mandatory reporting requirements placed on physicians of patients with perceived impairments.

Opposed to such mandatory reporting, the MMS worked with legislators to craft statutory language that strikes a balance between physicians' duties to their patients and to the public at large.

### Added Concern from Prior SJC Ruling

The Supreme Judicial Court's 2007 decision in the case of *Coombes v. Florio* complicated the debate. That highly controversial split decision found that individuals injured in driving accidents caused by patients could

bring cases against the patients' physicians. In this context, the MMS was concerned that standard procedure in all traffic accident litigation might evolve into deposing drivers regarding their medical histories, reviewing medical records for any medical factor that might have contributed to the accident, and then finding physicians and others responsible for not reporting the driver.



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The MMS maintained that the responsibility of the physician is first and foremost to the patient. Physicians are not an arm of the Registry of Motor Vehicles, but they are often confronted with requests from family members to convince an elderly parent, for example, to stop driving. Therefore, the MMS supported a provision in the law allowing physicians and other health care providers to report in good faith patients who they have reasonable cause to believe are not physically or mentally capable of safely operating a motor vehicle. It then falls upon the registry to determine whether that person is competent to drive.

The law also states that such reports cannot be based solely upon age or a diagnosis, but must be made on observations of the "actual effect" of the condition on a driver's ability to drive. These provisions help ensure that reports are not filed routinely and that elderly and handicapped individuals will not be denied the right to drive on a discriminatory basis.

### Two-Way Immunity

Just as important, the Legislature recognized that health care providers need immunity from civil liability for their good faith actions in reporting patients to the registry, as well as immunity from civil liability for *not* reporting patients.

The MMS worked hard to ensure that new laws to address very real safe-driving concerns did not create a statutory basis for physician liability, and the bill the governor signed contains immunity for reporting and for not reporting.

A physician's responsibilities to patients regarding driving with health issues are complex. There are still duties to warn patients about the potential impact of treatments on their ability to drive that reflect the potential for real harm to the patients and others. In addition, the new law gives physicians an opportunity to report to the registry, but does not impose unreasonable demands or conflict with a doctor's primary responsibility to the patient. **VS**

— William Ryder, Esq.

### AMA Pressures Health Plans

*continued from page 1*

many patients see numerous doctors, some plans assign the total cost to the physician who had the most visits, while others assign cost to the physician who accounted for the largest portion of spending. The RAND study provides evidence to support the logical assumption that neither cost-assignment option is accurate.

RAND researchers created 12 sets of attribution rules based on combinations commonly used by insurers. The set designated as the default rule used episodes of care and assigned costs to the physician who generated the largest percentage of spending.

The researchers then calculated what percentage of doctors would end up being assigned to a different tier if the other 11 non-default attribution rules were used. The researchers found that between 17 and 61 percent of all physicians would be assigned to a different tier under such circumstances.

In summarizing these two published studies, a RAND research brief concluded that "current methods of physician cost profiling are not ready

for prime time... Current cost profiling approaches need to be improved, or new approaches need to be developed."

### Let Unbiased Experts Weigh In

In light of the RAND findings, on July 19, the AMA and 47 state medical societies — including the MMS — sent a letter to the nation's largest health insurance companies calling for immediate action to "improve the accuracy, reliability, and transparency of physician ratings." The letter asks each insurer to publicly document the accuracy of their physician cost profiles by submitting the programs to external review by unbiased, qualified experts.

"We applaud the AMA and 46 other state medical societies for publicly challenging health plans nationwide to demonstrate the accuracy and reliability of their physician tiering programs," said MMS President Alice Coombs, M.D. "We support holding physicians accountable for the quality and cost-efficiency of their care, but we can do that only with accurate and reliable data. We can work together with the health plans toward that goal."

### An Illusion of Lower Cost

The aforementioned RAND research brief observed that "if more than 40 percent of physicians classified as lower cost are not actually lower cost, then the ability of insurance plans to control costs by channeling patients to lower-cost physicians could be severely hampered."

"These systems mislead patients and unfairly impugn the reputation of a great many physicians," said Dr. Coombs. "In some specialties, the accuracy of such programs is no better than a coin flip."

In May 2008, the MMS and five physicians filed suit against the Massachusetts Group Insurance Commission and two of its participating health plans, claiming that the commission's physician profiling program, initiated in 2006, misleads patients and harms physicians. That litigation is still pending in Massachusetts Superior Court.

The RAND research has nationwide ramifications, as well, beyond the fact that private health plans across the country are instituting such programs. The federal health reform legislation calls for Medicare-generated physician cost profiles by 2012. **VS**



## PHYSICIAN HEALTH MATTERS

## Stimulant Misuse among Physicians in Training a Growing Concern

Rates of drug and alcohol abuse and dependence for health care professionals, which range from approximately 10 to 15 percent during a career, are similar to those of the general population. But physicians who get appropriate treatment for substance misuse disorders often have a higher rate of recovery — in the range of 70 to 90 percent — than the general population.

In addition to long, stressful work hours and easy access to medications among physicians and medical students, the following individual factors may contribute to drug and alcohol abuse and dependence:

- Family history of substance abuse
- Sensation-seeking behavior
- Perfectionist behavior and high academic rank

Misuse of prescription stimulants by medical students, residents, and physicians has not been studied specifically, but given increasing trends of stimulant misuse in high school and college and the documented risks of misuse, abuse, and dependence during medical training, doctors and trainees should consider the following points.

While you may have participated in sharing non-prescribed stimulants to “enhance performance” or combat fatigue as an undergraduate, you may underestimate the vulnerability for abuse and dependence that comes with repeated misuse of stimulants.

Physicians and medical trainees have a professional and ethical responsibility to develop their own healthy patterns of self-care. If you are medicating yourself to stay awake or enhance performance, you may no longer notice or attend to your actual fatigue. This might lead to harmful inattention and errors in judgment not only during clinical hours, but also in your personal life — for example, while driving or taking care of children. Those who no longer rely on their own body cues

for signs of fatigue and who have not developed effective strategies for replenishing and reenergizing themselves are at increased risk of excessive use, abuse, and dependence.

Medical trainees are held to a higher professional standard of behavior and self-care than college students. What may have been normative in college may no longer be normative in medical school or residency. Misuse of stimulants may be reported by a peer and/or lead to behavioral or psychiatric problems. School administrators or residency directors could then become involved, with potentially serious consequences, such as failure to graduate, losing the right to licensure, and/or legal action.

Discard the notion that stimulants will actually enhance your performance. Misuse of stimulants can result in behavioral and/or psychiatric difficulties including irritability, depression, mania, and paranoid thinking/psychosis.

Medical trainees caught in such a downward spiral may hesitate to approach their own medical school or residency program for help due to fear of disciplinary action or expulsion. In Massachusetts, Physician Health Services (PHS) is a productive place to start addressing such problems. PHS helps physicians, medical students, and residents confidentially address substance abuse and dependence, as well as behavioral and performance difficulties, by arranging for further evaluation and treatment.

PHS can help facilitate continued participation in medical school or residency through treatment and monitoring contracts. PHS has assisted many medical students and residents in achieving successful rehabilitation.

— Laurie Raymond, M.D.  
Harvard Medical School  
Member, PHS Medical Student  
Advisory Committee

For more information, contact Physician Health Services at (781) 434-7404 or visit [www.physicianhealth.org](http://www.physicianhealth.org).

## Don't Delete That E-mail!

In its efforts to be more environmentally conscious and to control expenses, the MMS is taking advantage of technology to disseminate information via electronic means. *Vital Signs This Week*, continuing education updates, MMS Media Watch, MMS Health Policy Watch, and MMS Payer Watch are a few of the e-mail newsletters available for members to sign up to receive. *The Physician Volunteer* and *Residents' Report* are two former print newsletters that are now being distributed electronically.

These e-newsletters were created in such a way that the member reader can connect to a Web page devoted to the committee or section, thus allowing the reader to explore additional committee information if he or she so desires. A personalized memo to members who earned vouchers in

2010 is also being sent via e-mail. And this is only the beginning.

Electronic newsletters and other communications can be very useful, timely, and cost-efficient tools. However, it is necessary for the recipient to recognize the source of the e-mail, have some understanding of or connection to the subject line, and not mistake it for spam or clutter in his or her mailbox.

The MMS is adopting procedures that will attempt to keep e-mail to a minimum so members will not feel overwhelmed and ready to hit the delete button before reading the content. Having your current e-mail address is very important to the success of this form of communication. You can update any of your personal information at [www.massmed.org](http://www.massmed.org) by logging in and clicking on “Update Contact Info.” **VS**

— Carolyn Maher

## Mentorship Program for LGBT Medical Students

This past July, the Gay and Lesbian Medical Association (GLMA) launched the new Health Professional Student Mentorship Program. The GLMA enlisted the support of a group of mentors who work in a variety of settings and fields, all of whom are eager to work with lesbian, gay, bisexual, and transgender (LGBT) medical students. Students will be able to communicate and network with their mentors to address any concerns, including those related to academics, career goals, or personal interests.

Those interested in connecting with a GLMA mentor can fill out an application at [www.surveymonkey.com/s/L9H2GH6](http://www.surveymonkey.com/s/L9H2GH6). Students will be matched with a mentor

based on their geographic location, their field or interest, or, if possible, both. Physicians interested in becoming mentors can e-mail [glmamentors@gmail.com](mailto:glmamentors@gmail.com).

Many of the mentors are committed to attending the 2010 GLMA Annual Conference from September 22 to 25 in San Diego, where the GLMA will officially kick off the new mentorship program.

To learn more about the GLMA, go to [www.glma.org](http://www.glma.org). The MMS Committee on Lesbian, Gay, Bisexual, and Transgender Matters is also available for students seeking advice. To learn more, contact Erin Tally at [etally@mms.org](mailto:etally@mms.org) or (781) 434-7413. **VS**

### Young Physicians, Families Enjoy Best of Boston

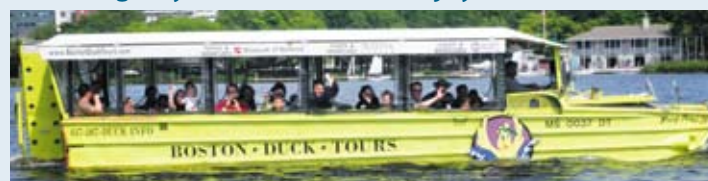


Photo by Colleen Hennessey

Sixty-four young physician members and their families enjoyed a beautiful May afternoon in Boston at a family networking event. Sponsored by the MMS Committee on Young Physicians, the event included lunch at Maggiano's Little Italy followed by a Boston Duck Tour.

# MMS Offers Plethora of Enrollment Options

## Group and Multiyear Discounts

Physicians enrolled in the Society's group enrollment program now represent 28 percent of MMS members. Groups of five or more physicians can receive discounts of up to 30 percent. Seventeen percent of our members realize the same discounts through multiyear savings options, where solo practitioners or groups of fewer than five receive discounts ranging from 5 to 30 percent.

## Life Membership

Life members receive a 20 percent discount on MMS state dues categories throughout their life membership. In addition, a percentage of life membership dues is donated to the MMS and Alliance Charitable Foundation. Life membership dues vary

based on the member's age at the time of enrollment and the member category.

## Other Membership Options

The MMS also offers part-time membership (a 50 percent discount on state dues for physicians working less than 20 hours per week) and family membership discounts. Finally, free MMS memberships are available to all Massachusetts medical students and active military. There is also a dues-exempt option for senior/emeritus status, and residents and fellows can become MMS members free of charge when all the trainees in their program join.

To learn more about these membership options, contact the Member Information Center at (800) 322-2303, ext. 7311, or [info@massmed.org](mailto:info@massmed.org). **VS**

# Interim Meeting Resolutions Due October 19

The 2010 Interim Meeting of the House of Delegates will be held on Friday and Saturday, December 3 and 4, 2010. 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 is October 19. Members can submit resolutions electronically (preferred method) online at [www.massmed.org/resolutions](http://www.massmed.org/resolutions),

via e-mail to [resolutions@mms.org](mailto:resolutions@mms.org), or via fax to (781) 434-7589.

Sponsors are encouraged to share draft resolutions with their districts and/or an MMS committee for feedback, which can improve the focus of a resolution, build consensus, and improve the chance of passage.

The deadline for hotel reservations at the Westin Hotel in Waltham is October 29. Please call (781) 290-5600 to make reservations. **VS**

## ACROSS THE COMMONWEALTH

### District News and Events

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

**Charles River — Executive Committee Meeting.** Wed., Sept. 15, 6:00 p.m. Location: MMS headquarters, Waltham. **Delegates Meeting.** Wed., Sept. 22, 6:00 p.m. Location: MMS headquarters, Waltham. For more information, contact the Northeast Regional Office.

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

**Hampden — 16th Annual Medical Legal Forum.** Tues., Sept. 21, 6:00 p.m. For more information, contact Suzanne Skibinski at (413) 736-0661 or [hdms@massmed.org](mailto:hdms@massmed.org).

**Middlesex — Fall District Meeting.** Sun., Sept. 26, 6:00 p.m. Location: DeCordova Sculpture Park and Museum, Lincoln ([www.decordova.org](http://www.decordova.org)). For more information, contact the Northeast Regional Office.

**Middlesex North — Golf Outing and Clambake.** Wed., Sept. 15, 1:00 p.m. golf, 6:00 p.m. clambake.

Location: Vesper Country Club, Tyngsboro. For more information, contact the Northeast Regional Office.

### Norfolk South — Executive Committee Meeting.

Tues., Sept. 21, 6:30 p.m. Location: Reggio's Restaurant, Norwell. For more information, contact the Southeast Regional Office.

### Worcester — 18th Annual Women in Medicine

**Breakfast.** Fri., Sept. 10, 7:30 a.m. Location: Beechwood Hotel, Worcester. Speaker: Michele Pugnaire, M.D., senior associate dean for educational affairs, UMass Medical School. For more information, contact Joyce Cariglia at (508) 753-1579.

## Statewide News and Events

### Arts, History, Humanism, and Culture Member Interest Network — Birding with a Purpose, Lecture and Field Trip.

Lecture: Tues., Sept. 7, 6:30 to 7:30 p.m. Field Trip: Sat., Sept. 11, 9:00 to 11:00 a.m. Location: Pleasant Valley Wildlife Sanctuary, Lenox. **Executive Committee Meeting.** Wed., Sept. 29, 6:00 p.m. Location: Mechanics Hall, Worcester. **Tower Hill Music and Medicine Program.** Sat., Oct. 16, 6:00 to 9:00 p.m. For more information, contact the West Central Regional Office.

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

# Poster Abstracts Due October 18

The Fifth Annual Research Poster Symposium, sponsored by the MMS Resident and Fellow and Medical Student Sections, will take place on Friday afternoon, December 3, at MMS headquarters in conjunction with the MMS Interim Meeting.

The symposium offers a venue for residents, fellows, and medical students to display their research and compete for cash prizes in four categories: basic research, clinical research, clinical vignettes, and health policy/health education.

The deadline for submission of abstracts is Monday, October 18.

For detailed submission guidelines and more information, go to [www.massmed.org/postersymposium](http://www.massmed.org/postersymposium) or call Colleen Hennessey at (800) 322-2303, ext. 7315. **VS**

## IN MEMORIAM

The following deaths of MMS members were reported to the Society in July and August 2010. We also note member deaths on the MMS website at [www.massmed.org/memoriam](http://www.massmed.org/memoriam).

**Robert J. Brockhurst, M.D.**, 86; Marblehead, MA; Harvard Medical School, 1947; died May 1, 2010. **Carroll Bryant, M.D.**, 94; Parker, CO; Tufts University School of Medicine, 1941; died June 18, 2010. **Julius E. Goldblatt, M.D.**, 90; Lexington, MA; Harvard Medical School, 1950; died April 12, 2010. **Edward D. Harris Jr., M.D.**, 72; Palo Alto, CA; Harvard Medical School, 1962; died May 21, 2010. **Frank M. Heifetz, M.D.**, 91; North Andover, MA; Tufts University School of Medicine, 1943; died May 9, 2009. **Helen M. Herzan, M.D.**, 95; New York, NY; University of Budapest, 1945; died July 17, 2010. **Joseph Levine, M.D.**, 78; Pittsfield, MA; Albert Einstein College of Medicine, 1959; died July 3, 2010. **John H. Selby, M.D.**, 90; Lubbock, TX; Boston University School of Medicine, 1944; died September 9, 2009. **Frank A. Slowick, M.D.**, 105; residence unknown; Tufts University School of Medicine, 1927; died October 23, 2006. **Joseph Winsten, M.D.**, 84; Lexington, MA; Indiana University School of Medicine, 1948; died March 1, 2010. **Ralph Zupanec, M.D.**, 96; Colorado Springs, CO; University of Kansas School of Medicine, 1934; died June 17, 2010.

## Dr. Coombs Attends Gov. Patrick Bill Signing



Photo by Leo Maley

MMS President Alice Coombs, M.D., conferred with Gov. Deval Patrick after the governor signed a bill that will help protect all health care workers from workplace violence.

**INSIDE ▶**

- ▶ **Payment Reform Prerequisites Page 1**
- ▶ **Urgent Care Expansion Page 3**
- ▶ **Stimulant Misuse among Doctors Page 6**



MASSACHUSETTS  
MEDICAL SOCIETY

# VITALSIGNS

VOLUME 15, ISSUE 7, SEPTEMBER 2010

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## MMS Sponsored and Jointly Sponsored CME Activities

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

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

**Live CME Activities** — Go to [www.massmed.org/cme/events](http://www.massmed.org/cme/events).

### Women's Leadership Forum:

#### The Power of Effective Communication and Negotiation

September 21, 6:30–8:00 p.m.

MMS headquarters, Waltham. 1.5 Credits

#### In the Wake of an Adverse Event: Healing the Healers

September 23, 5:00–7:30 p.m.

The Inn at Longwood Medical, Boston. 2.0 Credits (RM)

#### Federal Funding Opportunities

October 13, 3:00–6:00 p.m.

Harvard School of Dental Medicine, Boston. 3.0 Credits

#### Integrative Medicine 101: Practical Approaches for Primary Care Providers

October 28, 8:00 a.m.–4:30 p.m.

MMS headquarters, Waltham. 7.25 Credits

#### The Effects of Alcohol on Women Conference

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

**Online CME Activities** — Go to [www.massmed.org/cme](http://www.massmed.org/cme).

### Practice Improvement

#### Electronic Health Records Surge Despite Barriers\*

1.0 Credit (RM)

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#### E-mailing Patients without Worrying about Liability

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#### A New Kind of Bedside Manner: The Rise of Apology Policies

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CME CREDIT: Unless otherwise noted, each activity is designated for AMA PRA Category 1 Credits™. RM indicates that the activity or a portion thereof meets the Massachusetts Board of Registration in Medicine criteria for risk management study. CME ACCREDITATION: The Massachusetts Medical Society is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.