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What's in the stimulus for Rhode Island health care?

The prospect of hundreds of millions of new federal dollars sloshing around in the Ocean State this year and next inspires both hope and foreboding. Websites are proliferating locally and nationally to help individuals, families, homeowners, businesses and governments figure out how they can take advantage of the combination of new federal spending ($543 billion, $1.1 billion of which is said to be heading for Rhode Island) and tax relief ($244 billion), for a total of $787 billion to reinvigorate the economy.

The largest single chunk of the $787 billion is the $87 billion slated to help states close their budget gaps by increasing the federal share of the state/federal Medicaid match by 6.2%. In Rhode Island, that means the federal government will cover over 58.7% of the state's Medicaid program, up from 52.5%. The federal price tag for that increase to Rhode Island will be approximately $450 million.

For a while it looked as though Rhode Island might have outsmarted itself by getting an unprecedented "global waiver" from Washington last year in order to perform a radical restructuring of Rhode Island Medicaid. The state's waiver application, which was submitted last August and approved in December, included a cap on Medicaid spending in the Ocean State at about $12 billion over five years. That cap could have blocked Rhode Island's access to the extra stimulus money for Medicaid. However, Rhode Island's Congressional Delegation appear to have saved the state from that potential catastrophe.

In addition to massive investments for infrastructure (including the infrastructure of health care), the stimulus bill (officially known as the American Recovery and

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The 2009 state legislative session

A preliminary overview

For better or worse, economic slowdowns tend to depress legislative activity at the Rhode Island State House. The more the economy slows and the more daunting the State's own fiscal problems become, the more legislators' thinking is dominated by a limited number of immediate problems, – problems that this year have no easy or painless solutions. The state's crushing budget problems limit possibilities and make the state's future uncertain. As a result, legislators introduce and pass fewer bills.

Which is not to say that Rhode Island's 113 legislators have been idle or unproductive during the early weeks of the current session, which opened January 6, 2009. As of March 15, some 1738 pieces of legislation had been filed (an average of 15 bills per legislator); and although the official deadline for submitting legislation was mid-February, bills continue to appear, and the count can ultimately top 2000. However, even that substantial number would represent about a 25% drop compared with 2008, when over 2600 bills were introduced, including dozens in the final days of the session.

RIMS' 2009 legislative agenda

As always, therefore, the Medical Society's Public Laws Committee, chaired by Michael E. Migliori, MD, has its hands full. The RIMS Committee is monitoring or has developed positions and priorities on about 65 bills so far this session, including several of RIMS' own legislative initiatives, which were developed last fall in consultation with representatives of the medical specialty societies.

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The Rhode Island Medical Society was founded in 1812 to promote the art and science of medicine. RIMS is the eighth oldest state medical association in the country.

In cooperation with the Brown University School of Medicine, the Rhode Island Department of Health, and Quality Partners of Rhode Island, the Society also publishes a monthly magazine, *Medicine and Health Rhode Island.*

FROM THE PRESIDENT

Cost is in the driver's seat now

DIANE R. SIEDLECKI, MD
PRESIDENT, RI MEDICAL SOCIETY

Some sage is supposed to have said, "Don't ever get good at something that doesn't make you happy, because people will never let you stop doing it."

A corollary might be, "Don't base your livelihood on a set of skills that make you so indispensable to society that you lose your freedom."

Well, it's too late for most of us. We physicians long ago largely lost control of our business model, if not exactly of our destiny. What's more, as I look ahead, I am reminded of that mythic Chinese misfortune cookie that warns "A change for the better will be made against you."

Don't get me wrong! I absolutely love what I do and would not swap my lot in life for anything in the world. (I am a general internist, which means I am on the extinction list.) But at some point in the last 25 years it became difficult for me to look a young person in the eye and advise them to choose medicine as a career. It kills me every day to see how the intensely personal and profoundly valuable care we provide to our grateful patients is obstructed, delayed, devalued and demeaned by various extraneous parties.

At the same time, I have to concede that some of those other parties are not totally extraneous. After all, the health insurance premiums that we pay (more and more) do mostly go for care (about 88% of the time if we are talking Blue Cross; about 80% if we're talking United, who has its investors to pay, after all, some of whom are also us). The insurers and the regulators have a legitimate obligation to make sure the premiums we all pay are applied responsibly and do not go for excessive utilization, fraud, abuse or mismanagement on the part of anybody, anywhere in the food chain.

The point is that while physicians these days justifiably feel frustrated and abused, we must also have an eye to the bigger picture and maybe even find ways to embrace the profound changes that may be coming. The public is now aware that physicians have good reasons to be unhappy, especially in Rhode Island. But there are also limits to public sympathy for groups who will always be regarded as elite professionals.

When President Obama held his health care reform summit at the White House on March 5, Rhode Island had the singular distinction of having 50% of its Congressional Delegation in attendance among the President's 120 invited guests. Senator Sheldon Whitehouse and Representative Patrick Kennedy were both there, and that's where Senator Whitehouse made his well publicized joke about how we've moved from Harry and Louise (remember the insurance industry's TV ads that helped sink HillaryCare in 1994?) to Thelma and Louise (the 1991 road movie that ends with the car flying off the cliff).

Change may be coming because otherwise we seem to be headed for that cliff. There is one issue driving that car and driving the national debate on health care: it is cost. Even before the global financial meltdown, cost was the primary issue. America spends more than $2 trillion a year on health care, and at the rate we are going it will be $4 trillion ten years from now. (Remember when trillion seemed like a big number?) That would be 20% of GDP. And despite spending twice what other countries do, the U.S. ranks 19th out of 19 developed countries in mortalities that could be prevented by health care, while 46 million Americans are uninsured and another 29 million are underinsured. Health care costs are the leading cause of bankruptcies in the U.S. The status quo is hard to defend.

Now, with the global downturn, concerns about cost are absolutely all-consuming and may create the political conditions that bring major change.

It is fine to remind ourselves of the definition of a cynic: someone who knows the cost of everything and the value of nothing. But we have reached a point in this country where no one is willing to listen to that anymore. It's all about cost now, and that is why physicians need to be constructive participants in the coming debate; for while our services account for 21% of the health care dollar, what we order accounts for a much larger piece of the pie. What's more, government already pays for 48% of health care costs in this country; so to think we can keep government out of health care financing is naïve.

Believe me, I am no advocate for government-run single payer. I am just saying that medicine has to be constructively engaged, and we need to move forward from where we are, not from where we wish we were. Interestingly, the new administration in Washington seems to have learned something from history. It looks like the President is going to let Congress hash out health reform in an open process; and yes, medicine is already at the table this time. Even the health insurance industry has been saying for months now that it too favors comprehensive reform.

That said, I personally am not so sure the indefensible status quo won't find ways to persist for a while yet. There may be a broad consensus that change is needed, but when push comes to shove, there usually seems to be a broad consensus against any particular change. That is where we have mostly been in this country for decades. Moreover, if 46 million Americans are without health coverage, that means that another 258 million (85%) do have coverage – and are afraid of losing it if things change too much. That's why, politically, the issue is not the uninsured, but cost. And because the cost shoe pinches every foot, physicians must play a role in addressing that pain.

U.S. presidents do not control events, and neither do medical societies. Both have strong ideas about where they want to go, but both are buffeted by powerful headwinds and cross currents that force them to react and recalibrate constantly. That is how things work in a free society where there is always competition for limited resources. It's messy, frustrating, wasteful and prone to pitfalls. We may never get what we think we need, but if we persist, accept the inevitability of change, and recognize opportunities when they present themselves, we will gain some measure of success.

Whatever comes, we do well to be guided by the words of Rabbi Hillel: "If I am not for me, who will be for me? If I am only for me, what am I?" ❖

BRIEFLY NOTED

PATRICIA R. RECUPERO, MD, JD, has been elected President of the American Academy of Psychiatry and the Law. Dr. Recupero is CEO of Butler Hospital in Providence.

G. ALAN KUROSE, MD, is the new President of the Coastal Medical group, succeeding Robert A. Carnevale, MD.

PAUL B. LIEBERMAN, MD, received the 2008 Robert J. Westlake Award for Physician Excellence from Butler Hospital. Dr. Lieberman is chief of the Psychiatric Partial Hospital Program at Butler and chair of the hospital's Ethics Committee.

MICHAEL E. MIGLIORI, MD, was elected by the Trustees of the AMA to a seat on the Board of Directors of the American Medical Political Action Committee. Dr. Migliori's 2-year term began December 1, 2008. (More information is available on the RIMS website, www.rimed.org

HERBERT RAKATANSKY, MD, is the first recipient of a new Rhode Island Medical Society award recognizing medical professionalism, ethics and humanitarian service. The award was established by vote of the Council and will be known as the Herbert Rakatansky Award.

MICHAEL GILSON, MD, FACC, has been elected Governor-Elect of the Rhode Island Chapter of the American College of Cardiology. Steven R. Fera, MD, FACC, is Governor.

BARBARA ROBERTS, MD, FACC, was one of five cardiologists in the northeastern U.S. named a "Top Doctor for Women" by Women's Health magazine.

NEWELL E. WARDE, PHD, Executive Director of RIMS, was elected by his peers to serve on the Executive Committee of the Litigation Center of the American Medical Association. ❖

FROM PAGE 1 –STIMULUS

Reinvestment Act of 2009, or ARRA), also enables congressional Democrats to put national health care reform on a fast track and even to claim (as Senate Finance Committee Chair Max Baucus, D-Montana told the Congressional Quarterly in March) that health care reform "will not add to the deficit. It will be paid for."

The ARRA stimulus package includes $17.2 billion to provide incentives to health care providers to adopt and use health information technology (HIT). Another $1.1 billion is provided for Comparative Effectiveness Research (CER). Lawmakers are counting on HIT and CER to save money in the long run.

$10 billion of additional funding goes to the National Institutes of Health, which is undoubtedly good news for researchers at the Alpert Medical School of Brown University. $2 billion is slated for the Office of the National Coordinator for Health Information Technology.

Health information technology and the HITECH Act

The federal stimulus may provide Rhode Island with a significant opportunity to consummate its position as a national leader in the adoption and use of health information technology and health information exchange. One major component of the vast ARRA is the Health Information Technology for Economic and Clinical Health (HITECH) Act, which authorizes some $36 billion over six years for investment in the nation's health information infrastructure, including the $17.2 billion (already mentioned above) earmarked to provide adoption incentives for health professionals and institutions.

Rhode Island is already well positioned as a national leader in the use of electronic medical records and in electronic prescribing, and this should work to the state's advantage in competing for federal implementation grants. No state can lay a more persuasive claim to having developed a statewide plan for health information exchange than Rhode Island. (Visit www.currentcareri.com for an overview of the pilot program currently being implemented in the Warwick area.) It will be incumbent upon Rhode Island and other states to develop a functioning infrastructure for Health Information Exchange so that physicians, hospitals and others have an opportunity to earn substantial incentive payments from Medicare and Medicaid. Again, no state is closer having such a functioning, statewide infrastructure than Rhode Island.

Specifically, Medicare incentive payments will flow from CMS (the Centers for Medicare and Medicaid Services, formerly HCFA) through the Medicare contractors (i.e., National Heritage Insurance Company of Hingham, MA, which will be the Part A and B Medicare contractor for Rhode Island starting May 1, 2009) to hospitals, physicians and dentists who make "meaningful use" of electronic health records. Physicians may receive up to $44,000 in Medicare incentive payments over five years. However, HITECH includes a stick as well as a carrot: physician payments will be reduced by up to $35,000 per physician if electronic health records are not implemented by 2013 or 2014.

In addition, Medicaid incentive payments will flow from CMS and the states to hospitals, physicians, dentists, nurse practitioners, and Federally Qualified Health Centers that make "meaningful use" of electronic health records. Physicians may receive up to $75,000 in Medicaid incentive payments over five years.

The definition of "meaningful use" includes: using certified (presumably by CCHIT) technology; e-prescribing; having the electronic record connected to an infrastructure that permits information exchange; submitting certain clinical quality data electronically to Medicare. However, the "meaningful use" definition remains quite ambiguous; for example, the volume of e-prescribing required is unclear, as is the definition of "health information exchange."

In addition, the Office of the National Coordinator of Health Information Technology (a.k.a. ONC, which is part of HHS) will provide planning grants, implementation grants and loan funds to states and state-designated entities to pass through to health care providers.

Finally, the Department of Health and Human Services and the National Science Foundation will provide educational and research grants to medical schools and graduate schools to promote electronic health records in medical school curricula and medical health informatics education and technology development in graduate schools.

The stated goal of the HITECH Act is that every person in the United States will have an electronic health record by 2014.

Increased privacy protections

HITECH also tightens the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For example, it extends HIPAA requirements to business associates, including health IT vendors. HITECH also establishes the first national data security breach notification law, which requires providers, health plans and other HIPAA covered entities, as well as health IT vendors, to notify patients, government agencies and the media of un-authorized release of protected health information. (HIPAA currently requires only that covered entities mitigate the damage of improper disclosures.)

HITECH also provides for increased enforcement of HIPAA with greater civil penalties for violations.

It will be necessary for Rhode Island to analyze the Rhode Island Health Information Exchange Act of 2008 in light of the security and privacy provisions of HITECH. ❖

MOVING-THE-LEGISLATURE PRIMER FOR RHODE ISLAND PHYSICIANS

FIRST THINGS FIRST—WHO REPRESENTS YOU?

Know who your state Representative and state Senator are. You can find out from your town hall clerk or registrar. You can also use the Secretary of State's website, www.sec.state.ri.us. (If you forget the URL, you can always find this and many other useful links on the RIMS website, www.rimed.org.)

If you don't live in Rhode Island, what in-state connection do you have that may be important to your legislators? For example, you may be employed in Rhode Island, have patients here, etc. (When contacting legislators, DON'T pretend you are their constituent if you are not.)

HOW TO BEST CONTACT YOUR LEGISLATOR

A telephone call to their home is the most effective means. You may also send a letter to their home, button-hole them at the State House (not easy to do), or send an e-mail. The old adage for a legislator is "Five phone calls on one issue from five different constituents is a wake-up call."

WHAT TO SAY DURING THE CALL

Unless you know them personally, address legislators as "Representative Smith" or "Senator Jones" (NOT "Congressman" or "Congresswoman"; that's somebody else). Tell them who you are, what the issue is, and why it's important to you. If you are calling about a particular piece of legislation, knowing its number helps. Ask what you can do to get the outcome you'd like, and leave your contact information. Be clear, be honest, be helpful. DON'T be a Know-It-All.

TESTIFYING BEFORE A COMMITTEE

If you plan to testify on a bill, know its status and content. You can bone up on both by going to the General Assembly website, www.rilin.state.ri.us. You can verify that your bill is scheduled for a hearing and on a committee's agenda by calling the Speaker's office in the House (222-2466) or the Majority Leader in the Senate (222-6655). In order to testify, CANCEL YOUR APPOINTMENTS for the afternoon and come early. It is hard to find parking, the hearing rooms are notoriously small, and even if your bill will not bring out a large crowd, someone else's bill may. Find the Committee Room and SIGN IN on the witness form for your bill, or you will never be called to testify.

When called, thank them ("Thank you, Mister/Madame Chairman and members of the committee"), identify yourself, state who you are representing, and say right up front if you are speaking for or against the bill. You may bring written testimony with copies for each committee member, but if it's longer than half a page DO NOT read it to them. KEEP IT SHORT. Speak to your knowledge and expertise and how they inform your opinion. Anticipate the arguments of the opposition, and if possible, have a brief reply to them. Again, try to avoid seeming like a Know-It-All. Be helpful, answer the committee members' questions, if any, and remember that knowledge may be influence, but it is not power. The committee members (or at least their leaders) are the ones with the power, including the power to do the wrong thing from your perspective. Thank the committee.

RIMS HAS DECADES OF EXPERIENCE WITH THE LEGISLATURE

More advice is a phone call away:

Steve DeToy, RIMS Public Affairs Director, 401-528-3283.

By Nick Tsiongas, MD, MPH
Chair of the Rhode Island Medical Political Action Committee, Past President of RIMS, and a former member of the Rhode Island House of Representatives

How to find information about a legislative bill online

The General Assembly's website is known as the Rhode Island Legislative Information Network: www.rilin.state.ri.us. (You can get there through the Medical Society's website, www.rimed.org: click on "Links" at the top, then on "RI State Government" at the left, and finally on "Rhode Island General Assembly.")

Click on "Legislation" in the horizontal bar at top. The rest is fairly self-evident, except for the odd term "Public Laws," which has a special and limited meaning in Rhode Island. "Public laws" are recently passed laws that have not yet been incorporated into the General Laws of Rhode Island. (The "General Laws" are the full body of statutes that are currently in force in Rhode Island, excluding any "Public Laws" that have been enacted but have yet to be integrated into the General Laws.)

Finding a particular bill is easy if you know the bill's number, but it can be difficult if you do not. Also, quite a few days can pass between the introduction of a bill and the time it is assigned a number and thus becomes accessible. Bills can also be located under the name of their lead sponsor (click on "Bill Status") or by doing a search using key words, though this method can get tedious.

You can track the progress of a bill (hearings, votes, amendments) through the General Assembly website too. As bills are amended, the updated versions are posted on the website, often as "Substitute A" or "Substitute B" of the original bill.

The General Assembly website is also useful for identifying your own legislators (every Rhode Island resident is represented in the General Assembly by one State Representative and one State Senator) and communicating with them. ❖

FROM PAGE 1 – LEGISLATURE

RIMS' initiatives include (but are not limited to) the following House (H) and Senate (S) bills:

- H-5385 would prohibit the sale of tobacco products in a facility that also includes a licensed health care facility. (For example, this measure would address the potential incongruity of a drug store selling cigarettes next to an in-store clinic.)
- H-5413 would establish a loan-repayment program to help Rhode Island attract and retain physicians.
- H-5453/S-0548 would protect physicians against abuse by so-called "silent PPOs," which illegitimately exploit fee discounts that the physician may have granted contractually to others.
- H-5502/S-0248 would permit Physician Assistants to participate in emergency care and disaster relief with immunity from liability and with flexible provisions regarding physician supervision.
- S-0709 would incorporate the American College of Surgery definition of "surgery" into Rhode Island's medical practice act.
- H-5548 would impose a tax on sugary beverages.
- H-5778 would fine-tune RIMS' existing "prompt processing" law by reducing the turnaround time for electronic claims to a maximum of three days.
- S-0575 is RIMS' omnibus liability reform legislation addressing the statute of limitations, prejudgment interest, admissibility of certain communications ("I'm sorry" provision) and other improvements in the conduct of liability cases.

Payments to physicians and hospitals

Besides RIMS' own H-5453 (see above), RIMS is encouraged to see a number of legislative initiatives from others this year that reflect the heightened public awareness of the payment inequities and imbalances that handicap Rhode Island health care.

One such bill, H-5608, would require insurers to pay physicians at least 125% of Medicare, provided the physician sees Medicaid and RIteCare patients and devotes at least 5% of her or his practice to providing free care. Moreover, the bill would put into the law books some of the recurring themes of RIMS' advocacy for physicians in recent years, including the persistent regional payment inequities, Rhode Island's resulting disadvantage in recruitment and retention, and the dangers these conditions pose to Rhode Islanders.

However, H-5608 also points up some of the difficulties of reforming physician payment through legislation. For example, how would one measure "5% free care" to "the uninsured"? Moreover, given the fundamental flaws of SGR and the 21% cut in Medicare physician payments scheduled for January 2010, linking commercial payment to Medicare is problematic, to say the least. In addition, history demonstrates the danger of floors becoming ceilings.

S-0771 would allow physicians to claim a tax credit for 100% of the value of free care they provide to the uninsured, up to an annual total of $25,000.

A few bills address hospital reimbursements. For example, S-0244 would mandate public disclosure of insurers' payment rates to individual hospitals for services and equipment. Another (S-0186) would impose binding arbitration when hospitals and insurers reach an impasse in their contract negotiations (as Women & Infants and Blue Cross did for a period last December).

One new piece of legislation (S-0356) put in by a veteran legislator would limit hospital CEO's salaries to 2.5 times that of the Governor (which is about $120,000), an obvious reaction to the February 13, 2009, Providence Phoenix exposé about executive compensation at hospitals in Rhode Island.

CON

Two Certificate of Need bills have been put in at the behest of South County Hospital: H-5273 and H-5274. Both seek to protect hospitals from competition by non-hospitals. The Medical Society believes that in the absence of comprehensive, statewide health planning, the hurdles typically set up by Certificate of Need legislation can arbitrarily deprive the public of the convenience, cost savings and new technology that ambulatory facilities tend to offer. A state mandate for coordinated health planning was enacted with RIMS support in 2007, but state officials have largely ignored it. Until a plan exists, RIMS opposes CON; RIMS also favors a moratorium on all hospital mergers for the same reason, until a plan is developed.

Liability reform

In addition to RIMS' own comprehensive bill S-0575 (see above), a number of other welcome bills (S-0088, S-0090, S-0254, S-0187, S-0259) also seek to ameliorate various aspects of the liability system and reduce the expense and harm caused by the professional liability system.

S-0088 would require that medical liability settlements and awards be broken down into sub-amounts for economic damages, noneconomic damages, medical expense and accrued interest.

From Autism to Zygote

Other bills deal with tobacco taxes, breast cancer (H-5399), health workforce, autism, the creation of "compassion centers" for dispensing medical marijuana (H5385/S-0185), highway safety (including bans on texting and cell phone use while driving), mandated health insurance benefits, the nursing shortage, drug prescribing and dispensing (including the freedom of pharmacists to refuse to dispense Plan B), mandatory e-prescribing, coordinated statewide health planning (S-0182), extending health insurance to the unemployed (by expanding COBRA and RIteCare), protecting children from second-hand smoke (S-0209), mandating primary care (H-5399), and other topics.

H-5645 would consolidate the Department of Health; the Department of Human Services; the Department of Elderly Affairs; the Department of Mental Health, Retardation and Hospitals; and the Department of Children, Youth and Families into a single entity with six divisions.

In a few months, RIMS will report to members on the bills that make it through the legislative process, some of which will bear little resemblance to their original language. RIMS will also report to its members on any important interim developments, including matters that may call for grassroots action. RIMS occasionally depends on its members to lobby their legislators on key issues; RIMS makes such constituent interventions easy through an email program that connects physicians with their own state Representatives and Senators, or sometimes with entire committees of the legislature.

The importance of the regulatory process

In any case, supporting or opposing the passage of a new law is often less than half the battle. New laws are often implemented by regulation, which is where the devil emerges from the details. Drafting regulations entails a quasi-legislative process of its own, involving public hearings, testimony and negotiation.

RIMS routinely participates in regulatory processes conducted by the Department of Health, the Department of Business Regulation, the Attorney General's Office, the Department of Human Services, the Department of Labor and Training, and other state agencies. ❖

Volunteer for a RIMS "House Call" at the State House

During his 2007–2008 presidency of RIMS, Dr. Nick Tsiongas encouraged members of the RIMS Council, RIMPAC and the Public Laws Committee to set aside a Tuesday, Wednesday or Thursday afternoon and evening (usually from 4 pm on) to accompany RIMS' Government Affairs Director Steven R. DeToy on his rounds at the Capitol. The initiative was well received by physicians and legislators alike and so has not only been renewed this year but also broadened to encourage participants to bring along a colleague, including possibly a resident or a medical student. RIMS members interested in spending a few hours at the State House are welcome to email Sarah Stevens (sstevens@rimed.org) and volunteer. Volunteers receive an information packet in advance of their State House visit; out of an abundance of caution, RIMS also registers each volunteer as a "limited lobbyist." ❖

Who, Why and How

DIANE R. SIEDLECKI, MD

SEPTEMBER 27, 2008

First I want to thank my family and friends, especially my co-workers. They will sacrifice a lot over this next year. I especially would like to thank my husband, Ken Kelly. Without your love and support I could never do this. I love you. You all know me… I would never be married to me!

I am very much aware of the fact we are near the end of this evening's formal program, so I will try to speak from my heart and make my comments as brief as possible.

It was very difficult for me to write this speech. The last time I had to write a speech for a large audience was 25 years ago at my commencement from Georgetown Medical School. Since then, my speeches have been to smaller audiences and usually more personal. You see, I seem to have fallen into the role of eulogist. Just ask Dr. Troise. Several years ago she received the award for the Rhode Island Medical Women's Association Physician of the Year, and I gave the introduction. Afterwards several women I never met suggested when the time came I might be called upon to give their eulogies.

So my main goal tonight is not to bury this speech. I think I can best pull it off by addressing the WHO, the WHY and the HOW.

WHO

I am Diane Siedlecki, the oldest of 5 children. My father affectionately refers to me as to the fifth from the bottom. I am from my paternal grandfather, Teofil Siedlecki, originally from Poland, a butcher, who taught me love for his country, this country, and who lived a quiet pious life, loyal to faith and family.

I am from Julia Herkert, my maternal grandmother who raised 13 children, 9 to adulthood after her husband left her widowed at age 40. She taught me what it takes to survive, to do what was needed to get the job done and to NEVER, EVER quit.

I am from Mary Herkert Siedlecki my mom, who passed away almost 10 years ago. She could have been CEO of any company but instead chose to be CEO of our home. From her I learned the art of conversation, to ask, to listen and hold the world close to my heart. From her I learned unconditional love.

I am from Eugene Siedlecki, my papa who is here this evening. From him I learned the importance of getting the job done. He was an insurance agent who took part in several class action suits against his parent company. He taught me that when it came to principles, no matter what you perceive the cost to be, it will cost you more in time, money and honor if you settle for less than the right thing.

The WHY

Why am I here? Simple. I'm here because I was asked. Around eight years ago I got call from Dr. Yul Ejnes, a Past President of the Rhode Island Medical Society. He asked me if I would be willing to serve as Secretary of the Medical Society. I told him I do not do minutes. They would be waiting for them for ever. He said you do not need to do minutes; someone else does that. I asked him did he call me because he needed a woman on the Council, and I was a middle-aged woman with no children at home. He said yes, and I said ok. It was as simple as that.

I came to the table because I was asked.

What we need to accomplish is enormous. We need to step in and save our profession. I am here because 25 years ago I graduated medical school. I still could not believe that I was blessed to be part of the profession I thought I would only be able to dream about. I was excited about everything. The opportunities and options seemed endless. I felt part of a great profession, charged up and in charge.

Somewhere along those 25 years so many things have changed. It was no longer a profession I recognized. It became very difficult for me to be able to look a young person in the eye and say choose medicine. It was hard for me to say to a medical student choose primary care – even when I still believe I have the best job in the world. I am doing this because I am an Internist, a primary care provider and, let's face it, we are on the extinction list.

Primary care / psychiatry is the elephant in the room we need to acknowledge. Over the years we have slowly created two classes of physicians, the primary care docs and psychiatrists on one hand and then the rest on the other. No blame. Much of this has been due to the advances in technology, and much of it also has been secondary to the shrinking health care dollar that needs to be split in ever smaller proportions. We are…no, we were an easy target. But that can no longer be. If we do not fix this disparity it will become more difficult for the specialists to do their job, because they will be doing our job. And we know that they do not want to be doing that.

HOW

And that leads me to the how. The how is simple. We do it together. I am going to steal a line from a tribute piece that Dr. Ken Mayer wrote for the late Dr. Al Fischer. He quoted an old sage, Rabbi Hillel, who said "he who saves a single life has saved a universe." We have been given the honor to practice medicine, and in essence each one of us has been blessed with the saving of a life. It could have been as dramatic as surgery, a discovery, a correct diagnosis, or as simple as a word, a touch, a connection. In doing such things, we have saved our own lives.

I believe part of the "how" we will do this is to remind ourselves of our ultimate task, and this is taken directly from our website: "to support physicians in their efforts to serve their patients, succeed in their medical practices and in other ways realize their professional potential and achieve their personal goals."

I believe in the "how" of doing this by reaching out and getting the younger generation involved. Not by expecting them to join, but by asking them specifically to join and to be involved in a committee, to represent RIMS to the legislature, to hand out bike helmets to the RIteCare kids. By asking them individually, directly, one by one, to join, to attend, to represent, to take part in their future. Their future should not be solely represented or molded by us. Because I will not accept that the "whatever" generation is really not interested. I will not accept that the youth of today will embrace mediocrity and thus change the face of medicine from a calling, from a profession, to a job.

And given the choice, I choose passion, always. I leave you with a quote, this time from a new sage. She is my niece Laura, who turned 14 today. She actually wrote this when she was 12. It is the last two lines of a poem she wrote.

Don't march to the beat of my drummer,
for the song bird sings his own song.
Don't wait for inspiration,
for you could simply be your very own.

Let us work together toward an inspiring and productive year. ❖

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RI Foundation boosts primary care

The new Fund for a Healthy Rhode Island

In February 2009, the Rhode Island Foundation announced the establishment of a new, permanent endowment that will focus on increasing access, affordability and quality of primary care in Rhode Island. In each of its first three years, this endowment, known as the Fund for a Healthy Rhode Island, is expected to distribute $800,000.

Six hundred thousand of this amount each year will be distributed in the form of grants ranging from about $50,000 to $250,000 each. These competitive grants will be intended to promote improvements in three areas: making primary care more accessible; making pharmaceuticals more affordable; and raising public awareness of the importance of primary care, prevention and personal responsibility.

Individuals and organizations interested in applying for a grant should contact Elaine Saccoccia at the Rhode Island Foundation: 401-427-4029, esaccoccia@rifoundation.org. The first deadline is April 15.

The remaining $200,000 from the Fund each year will be used to support a loan forgiveness program for primary care professionals. The Foundation, the Rhode Island Medical Society and Blue Cross & Blue Shield of Rhode Island are working together to create a robust loan forgiveness program and identify additional sources of funding for it.

The Rhode Island Foundation defines "primary care" as the "medical home for a patient, ideally providing continuity and integration of all aspects of health care. All family physicians and pediatricians and most internists provide primary care, as do nurse practitioners, mental health workers, case managers, and others who work with them."

According to the Foundation, the Fund for a Healthy Rhode Island will not make grants to fund capital improvements or medical research. Proposals will be evaluated based on effectiveness; ability to provide clear outcome measures and document results; applicability to other settings; and sustainability beyond the grant investment. The Fund will support projects of one to three years' duration. ❖

New AMA resources for your practice:

Claims process check-up; the cash practice alternative; keeping your practice competitive

The Practice Management Center and the Private Sector Advocacy unit of the AMA have developed practical new tools and resources for help medical practices keep their heads above water.

For example, as part of its "Heal the Claims Process"™ campaign, the AMA helps physicians analyze their practice's ability to detect payer problems and address delays, denials and payment reductions. The title is "Prescription for a healthier practice: Physician claims process check-up"; it is part of the AMA's "Heal the Claims Process" campaign kit and is available through the AMA website, www.ama-assn.org/go/pmc.

In addition, "Cash practice alternatives: Considerations for physicians," shows doctors how to assess whether limiting their financial dependence on health insurer contracts may be a viable option. This publication too is available through the Practice Management Center section of the AMA website, www.ama-assn.org/go/pmc.

The AMA's office of Private Sector Advocacy has published a second edition of its booklet "Competing in the Marketplace: How physicians can improve quality and increase their value in the health care market through medical practice integration." Its focus is on the timely issue of survival through aggregation. Many physicians have long resisted the option to band together in order to share resources and gain clout with payers. Understanding the various degrees of integration, including financial integration, clinical integration, and merger, may enable physicians to preserve their independence while also gaining market advantages by cooperating in ways that do not violate antitrust. The second edition includes a new preface and appendixes that highlight the AMA's antitrust activities. It is available through the Public Sector Advocacy section of the AMA website, www.ama-assn.org/go/psa. ❖

Medicare e-prescribing incentive payments

To encourage physicians to adopt electronic prescribing, Medicare is providing incentive payments in 2009 and 2010 equal to 2% of the physician's total Medicare payments for the year, payable in a lump. In order to be eligible for the incentive payments, physicians must have a CMS-compliant system and have at least 10% of their Medicare charges represented by office visits, consultations, eye exams, psychotherapy and certain other services. They must also report one of three e-prescribing G codes for at least 50% of all their Medicare office visits, consultations, and certain other services.

In 2012, the carrot will become a stick, with penalties for physicians who have not implemented e-prescribing.

More information is available from the AMA website, www.ama-assn.org, and from CMS at www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp#TopOfPage.

Electronic prescribing is regarded as effective in preventing medication errors, reducing adverse drug events and making patients' coverage and co-payment information conveniently available to prescribers. ❖

Reminder: All RIMS members have privileges at Brown's libraries

RIMS members are reminded of the 22 year-old agreement under which RIMS members are "guest borrowers" in the Brown library system without charge. As guest borrowers, members have physical access to all the libraries and may borrow books for up to one month; they may also use the guest workstations located on the first floor of the Rockefeller Library and on Level A of the Sciences Library. Members of the general public pay $400 a year for comparable privileges. Brown affords all RIMS members and RIMS staff free access in recognition of RIMS' gift of the Society's 50,000 volume library collection to Brown in 1987. Not included is remote access to the libraries' online resources. Also, certain materials, like periodicals and recordings, do not circulate. ❖

Does RIMS have your email address?

Email is increasingly the preferred medium by which RIMS communicates with its members. Please keep Sarah Stevens (sstevens@rimed.org) apprised of your address.

In the first two months of 2009, RIMS sent the following timely broadcast emails to members:

JANUARY 2	The Insurance Commissioner's survey of physicians on BCBSRI and UHC
JANUARY 14	The dismantling of Ingenix, and why it is especially good news for Rhode Island
JANUARY 21	United's $400 million payment to settle with AMA, medical societies and the State of New York
JANUARY 30	United's "Premium Designation" appeal process
FEBRUARY 12	RI's new Medicare Contractor, NHIC
FEBRUARY 13	Rhode Island's Michael Migliori, MD, elected to AMPAC Board
FEBRUARY 19	The Rhode Island Foundation's announcement of new programs and resources to boost primary care

In addition, RIMS sent alerts regarding three notable CME opportunities in Rhode Island and one in Massachusetts.

If RIMS does not have your email address, you missed some or all of these communications.

RIMS will never give your email address to any third party. RIMS uses its broadcast email capability judiciously and exclusively for communications that are timely, important, informative and concise. ❖

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