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Getting ready for ICD-10 by 2013

ICD-9 is more than 30 years old and outdated. Its successor will reflect advances in medicine and be a boon to research and public health, -- but the transition will be a burden for physicians

ICD-10 is slated to succeed ICD-9 effective October 1, 2013, as the HIPAA-required system for coding diagnoses in all clinical settings and for hospitals to report inpatient procedures. (CPT will remain the coding system that doctors use to report services and procedures, regardless of setting.)

The U.S. Department of Health and Human Services (HHS) is mandating the change because ICD-10 better reflects current medical knowledge and technology and also permits greater specificity in coding and reporting diagnoses and procedures. Consequently, ICD-10 will provide a more consistent and logical framework and yield better data to support public health surveillance and research.

The differences between ICD-9 and ICD-10 are substantial, and therefore the transition is certain to be burdensome for physicians. Practice management staff and physicians should begin taking steps now to prepare for the October 2013 compliance date.

AMA and RIMS advocacy

HHS initially called for a much tighter compliance date of October 1, 2011, for nationwide implementation of ICD-10. In 2008, RIMS joined the AMA and other medical organizations in calling for a revision of that timetable. The physician groups argued that CMS underestimated the time and expense involved in retraining and retooling from a system of about 16,000 procedure and diagnosis codes to a new system of 155,000 codes. In January 2009, HHS relented, pushing the deadline back by two years to October 1, 2013.

Besides extending the *continued page 6*

Liability notes: Rhode Island and the federal "demonstration projects"

When U.S. Senator Sheldon Whitehouse addressed the RIMS Council on August 17, 2009, physician members of the Council repeatedly expressed their disappointment and incredulity that health system reform efforts in Washington allegedly aimed to control costs but were perversely ignoring a major driver of unproductive expense in American health care: liability and defensive medicine.

Three weeks later, in his September 9, 2009, address to a joint session of Congress, President Obama announced a new federal program of liability "demonstration projects," the purpose of which would be to identify and measure effective strategies to improve the liability system in ways that would better serve patients, reassure doctors and save the system money as a result.

Presidential recognition that the liability system might be a major part of the problem was encouraging. Add the promise of a new opportunity, supported with government funding, to demonstrate better models, and the message was more encouraging still. Yet one had to reflect: we already have lots of data on what works and does not work in liability. For example, California's successful "demonstration project" has been running for 34 years. Many other states have long been "laboratories of democracy" for testing various kinds of liability reforms.

Nevertheless, the health care community can hardly fail to respond to the President's challenge and must seek to make the most of it.

Accordingly, on September 10, 2009, the Rhode Island Medical Society (RIMS) and the Hospital *continued page 7*

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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.*

RIMS President Vera A. De Palo, MD, addresses the Annual Banquet crowd at the Dunes Club in September

Moving ahead collaboratively

Inaugural remarks of Dr. De Palo delivered at the Dunes Club on September 26, 2009

Medicine is changing. It has always been changing. In fact, change is what advances us. Sometimes, the pace of that change can be unsettling. For years, the changes have included additions to our knowledge base or to our skill set. The options of diagnostics and therapeutics in medicine and surgery are much different today than they were 30 years ago. In the last few years however, the changes really have focused on our system. How do we deliver care? Is it the best care possible? Is it the care that has been proven to give the best outcomes? Is it efficient? Is it affordable?

Well, we stand at the edge of the precipice. To use a metaphor from this lovely location, we are riding the crest of a wave. There is much discussion of what health care will look like in the future. Many in this room and in our society have risen to the challenges through the year and have led us along the bumpy road of health care. We have collaborated for quality. We continue to do so. It is time that we collaborate for system change. It will be with the insight and wisdom of our past presidents, our health care leaders, our partners and collaborators, that we will enrich the debate and bring us to a better system of care for all.

But this will not come easily. It comes with hard work and attention to detail. Communication is key. It is with communication and collaboration that not only will we continue to bring about knowledge base, technology, and quality advancements, but together we will help to shape our health care delivery system.

During this past week, I had conversations or communications from several past presidents. I will mention two. The first was a conversation with Dr. Bud Kahn at the Medical Society Golf Tournament. He took me aside to tell me about his presidency year. He told me what a wonderful year it was and that I would get to work with an amazing staff. The second was a note from Dr. Ric Christian. Ric told me what an exciting and professionally satisfying year he had. Both told me how hard it was and were full of words of support and encouragement.

Well, I agree with them. The staff at the Rhode Island Medical Society is an amazing staff. I have gotten to know them this year. I am looking forward to working closely with them during the next year. To my colleagues, my partners, my collaborators, and to my friends, I look forward to working together with you.

The challenges will be great, and I will surely need everyone's help. This is our opportunity to contribute to the discussion which will shape the health care landscape. It will be with communication, collaboration and focus on the noble profession to which we are committed that we will make our greatest impact! Thank you. ❖

Regional variations in Medicare payments

If there is one thing that physicians of all specialties and in all parts of the country might agree upon, it is that Medicare payments for physician services are inadequate and are becoming more so each year, – even without the periodic threat of catastrophic cuts like the 21.2% drop that is looming on March 1, 2010.

In particular, physicians in Rhode Island and in certain other parts of the country, especially in rural areas, often voice the impression that Medicare's Resource-Based Relative Value Scale (RBRVS) short changes them to an even greater extent than it does other physicians who are fortunate enough to practice elsewhere. Rhode Island physicians often assume that the discrepancies in commercial insurers' treatment of physicians within New England are reflected equally greatly in Medicare, though this is quite certainly not the case. Some physicians seem to conflate Medicare rates with a comparative survey of Medicaid fee-for-service rates that was published by RIPEC in 1994 – before RIteCare – and showed Rhode Island next to the bottom nationally.

The RBRVS, developed at Harvard in the 1980s and implemented by Medicare in the early 1990s, is far from perfect. It has probably not served the country well (some say its overemphasis on effort and its undervaluation of effect have helped to undermine primary care) and is likely to be substantially modified or supplanted in coming years.

For all its shortcomings, RBRVS is not static and is designed to be self-correcting, to an extent. For example, the RBRVS is systematically updated and modulated to reflect geographic changes and differences in living costs and in the prevailing value of professional work in different parts of the nation. As a result of these modulations, Rhode Island physicians today are paid about 12% more than Arkansas physicians, about 6.6% less than Connecticut physicians and about 11% less than physicians in metropolitan Boston. The differences arise mainly from the federal government's measures, which are updated every three years, of living costs in the various markets as an index to differing overhead expenses for medical practices.

Below is a more detailed explanation of how these calculations come about.

Medicare payment to doctors everywhere in the U.S. is a product of the following three factors: 1) a nationally uniform RBRVS; 2) a set of Geographic Practice Cost Indices (GPCIs) that modulate the RVUs (Relative Value Units) to reflect local economic conditions; and 3) a nationally uniform Conversion Factor (CF), which is currently $36.08.

Let us take a closer look at the first two factors. The nationally uniform RBRVS assigns a relative value to each of the thousands of discrete services identified by the CPT coding system. The relative value of each service is expressed as a number, which is the sum of the RVUs that Medicare assigns for each of three components of every service: the value of the work involved (time, intensity, skill, training, experience, etc.), the general practice overhead expense (office rent, personnel, utilities, equipment, supplies etc.); and the medical professional liability insurance expense that can be allocated to the service.

The weight given to work, overhead and liability varies slightly from code to code, but overall in the RBRVS system the "work" component accounts for 52% of RVUs, general overhead accounts for 44% of RVUs and liability expense for only about 4% of RVUs.

The RVUs assigned to each of the three components (work, overhead, liability) of each CPT service are multiplied by a geographic adjustment factor that is specific to that component and to that geographic area or "locality." Medicare divides the nation into 89 "localities." Rhode Island and Connecticut are each a single locality; Massachusetts is two localities, namely "Metro Boston" and "the rest of MA." Every three years, Medicare measures the going rates for professional work, for living costs/practice overhead, and for medical professional liability insurance in each locality and updates the geographic adjustment factors accordingly.

The three geographic adjustment factors compare each locality with the rest of the country. That is to say, an adjustment factor of "1.0" corresponds to what Medicare

Ten Past Presidents of RIMS were hosted by President Vera A. DePalo, MD, for a holiday get-together at RIMS in December. [L–R] Herbert Rakatansky, MD; Arthur A. Frazzano, MD; Richard Wong, MD; Barbara Schepps, MD; Tilak K. Verma, MD; Diane R. Siedlecki, MD; Dr. DePalo; James P. Crowley, MD; Fredric V. Christian, MD; J. Jefferys Bandola, MD; Yul D. Ejnes, MD

considers to be the national average and results in no adjustment in payment. A factor >1.0 means the value is above the national average, and this higher factor results in a higher payment. A factor <1.0 means the value is below the national average, and this lower factor results in a lower payment.

These three adjustment factors are called Geographic Practice Cost Indices or GPCIs. Medicare assigns each locality its own three GPCIs (one for work, one for practice overhead and one for liability cost), in order to account for regional differences and thus make the RBRVS payment system equally fair to doctors everywhere.

Thus, the formula for payment for each service would look like this:

[(Work RVUs x work GPCI) + (overhead RVUs x overhead GPCI) + (liability RVUs x liability GPCI)] x CF = payment

How Rhode Island stacks up

Rhode Island's current GPCI for the "work" component is 1.029; thus, it is above the national average and is identical, in fact, to the work GPCI for Metropolitan Boston. The rest of MA, at 1.007, is lower than Rhode Island; CT, at 1.038 for work, is higher than both Rhode Island and Metro Boston.

Rhode Island's "overhead"/living expense GPCI is 1.04; Metro Boston's is 1.311, and the rest of MA is 1.106. CT's is 1.179. Apparently, then, Medicare finds RI's overhead costs (office rent, etc.) are generally lower than those in MA and CT but still higher than the national average.

Rhode Island's liability GPCI is 0.946. Thus, Medicare finds RI's liability expense to be below the national average but higher than that of Metro Boston and the rest of MA, which are both pegged at 0.787, and also higher than CT at 0.934.

To compare Medicare's overall physician payment levels in RI, MA and CT, we have to take into account the different weighting of the three factors (52% work, 44% overhead, 4% liability expense). Doing so, we can arrive at a rough composite geographic adjustment factor for RI of 1.03052, for CT of 1.09588, and for Metro Boston of 1.14340. (Note: these "composite" factors were generated by RIMS and are not known to be calculated or used by Medicare in any way.) It follows that Medicare pays doctors in all three states at rates that are above Medicare's national average.

Because the actual weighting varies slightly from code to code, these calculated composites are not precise, but they suggest that Medicare pays Metro Boston physicians at rates about 11% higher than what RI physicians receive, and that Medicare pays CT physicians at a rate about 6.6% higher than what it pays RI physicians.

These differences in payment rate are not insignificant, but they are narrower than many Rhode Island physicians may believe them to be. (Rhode Island physicians may tend to generalize from the commercial side, where the discrepancies have been much greater, as the Massachusetts Medical Society's study released in 2003 demonstrated.)

For comparison's sake, add Arkansas to the mix

A state where the three components of RBRVS are lower provides some additional perspective on the range of payment differences that exists within the Medicare system. Arkansas, like CT and RI, is a single "locality" in Medicare's payment system. AR's GPCIs are 1.0 for professional work (thus, neither higher nor lower than the national average), 0.846 for practice overhead (below the national average), and 0.446 for liability insurance expense (well below the national average), which would yield a composite geographic adjustment of about 0.91008. From this calculation, one can infer that Medicare pays AR doctors at rates that are about 12% less than what RI doctors receive from Medicare and 23% less than what Metro Boston doctors receive. ❖

Will you be ready for PECOS by April 5?

An understated communications effort by CMS has left some medical practices in the dark about a looming deadline that could confront some doctors with a string of Medicare claims rejections starting April 5, 2010.

In a nutshell: all ordering and referring physicians must be enrolled in the Medicare Provider Enrollment Chain and Ownership System (PECOS) by April 5 of this year, or their claims will no longer be paid. (This requirement was originally slated to go into effect on January 4, 2010, but AMA prevailed upon CMS to delay the effective date in order to give physicians more time to comply.)

All physicians and non-physicians who order services or items for Medicare patients or refer Medicare patients to other Medicare professionals or suppliers are included under the new requirement.

Doctors who signed up with Medicare after November 2003 are probably in the clear. However, doctors who enrolled in Medicare earlier and have not updated their Medicare enrollment since November 2003 must do so before April 5, 2010, or their Medicare claims will be automatically rejected starting on that date. During the current phase-in period, physicians who do not have a current enrollment record in PECOS are supposed to be receiving warnings when they submit claims, but for now their claims are still being paid – until April 5.

Medicare-enrolled physicians can enroll in PECOS or verify that their enrollment is up to date by visiting pecos.cms.hhs.gov and logging in as they would for the National Plan and Provider Enumeration System (NPPES), using their NPPES user ID and password; (one can call 1-800-465-3203 if one does not have these, or email customerservice@npienumerator.com). PECOS offers step-by-step on-screen instruction, but users should work along steadily, because PECOS will automatically log off any user who leaves the connection idle for more than fifteen minutes.

There is more. **Having updated their enrollment online in PECOS, physicians must still print out, physically sign and mail the two-page certification form within seven days of their online submission.** They must also mail any supporting documentation that may be required, such as IRS CP-575 (the form that documents one's employer identification number) or CMS-588 (the form that authorizes electronic funds transfer). Before mailing, one should check to make sure that CMS provided the correct mailing address to Rhode Island's Medicare Contractor, NHIC, Corp. in Hingham, MA; CMS system errors have been known to occur at this point in the process. **Medicare contractors will not process on-line enrollments through PECOS until they also receive a hard copy of the 2-page Certification Statement by mail. Failure to complete this step has delayed the PECOS enrollment of many physicians.**

In case of technical trouble on the PECOS website, one can call the CMS Help Desk for "External Users Services" (EUS) at 1-866-484-8049 Monday through Friday between 7am and 7pm EST or email EUSSupport@cgi.com.

Physicians can also contact Deanna Batstone at NHIC, Corp. (781-741-3479 or deanna.batstone@eds.com) for information on PECOS.

Physicians who prefer not to work online with PECOS may update, enroll or re-enroll by competing and submitting a hard copy of CMS Form 855I. ❖

March 17 is the new deadline for Medicare participation decisions

In response to the lingering uncertainty regarding the level of the Medicare conversion factor for 2010, CMS has extended the deadline for physicians to notify Medicare of a change in their participation status. The new deadline is March 17, 2010. As usual, physicians who do not wish to change their participation status need do nothing.

Congress acted in December 2009 to postpone from January 1 to March 1, 2010, the scheduled 21.2% reduction (from $36.08 to $28.39) in the conversion factor. That postponement was supposed to give Congress time to stop the cut, either with another legislative band-aid, as has become almost customary in recent years, or possibly by actually eliminating the troublesome SGR formula that for years has generated recurrent threats of ever more draconian cuts in Medicare Part B payments.

Thus, by March 1 at the latest, something will have happened to provide physicians with a clearer picture of how Medicare will be paying them in 2010. Physicians will then have until March 17 to consider whether to change their participation status. Any change, however, will be retroactive to January 1. That means, for example, that in the unlikely case that a physician opts to change from non-participating to participating, he or she might have to refund any amounts that had been balance billed to patients since January 1, 2010.

The familiar three options still exist: participation, whereby the physician agrees in advance to accept assignment all of the time for all Medicare beneficiaries who are admitted to the practice; non-participation, whereby the physician reserves the right to balance bill patients on a case-by-case basis, albeit under Medicare's limited rules for balance billing; and private contracting (also known as "opting out"), whereby the physician and all of the physician's patients eschew all Medicare payment for any services provided by that physician, with the possible exception of emergency services under certain conditions.

The AMA provides detailed guidance on physicians' Medicare participation options, including a sample private contract and affidavit, through the AMA website, www.ama-assn.org.

A note about Rhode Island: For a few years in the late 1980's and early 1990's, Rhode Island was among the states that prohibited doctors from balance billing Medicare beneficiaries. It is unlikely that the law ever had any practical impact for any patient, and no doctor was ever disciplined under it. While the law is technically still on the books, its language became obsolete and irrelevant with the advent of the RBRVS system in 1992. Medicare itself now effectively limits balance billing by non-participating physicians to no more than 9.25%. ❖

EDWARD FELLER, MD, received the Medical Senior Citation from graduating Brown medical students for the sixth time last year. Dr. Feller is the most frequent recipient of this prestigious award in the history of medical education at Brown. Each year the Brown graduating class presents the Senior Citation to the most outstanding faculty mentor and role model encountered during their medical school years. Dr. Feller is Clinical Professor of Medicine and Community Health and co-director of the Community Health clerkship at Brown.

The Rhode Island Pain Society is the Ocean State's newest medical society. Officially established in July 2009, the Society brings together anesthesiologists, physiatrists, neurologists, rheumatologists, chiropractors and others who have an interest in pain management. The inaugural officers are: **MATTHEW SMITH, MD**, President; **CASEY O'DONNELL, DO**, Vice-President: **TODD HANDEL, MD**, Secretary; **ADRIAN HAMBURGER, MD**, Treasurer. The officers welcome inquiries regarding the Pain Society. Dr. Smith can be reached at smith@egss.us or 401-886-5907.

PAMELA C. HIGH, MD, has been elected President of the Society for Developmental and Behavioral Pediatrics, an international organization dedicated to improving the health of infants, children and adolescents by promoting research, teaching and clinical practice in developmental and behavioral pediatrics. Dr. High serves on the staff of Hasbro Children's Hospital and the faculty of the Warren Alpert Medical School at Brown. Her community service includes the advisory board of Reach Out and Read Rhode Island and the board of directors of Rhode Island Kids Count.

The **DR. MICHAEL B. MACKO** Library and Conference Room was dedicated by the medical staff of the Roger Williams Medical Center on November 30, 2009. Dr. Macko served as President of the Rhode Island Medical Society 2000–2001, as a member of Rhode Island's Delegation to the AMA 2004–2008, and as a member of RIMS' Committee on Continuing Medical Education for eleven years. Dr. Macko retired in December and died on January 24, 2010, after a long illness. ❖

ICD-10 – continued

ICD-10 deadline, CMS also delayed until January 1, 2012, the deadline for doctors to adopt the 5010 electronic transaction standards under the Health Insurance Portability and Accountability Act.

Major differences between ICD-9 and ICD-10

Compared with ICD-9, the ICD-10 system involves longer codes (more characters per code) and an explosion in the overall number of codes. More specifically, while there are currently some 14,000 ICD-9-CM diagnosis codes, each one of which is 3 to 5 characters in length, the ICD-10-CM system has 68,000 diagnostic codes of 3 to 7 digits in length. The expanded characters of ICD-10-CM permit greater detail in reporting disease etiology, anatomic site and severity.

The increased number and length of the codes will require medical offices to invest in planning, training, and upgrades of their software and perhaps hardware. In particular, the administrative transactions software required by HIPAA will have to be upgraded from version 4010 to version 5010 in order to accommodate the longer codes and expanded data fields.

The upgrade to 5010 transactions must precede the implementation of the ICD-10 code sets. HHS has set a compliance deadline of January 1, 2012, for implementation of 5010 transactions.

The National Center for Health Statistics (NCHS) maintains the ICD-10-CM code set for diagnoses and makes information and code set files available on its website: www.cdc.gov/nchs/icd/icd10.htm.

The American Medical Association's website (ama-assn.org) is an invaluable source for on-going information on ICD-10. Among the resources currently available there is the AMA's 11-page guide to "Preparing for the Conversion from ICD-9 to ICD-10: What You Need to Be Doing Today" (ama-assn.org/go/hippa). This AMA document provides practical advice on taking the following 8 steps:

1) Identify the electronic and manual systems and work processes in which your practice currently uses ICD-9.

2) Consult with your practice management service vendor.

3) Consult with your clearing houses or billing service, if any, and with payers.

4) Consult with your payers regarding possible changes to your contracts as a result of ICD-10 implementation.

5) Identify potential changes to existing practice work flow and business processes.

6) Identify staff training needs.

7) Test with your trading partners (payers and clearinghouses).

8) Budget for implementation costs (system changes, resource materials, consultants, training).

More background and a little history

ICD-10 includes ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) and ICD-10-PCS (International Classification of Diseases, Tenth Revision, Procedure Coding System).

ICD-10-CM is the code set for reporting diagnoses in all clinical situations; it is the updated version of ICD-9-CM Volumes 1 and 2. ICD-10-PCS is the code set used only by facilities for reporting inpatient procedures. It is the updated version of ICD-9-CM Volume 3. The implementation of ICD-10-PCS may lead hospital coders to ask doctors to provide more detail in operative notes, but otherwise should have little or no impact on physicians. CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) will continue to be the code sets that doctors will use for reporting procedures in all settings.

Both ICD-9 and ICD-10 were developed by the World Health Organization. ICD-9 has been widely used in the U.S. since 1978. The WHO endorsed ICD-10 in 1990, and many countries have already adopted versions of it. ❖

Federal demonstration projects – continued

Association of Rhode Island (HARI) and Quality Partners of Rhode Island (QPRI) began working together to prepare for the Washington rollout of the specifics of the Obama Administration's newly announced program. It was quickly apparent that Rhode Island would have plenty of material to work with in making a case for a demonstration project, or at least for a planning grant. For one thing, the state is close to being a *tabula rasa* for liability reform, and therefore the results of any experiment would be complicated by fewer variables. In addition, groups in Rhode Island had recently put in huge amounts of highly sophisticated and successful work in such areas as ICU safety, wrong-site surgery, the medical home model, e-prescribing, HIT and others.

When the U.S. Department of Health and Human Services (HHS) released the parameters of the administration's plan, it was unclear whether organizations like RIMS, HARI or QPRI could actually qualify to apply for the new federal funds. (The pot of funding, it turned out, would amount to only $25 million nationwide, for which the competition is likely to be fierce.) Direct discussions with HHS clarified that neither RIMS, nor HARI nor QPRI was eligible to apply for the program. Indeed, only an integrated health system or an agency of state government would be eligible.

RIMS, HARI and QPRI therefore next approached the Rhode Island Department of Health and offered to perform the work of applying for the funding and of executing the project if the Department would only sponsor the effort and lend its name to it. The Department declined, credibly citing its acute lack of resources.

Meanwhile, Mary Cooper, MD, JD, a Lifespan Vice President, was on a similar quest. Lifespan itself, with its member hospitals and its captive liability insurer (Rhode Island Sound Enterprise, or RISE), has all the attributes and components to be a credible applicant. Moreover, Dr. Cooper has close, personal connections with colleagues in New York and Colorado with whom she quickly designed a creative proposal for a three-state demonstration project she dubbed "ON BASE": Operating under New Boundaries for Adverse and Serious Safety Events.

ON BASE proposes to focus on five areas of patient safety: bloodstream infections; wrong-site surgery; retained foreign object; pressure ulcers; and venous thrombo-embolic events. Dr. Cooper envisions informing patient expectations through a redesigned informed consent process; decreasing the incidence of the five kinds of adverse events by drawing on best practices; implementing disclosure and apology when such events do occur; and mitigating losses in part by moving toward a model that emulates worker's compensation.

RIMS, HARI and the AMA have endorsed ON BASE. The application deadline was January 21, 2010. ❖

Michael Migliori, MD appeared on a special edition of Channel 10 Newsmakers discussing health system reform with WJAR health reporter Barbara Morse Silva (right) and public policy analyst Stacy Paterno (left).

MinuteClinic™ moving its headquarters from Minnesota to Woonsocket

MinuteClinic, the company that started placing health care kiosks in big box stores, supermarkets and drug stores ten years ago, was acquired by CVS Caremark of Woonsocket, RI, in 2006. In November 2009, it was announced that MinuteClinic would move its corporate headquarters from Minneapolis to Woonsocket in order to be closer to its parent. The move eliminates 150 jobs in Minneapolis but raises hopes that a similar number may be created in Woonsocket.

The move "supports our goal of tighter integration of MinuteClinic with CVS Caremark," CVS spokeswoman Carolyn Castel told the media. It also will "foster better alignment with CVS Caremark's chronic care, patient engagement and disease management initiatives."

MinuteClinic is the largest chain of retail-based clinics in the country with 500 outlets. Just one of those clinics operates in Rhode Island; it is located inside CVS Caremark's corporate headquarters. (Walgreens' TakeCare is the second largest chain of retail-based clinics with about 350 outlets.)

CVS Caremark operates the largest network of retail pharmacy stores in the nation, with more than 7,000 outlets in 43 states. ❖

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197th Annual Banquet and Inauguration of Officers

September 25, 2009
Dunes Club, Narragansett

Annual RIMS Member Banquet honorees, l to r: RIMS President Vera A. DePalo, MD; Philip R. Hinderberger, Esq., General Counsel, NORCAL Mutual Insurance Co.; Diane R. Siedlecki, MD, Immediate Past President of RIMS; Edwin N. Forman, MD, recipient of the Rakatansky Award; Michael E. Migliori, MD, recipient of the Hill Award.

Remarks of Dr. Diane Siedlecki upon presenting the Dr. Herbert Rakatansky Award to Dr. Edwin Forman

This year's recipient is one of the all-time giants of Rhode Island medicine. It is really not possible to exaggerate the degree to which Dr. Ed Forman exemplifies the attributes that we, as doctors, all admire and aspire to in our own daily work.

I am very grateful, by the way, to Dr. Elizabeth Lange, as a practicing pediatrician in our community, and to Dr. Milton Hamolsky, the former Chief of Medicine at Rhode Island Hospital, for sharing some of their thoughts and perspectives on Ed Forman and his career. It is frankly not easy to find words to do justice to a man who has been a consummate physician and a consummate role model in our community for 40 years.

Let me make a point of telling you who we did not consult with when we were considering Dr. Forman for the Rakatansky Award: We did not consult Dr. Rakatansky himself. He didn't find out until all of you did. But we knew he would be pleased, because Dr. Forman and Dr. Rak have been close friends since their undergraduate days at Brown University. And you may be aware that they are brothers-in-law. Dr. Forman happens to be married to Dr. Rakatansky's younger sister, Silvia. So there is a certain poetry in this.

But that's not why we are honoring Dr. Forman tonight!

It takes a special person to be an oncologist, and pediatric oncology has to be the saddest and most difficult medical specialty of all. Ed Forman is always quick to give full credit to other people, but it is absolutely fair to say that Ed Forman, more than any other one person, revolutionized children's cancer care here in Rhode Island.

Before Ed came to town, any child with leukemia was automatically sent to Boston. Then all of a sudden, thanks to Ed, starting around 1975, we didn't have to do that anymore. The children could stay in Providence. That was much easier on the kids and their families, and the care they got here was every bit as good as what they could get in Boston, if not better. Today 90% of the kids with cancer in Southeastern New England come to Providence for treatment. That wasn't true 40 years ago.

How did that come about? Here are a few highlights:

- Ed Forman was the early principal investigator for the New England Pediatric Oncology Consortium of 5 hospitals, and a founding member of the national Pediatric Oncology Clinical Trials group. In short, he put Rhode Island pediatrics on the map.
- Dr. Forman is the individual most responsible for founding – from scratch – one of the premier Pediatric Residency Programs in the nation at Rhode Island Hospital.
- Ed started the first ethics committee in the Department of Pediatrics and nurtured its growth into a hospital-wide program.
- Ed co-founded the Tomorrow Fund in 1985. He also developed Camp Hope and established Remembrance Day for the staff and the families of cancer victims.
- He co-founded the Providence Ronald McDonald House in 1989
- He lobbied successfully for the establishment of Hasbro Children's Hospital, which opened in 1994.
- Ed has been highly productive as a scholar and author, revered as a teacher and colleague, and beloved by his patients and their families.

Above all, Ed has taught us that with cancer patients, treating their cancer is not enough. Hope is critical for these patients. But it has to be tempered with reality.

What everyone remembers and remarks about in Ed is the depth and authenticity of his humanity, his wisdom and his compassion. Students remember a favorite saying of his: "People don't care how much you know until they know how much you care."

One of his patients wrote, "It's not so much that Dr. Forman has a gift, or the fact that he has many gifts. – Dr. Forman *is* a gift."

We are all better doctors for having known Ed Forman, and this Award for Professionalism in Medicine is a small token of our great esteem and gratitude. ❖

Note: The Dr. Herbert Rakatansky Award of the Rhode Island Medical Society was established by vote of the Medical Society Council on July 28, 2008, to recognize the continuing contributions of Dr. Rakatansky as a leader, teacher and healer of health professionals over more than three decades. The Award was conceived as an honor to be bestowed upon individuals who distinguish themselves through exemplary devotion to professionalism, medical ethics and humanitarian service.

Remarks of Dr. Diane Siedlecki upon presenting the Dr. Charles L. Hill Award to Dr. Michael E. Migliori

Now we're going to shift gears a little and talk about hockey. (That's ice hockey, of course; this is Rhode Island!) In particular, I want to talk about hockey goalies for a moment.

One sports writer [Jim Taylor] put it this way: "Any discussion of hockey goaltenders has to begin with the assumption that they are about three sandwiches shy of a picnic. Consider the evidence: From the time primitive man first walked erect, he survived on the principle that when something hard and potentially lethal comes flying at you at 100 miles an hour, you get the hell out of the way. Goalkeepers throw themselves *in* the way."

The great Jacques ("Jake the Snake") Plante, who led the Montreal Canadiens to five consecutive Stanley Cups, had this to say about his job: "Goaltender is a normal job. Sure it is. How would you like it if at your job every time you made the slightest mistake, a little red light went on over your head and 18,000 people stood up and screamed at you?"

Hockey goalies have to be a special breed. No doubt about it. The pressure is always on them. A forward or a defenseman can get away with a bad game once in a while, but a goaltender never can. With chaos and mayhem going on all around him, he has to concentrate on stopping a little 6-oz. piece of rubber from invading his private 4 by 6-foot space.

Coaches say that goalies tend to be the most even-tempered, most focused, most determined and the most respected members of the team. Hockey is a team sport. But for the goalie, it's more like an individual sport.

Our Hill Award recipient tonight was once the top-ranked high school hockey goalie in New England. In fact, somebody once said that "Mike Migliori has seen more rubber than a dead skunk on I-95."

During the 1973-74 season, his Cranston West High School team beat Mount Saint Charles handily – three times. They won the state championship that year and went on to finish third in New England. Mike, as a junior, was the starting goalie in every game but the first one that season.

Well, you can imagine, there's tons of good stuff to tell about Mike's heroics as a young scholar and athlete – from three-sport captain to class president, to champion discus thrower – he did it all – of course!

Those of you who know some Italian may be aware that Mike's family name, Migliori, actually means "The Best"! And he was, and he is, the best at everything.

But my point is something different. My point is that some of the special qualities that made Mike an outstanding goalie are also qualities that have made him a great doctor and, above all, a great leader of organized medicine. The qualities I am thinking of are mental fortitude, patience, courage, an ability to stay focused on what really matters, and his willingness, always, without hesitation, to put himself on the line.

Mike was President of Rhode Island Medical Society in 1997-98, and of course he was President of the Eye Society before that. He has been in our leadership continuously ever since. He has Chaired the Rhode Island Delegation to AMA for years now. He has chaired the New England Delegation and the New England Council of State Medical Societies. He is the Chair of our Public Laws Committee. And last year the AMA Board of Trustees elected him to a national position on the Board of Directors of AMPAC.

During my years on the RIMS Council and Executive Committee, I have learned a lot from Mike. One thing I have learned is that I will never match his calm, steady, rational, insightful and pragmatic approach to the game we call "politics" – and the circus we call "state government." Mike takes a lot of hits for us. We have to pinch ourselves sometimes and ask "How did we get so lucky as to have this remarkable guy in our leadership for so long?"

There is an old saying in hockey: "Scoring wins fans. But goaltending wins championships." Tonight we salute a champion: Mike Migliori.

The award inscription reads:

> A leader of rare and dependable insight, generosity, talent, and courage, Dr. Migliori has earned the admiration and gratitude of all who love the profession of medicine. His patient, pragmatic and intuitive appreciation of public policy and political process continues to serve medicine well, both locally and nationally, and endows Dr. Migliori with unique powers as a mediator, peacemaker and problem solver. His service to medicine has already been inestimable. As a leader's leader, a doctor's doctor, a teacher's teacher, and a friend's friend, he is truly *il migliore dei migliori.* ❖

Remarks of Dr. Michael E. Migliori upon accepting the Dr. Charles L. Hill Award

I would like to acknowledge my parents, Julius and Gloria. Many of you know my father; he has been practicing anesthesia for the past 47 years. In my third year of medical school, he told me to join the AMA. I asked him why, and he told me because you're supposed to. Up to this point, being a good kid, if my father told me I was

supposed to do something, most of the time I did it. Growing up, that was often all the explanation we would get, or we would need. I joined, figuring it was a bargain for $20 to get *JAMA* and the *Archives of Ophthalmology*.

When I got back from residency and my fellowship, I thought I would end up practicing, doing a little teaching, maybe write a few papers. Four months into my practice, Peter DeBlasio calls me and tells me to meet him at the State House; the optometrists want to treat eye diseases. I went because I didn't want to lose a referral source. Hearing the arguments, I thought all you needed to do was explain to a legislator why something was a bad idea, and that reason and logic would win the day. That was the day I reached maturity.

It became clear that, especially where the General Assembly is concerned, reason and logic have nothing to do with anything. If it did, this state would not be in the state it's in. There will always be assaults on the practice of medicine, and there will always be a need for vigilance and action to turn back those assaults. And that is when it hit me; that is what my father meant. He said I was supposed to join the AMA, but not because he told me to. I was supposed to support the organizations that represent me, that are the advocates for my patients and me.

I have been extremely fortunate to have been able to actively participate in advocacy at both the local and national levels, and I hope that my efforts have played at least some small part in trying to maintain the honor of medical practice.

I have to recognize my family for all they have done, and put up with, along this journey. Missed dinners, travel away from home, phone calls and meetings all take time away from family, and I thank them for their support, patience and understanding.

You have all heard some guy getting up to accept an award, and saying that he could not have done it without his wife, which is usually true, and he usually says that because his wife even wrote his speech. I wrote this speech myself, so I can say it from the bottom of my heart, that my wife Marianne deserves this more than I do. Not only has she had to hold things together while I am jousting with windmills, she has been my best sounding board, critic, and cheerleader, and it is she that you should be giving this award to tonight.

This award is truly an honor for me; to be recognized by your peers is one of the greatest tributes, and for that I am deeply grateful. *Dzhehnkooyeh*, Diane. ❖

Mental health CME for primary care

May 7–8, 2010

The Rhode Island Chapter of the American Academy of Pediatrics, together with the Massachusetts and Connecticut chapters of AAP, will present a two-day CME program on mental health care for primary care physicians.

Friday and Saturday, May 7–8
Biltmore Hotel, Providence

Watch for further information soon at www.riaap.org.

Remarks of Dr. Diane Siedlecki upon making a special presentation to Marianne Migliori

You know the old saying: "Behind every successful man there is a surprised mother-in-law."

Actually, in Mike's case it's a little different. It is a little-known fact that Mike's wife, Marianne, is one of the Medical Society's secret weapons. Marianne is a member of the faculty of the Rhode Island School of Design. As many of you probably know, she is an incredibly clever and talented graphic artist. She donates huge gobs of her time and talent to helping RIMS look good and communicate effectively. This happens almost on a daily basis.

It's incredibly helpful to have such a gifted person on call, especially one who knows us so well that she practically reads our minds. In fact, she knows our minds better than we do.

It is a great pleasure to recognize her tonight with a small token of our very special appreciation. ❖

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EHR Financing Available from Webster Bank

Financial incentives available from Blue Cross, United and through the federal stimulus program have unquestionably been useful in helping some physicians move from paper to electronic record-keeping. However, the cost of implementing Electronic Health Records (EHR) – both in dollars and staff time – still remains daunting for many medical practices, both large and small. The direct cost of making the switch is still conservatively estimated to range from $25,000 to $50,000.

An increasing number of medical practices are nevertheless making the leap, and many more want to do so. While EHRs are not always an unmixed blessing, there is little doubt that a quality EHR, when well-implemented and carefully used, can contribute substantially to improving patient care, reducing overhead in the long run, and creating efficiencies that can enhance the economic viability of a medical practice.

Interestingly in this context, Webster Bank two years ago reached out to the Rhode Island Medical Society to highlight the bank's interest in building relationships with the medical community by offering advantageous financing to RIMS and its members.

Webster itself has been visibly expanding its presence in Rhode Island, Connecticut, Massachusetts and New York recently and is now the largest independent commercial bank headquartered in New England. The Rhode Island Medical Society now does its banking with Webster.

Of particular interest to Rhode Island physicians is a package Webster designed for RIMS members to help make the switch from paper to EHR more affordable. Features of the package include:

- Check access revolving line of credit (up to $500,000) that can be used to finance EMR hardware, software, training costs and healthcare IT solutions.
- Interest-only payments for one year at competitive rates
- At the end of one year, the outstanding line of credit balance will convert from interest-only to a term loan (up to five years).
- Financing is available for up to 100% of the project cost

More information is available through Webster's local medical financial services specialist:
Joseph P. Lopes, MBA, Vice President
401-421-1548 or email jlopes@websterbank.com. ❖