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MEDICAL NEWS

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2011 General Assembly preview

First physician elected in 20 years

Twenty-nine new faces graced the House and Senate chambers when the current General Assembly first took its seats on January 4, 2011. Among those 29 were 22 men, 7 women, 7 Republicans and 22 Democrats, one nurse and one physician.

The physician is Christopher S. Ottiano, MD, a board-certified general surgeon and spine specialist who is the new Senator representing District 11 (Portsmouth and Bristol). In his third run for public office, Dr. Ottiano, a Republican, defeated the incumbent Democrat, Charles "Chuck" Levesque, who had served in the General Assembly (both House and Senate) since 1993.

Dr. Ottiano received his medical degree from Tufts University School of Medicine in 1995 and did his residency at Baystate Medical Center. He has offices in Smithfield and Johnston. Dr. Ottiano is the first physician elected to the General Assembly since 1990. (The last was former RIMS President Nick Tsiongas, MD, MPH.)

The other health care professional newly elected to the Rhode Island General Assembly is David Bennett, RN, a psychiatric nurse working at Butler Hospital. In his second run for public office, Mr. Bennett first had to defeat incumbent Al Gemma in the September 14 Democratic Party primary. Having then prevailed in the November 2 general election as well, Mr. Bennett now represents House District 20 (Warwick).

Making a very strong but ultimately unsuccessful bid to represent Senate District 35 (North Kingstown, East Greenwich, Warwick) was Mark Schwager, MD. Dr. Schwager, having already served two terms as an East Greenwich Town Councilman, handily defeated a strong and *continued p.2*

"Prior Authorization": a hot issue again

Having demanded RIMS' considerable attention on and off for a decade already, "prior authorization" requirements for high-end imaging studies are once again on the front burner, thanks to recent moves by both Blue Cross and UnitedHealthcare that many physicians find onerous, wasteful and costly.

While payers in much of the rest of the country years ago turned to vendors like MedSolutions to ratchet down utilization of expensive imaging modalities, the principal Rhode Island payers, including Blue Cross, United and Neighborhood Health Plan, long displayed a commendable willingness to accept RIMS' leadership in a cooperative search for a better approach for Rhode Island.

In two notable efforts undertaken since the year 2000, both of which were spearheaded by former RIMS President Yul D. Ejnes, MD, physicians representing the key medical specialties sat down with the payers to identify best practices and work out a community-based, educational approach toward the common goal: assuring optimal and efficient use of advanced imaging in patient care, based on standards developed and endorsed by national medical specialty societies.

Despite a general spirit of cooperation and good will, the success of these efforts turned out to be limited by the available data of the day. Some national specialties had far more complete and credible protocols than others. On the payers' *continued p.3*

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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 PAGE ONE

well-financed Democratic opponent in the September 14 primary but in the general election faced a Republican with deep pockets and a well-known family name.

Budget woes, redistricting will dominate this Assembly session

Given the deep rut the state's economy and budget find themselves in, Governor Lincoln Chafee and the General Assembly will face hard choices and be forced to make unpopular decisions this year. Tax increases and further cuts in state services appear inevitable.

The Governor's choice to head the Department of Human Services, former House Finance Chair Steven Costantino, has long been on record favoring consolidation of the state's social service agencies, including the Department of Health; the Department of Children, Youth and Families; the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH, nicknamed "Buddha," formerly MHRH), and the Department of Elderly Affairs under the Department of Human Services. Such consolidation would promise more seamless delivery of services and perhaps realize some economies for the state budget.

Meanwhile, 2010 census results will trigger redrawing of the 113 House and Senate districts. The line dividing the state's two congressional districts will shift as well, in order to balance out the populations in the districts, as required by law. Changes in the General Assembly districts always have potential to generate some friction here and there.

RIMS' legislative agenda

Despite the challenges, the Rhode Island Medical Society will be asking the General Assembly to consider an ambitious and far-reaching series of new and reintroduced proposals to promote the public health. These include a new state mandate for health insurers to spend a greater proportion of premium dollars on health care, new taxes on sugary beverages and tobacco, liability reforms in three key areas, mitigation of the burdens ofhealth insurers' prior authorization requirements, new restrictions on tanning salons, relaxation of physician dispensing restrictions, tax credits for on-call services, expansion of e-prescribing to include controlled substances, among other RIMS initiatives.

Meanwhile, RIMS' leadership will also be deeply involved in shaping state efforts to prepare Rhode Island for the next phases of national health care reform, including the requirement that states set up health insurance exchanges by 2014. Reelected Lieutenant Governor Elizabeth Roberts will be getting more support from Governor Chafee than she did from Governor Carcieri as she moves ahead with what she calls "getting national health reform right for Rhode Island." ❖

FROM PAGE ONE

Prior Authorization, *continued*

side, data systems turned out to have a crippling weakness: they could identify where the tests were performed, but far too often could not identify who ordered them.

Ultimately the payers, while acknowledging the value and validity of RIMS' process, found that rapidly rising cost pressures compelled them to move ahead with more aggressive, bureaucratic measures – namely, prior notification and prior authorization – which in the meantime had been "proven" to save millions of dollars for other payers across the country.

In the end, Blue Cross was the first the Rhode Island payer to require prior authorization for non-emergent, high-end imaging studies. Their chosen vendor to manage the new imaging program, MedSolutions of Franklin, TN, promised BCBSRI that the insurer would save at least seven million dollars in the first year; and indeed, Blue Cross' outlay for imaging dropped by more than the predicted amount during the first year under "prior authorization." Moreover, it dropped that much despite the fact that Blue Cross did something that it long refused to do and repeatedly told RIMS it would never do: namely, accede to RIMS' demand that radiologists be permitted to relieve ordering physicians of the burdens of securing prior authorizations, as, RIMS argued, had been successfully implemented in other jurisdictions.

BCBSRI's ultimate willingness to permit ordering physicians to delegate the authorization process to radiologists has been a major saving grace of the prior authorization program – until now. In 2010 BCBSRI announced it would revert to its original intent and bar radiology centers from performing pre-authorization work on behalf of ordering physicians, effective January 1, 2011.

At this writing, the shift in Blue Cross policy continues to be a major topic of RIMS' discussions with Blue Cross, the Health Insurance Commissioner and the Director of Health.

Two ironies are apparent in this turn of events. One irony is that the Medical Society, in response to members' complaints about United-Healthcare's newly onerous imaging management program, had been preparing to demand that United revise its processes so as to be more in line with those of Blue Cross.

A second and greater irony is the contrast between BCBSRI's acknowledged leadership in promoting primary care in recent years and this new burdensome imaging policy, which primary care physicians regard as a setback. It is primary care physicians who order about 55% of advanced imaging studies and are most heavily burdened by the new obligation to secure prior authorizations themselves. One physician observed that the new imaging rules could serve to offset the good will and respect Blue Cross has earned under its new leadership since 2004. ❖

Provider taxes

RIMS reaped a bitter reward for three and a half years of effort and tens of thousands of dollars expended, when the Providence District Court finally handed down its decision in November in the case of Rhode Island Medical Imaging et al vs. Sullivan.

The RIMS-sponsored lawsuit against the state was the Medical Society's response to the legislature's enactment in June 2007 of two taxes (or "surcharges," as the law calls them) imposed on many physician-owned facilities that perform imaging, surgery and endoscopy on an ambulatory, non-emergent basis. Proceeds from the taxes flow into the state's general fund.

Three national medical associations contributed financially to RIMS' fight, recognizing that American physicians everywhere have a stake in the Rhode Island tax case. The AMA's Litigation Center contributed $20,000. The American Academy of Ophthalmology contributed $5000, and the American Academy of Dermatology $2500. RIMS is grateful to these national organizations and to the many medical practices and individual physicians who strongly supported RIMS' efforts to fight the good fight on behalf of the medical community.

Judge Robert Pirraglia's 43-page decision rejected every one of the physician plaintiffs' arguments, which contended that the tax laws were unconstitutionally vague and discriminatory. The full text of Judge Pirraglia's decision is available at www.rimed.org.

While the judge's ruling was disappointing, it was hardly surprising. Though RIMS' legal arguments were thoroughly researched, well constructed and cogent, the court nevertheless found that they were insufficient to overcome two major hurdles that RIMS recognized clearly from the beginning: First, courts tend to be especially deferential to legislatures in tax matters, where legislatures have broad powers, not only to levy taxes, but to do so in ways that may be permissibly discriminatory.

Second, when it comes to questions of equal protection under the 14th Amendment to the U.S. Constitution and analogous provisions of the Rhode Island Constitution, legislatures need have only a "rational basis" for discriminating against physicians, because physicians are not regarded as a disadvantaged group in American society. The "rational basis" standard happens to be easy to meet. Furthermore, the legislature need not articulate any actual rationale at the time it passes a discriminatory bill. If the constitutionality of a law is later questioned on an equal protection basis, defendants and courts are free to speculate and backfill any number of "rational bases" that might possibly have been on the legislature's collective mind as justification for a discriminatory law.

In consultation with RIMS' attorneys in the Boston and Providence offices of Donoghue Barrett and Singal, with the five named plaintiff physician groups, and with the numerous special stakeholders in the lawsuit, consensus emerged that an appeal to the Rhode Island Supreme Court was certain to be costly and unlikely to yield a better result, and was therefore inadvisable. Moreover, a rejection by the Supreme Court would lend greater weight to the matter and could thus make things worse. The matter is therefore considered closed. ❖

GARY BUBLY, MD
PRESIDENT

Time is flying by!
As I write this, we are smack in the middle of December. After a great summer and gentle transition through fall, we are easing into another winter. With New Year's approaching, we naturally reflect back and look ahead, so this is a perfect vantage point on the trail to update you on our activities.

The **Annual Meeting** on October 2 at the Squantum Club was terrific. All who attended had extremely positive feedback about the event! We had inspiring speeches from our award recipients, **Drs. David Ettensohn and Caroline Troise**. We thanked **Dr.Vera De Palo** for her fantastic efforts as outgoing President, and she officially transferred the gavel to my hands. Add in great food, wine, music and dancing in a very warm venue, and you could not help but have a really nice evening. Seems like I barely finished savoring that experience, though, before presiding over my first Council meeting less than 48 hours later.

October 4th Council meeting

We introduced the concept of going green with electronic council handbooks to help reduce expenses for the organization. We also asked Council members to send in a picture and brief bio for the website, since we have several new faces on board. This also seems to be an obvious means of identifying any conflicts of interest represen tatives may have. We voted to keep dues level for the seventh year in a row, and amended our bylaws to add the AMA alternate delegate to the Executive Committee. We updated the group on the status of the provider tax appeal, which was in the hands of Judge Robert Pirraglia (more below).

November 1st Executive Committee meeting

We had a pretty animated discussion about the prior authorization topic, intensified by BCBSRI's decision to remove the radiologists from the pre-auth permission loop.

Gamm Theater

For those of you who joined us for the **Gamm Theater** evening on November 4th, I think you will agree the evening was a success. The Gamm is a neat hole in the wall, hidden gem of a place that put on an excellent production of *Mauritius*. We had a nice reception before the show, with a little talk from Tony Estrella, the artistic director of the Gamm. It was actually a nice networking, feel good experience. The show itself was a pretty interesting tale that could have been worthy of CME credits for negotiating skills…profuse thanks to **Drs. Adrain and Cutitar**, **Sarah Stevens**, and **Steve DeToy**, collectively known as the "Not Golf Committee" for organizing the event. Look for more events to follow this spring and summer….

The AMA interim meeting took place in early November. Rhode Island was well represented with Peter Hollmann filling in for Mike Migliori as our delegate. Other Rhode Islanders present included strong medical student showing from Steve Lee and Gene Cone, Barry Wall as delegate for the psychiatric society, and Stuart Gitlow representing the society of addiction medicine. Newell Warde did an excellent job running the meeting for the AMA Litigation Center. He received compliments from AMA president Cecil Wilson for his work, so well done Newell! As you may know, the interim meeting focuses on advocacy issues. There were heated debates on a number of controversial issues in the reference committees and on the floor, including resolutions on the health care impact of same sex marriages, and statements related to the mandates for insurance coverage in the PPACA…one resolution snuck through on medical marijuana research, seemingly after more controversial items consumed people…it was pretty entertaining sport for a while…and I have to say I was impressed with the testimony of our medical students Steve Lee, Gene Cone and one of our young physician members, Adam Levine, who was there for Massachusetts as one of the young physician section representatives, on a number of issues. We saw a lot of leadership potential in those individuals, and they really did a fine job of getting Rhode Island out there….

December 6th Council meeting

This was a memorable, animated discussion that focused on prior authorization requirements for advanced imaging. We had presentations by guest **Chris Koller**, Health Insurance Commissioner for Rhode Island, Nitin Damle, our president-elect, who gave the providers' perspective, and Peter Hollmann, Associate Medical Director for BCBSRI providing the insurers' perspective. There was no question from the Council's questions and comments that providers clearly feel the process is overly complex, and burdensome to the ordering physicians, both in primary care and the specialties. Mr. Koller also touched on the impact of new guidelines for contracting on hospital cost containment and his view of the insurance exchanges in PPACA.

The **RIMS Public Laws Committee met on December 8th**. For those of you who have never been, this is open to the membership, and helps us develop our legislative agenda. This committee is chaired by Past-President **Michael Migliori**. Mike and Steve DeToy help us navigate the process of legislation and regulation. Although we discussed dozens of issues, this year we are hoping to develop something to ease the burden of prior authorization. More to come on this.

We have continued our monthly meetings with **Dr. David Gifford, Director of Health**. We discuss more than a dozen topics ranging from the CMS audit of RIH, to the prescription monitoring program (reportedly six months away) to physician dispensing issues (follow the labeling rules and talk to your hospital pharmacist), to vaccination issues, reimbursement for HIV drugs, prior authorization (which he referred to as the wrong tool for the job) and legislative issues.

HealthRIght

RIMS leadership also met with our own **Dr. Nick Tsiongas** to discuss HealthRIght's mission and the future of RIMS' involvement with the organization. **Beth Lange** had been approached to serve—we asked for her to be a voting member of its Board of Directors. It looks likely this organization will be given a chance to get involved with the Health Insurance Exchange.

Provider Tax Appeal

Judge Pirraglia handed down his decision about the provider tax case. The verdict wasn't what we were hoping for, but not unexpected. In a well written 43-page statement, the Judge basically refuted our legal team's arguments. This was a painful lump to swallow. Although I had a fair amount of fire in my belly about continuing to appeal this decision, after looking at the odds of winning versus the continued cost, all of the plaintiffs and leadership agreed it was time to move on and cut our losses.

Minute Clinic

Our RIMS leadership team met with the leadership of Minute Clinic—Andrew Sussman, MD, President of Minute Clinic, an impressive internist and former Chief Medical Officer at the Brigham, and as of the October Council meeting, a RIMS member, and Tim Buono, VP of Business Development Minute Clinic. They are interested in adding 3–4 sites in Rhode Island, and are looking to collaborate with Rhode Island's medical community. Their presentation gave us an overview of their business plan, including their affiliation with Lifespan. They emphasized filling a void in access to health care that addresses the shortage of primary care providers. They dangled a few carrots like medical directorship opportunities and referral of new patients to those practices willing to take new patients…and mentioned a stick in the Federal Trade Commission if we try to block their entry…they have already met with some specialty groups within Rhode Island. We invited them to address the RIMS Council at our next meeting February 7th, 2011. We also specifically asked them to address the pediatric community's concerns and the points articulated in our white paper of 2008. Please advise your Council rep to attend this meeting and express any concerns you may have on this issue!!!

Other committees and work

I am also representing RIMS on the following committees: **Health Insurance Advisory Council** (chaired by Chris Koller), the **Medicaid Hospital Payment Study Commission**, the **Special Senate Commission to Study Cost Containment, Efficiency, and Transparency in the Delivery of Quality Patient Care and Access by Hospitals**, the **Rhode Island Health Promotion Policy Council** (at the request of Director Gifford), and **HealthCare Community Exchange Council** (of BCBSRI). I am doing this with input and feedback from Steve, Newell, and Nitin.

I have also volunteered at the **RI Free clinic** since our last Council meeting, and can attest to a very positive experience, and would again remind members to consider volunteering there, or to contact them regarding absorbing any of their patients into your practices.

Lieutenant Governor

This past week we met with **Lieutenant Governor Elizabeth Roberts** and her Chief Counsel, **Jennifer Wood**, to discuss the next phase of PPACA implementation. We have invited them to address the Council in April, at which point there should be a little more meat on the bones of PPACA, particularly the Health Insurance Exchange piece. She seems sincerely interested in including providers in the process.

We are planning to arrange meetings with **Ed Quinlan of the Hospital Association of Rhode Island**, the **RI Board of Pharmacy,** and to continue our meetings with **BCBSRI**, **Tufts** and **UHC**.

All in all, this has been an exhilarating experience for me. The leadership team we have with Nitin Damle (who I am convinced is going to be an outstanding President), Newell and Steve, and all of our support staff, an engaged Council and Executive Committee gives me a lot to be thankful for and encourages me that the future looks bright. ❖

Does RIMS have your email address?

Email has become the preferred medium by which RIMS communicates timely information to its members. Please keep Sarah Stevens (sstevens@rimed.org) apprised of your address.

RIMS never gives members' email addresses to third parties. RIMS uses its broadcast email judiciously and exclusively for communications that are timely, important, informative and concise. ❖

"Red flags" threat recedes

A tenacious AMA wages and wins a multi-front battle

In the end, it took an act of Congress to vanquish the Red Menace. For two years federal regulators have been threatening to impose incongruous new bureaucratic requirements on medical offices with potential heavy penalties for non-compliance, all because of the perverse idea that physicians are "creditors," and as such are obligated to implement "Red Flag Rule Programs" in order to protect those to whom they extend credit (i.e., patients) from identity theft.

The "creditor" notion arises from the fact that physicians typically are not paid at the time they render services. In the blinkered view of the Federal Trade Commission (FTC), that means that doctors, like banks and institutional money lenders, need to be legally required to keep a systematic eye out for "red flags" that may indicate identity theft – and they need to be punished if they fail to comply.

Enter the AMA, which opened regulatory, legislative and judicial fronts in a years-long battle to protect doctors from the disproportionate burden of the FTC's Red Flags Rule. Since the original November 1, 2008, compliance date, the AMA has won multiple reprieves for doctors, the last of which was due to expire effective January 1, 2011, giving AMA's simultaneous legislative strategy in Congress just enough time to work.

Meanwhile, on May 21, 2010, the AMA and the American Osteopathic Society opened another front against Red Flags with a lawsuit against the FTC. (Perversely, the courts refused to recognize the fact that other professionals, such as lawyers and dentists, who were also deemed "creditors" by the FTC, all had the very same legitimate issue with Red Flags; as a result, each professional group had to fight its own separate legal battle.)

Finally, in December 2010, with President Obama's signature on the Red Flag Program Clarification Act of 2010, the AMA's victory on behalf of all physicians appeared to be complete.

As the Red Flag Affair properly fades into history, it remains a striking example of two things: bureaucratic overreach by government, and tireless advocacy by the AMA. ❖

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AMPAC 2011 political education programs

The American Medical Political Action Committee will host its annual Candidate Workshop on February 18–20, 2011, in Pentagon City, Virginia. The Workshop is designed for AMA members and their spouses who are considering a run for public office. It includes training on campaign strategy and media advertising as well as hands-on sessions in public speaking and fundraising.

AMPAC will conduct its annual Campaign School April 13–17, 2011, also in Pentagon City. The School is designed for AMA members who wish to become involved in the political process as advocates and volunteers for medicine-friendly candidates. The School is organized around a simulated congressional campaign. Participants are assigned to campaign "staff" teams and attend daily lectures on campaign strategy, media advertising, and political fundraising. Each team participates in nightly exercises such as creating a campaign strategy, taping a radio commercial, and writing a political fundraising letter.

For both programs, all costs for AMA members, except transportation to the Washington, DC metro area, are borne by AMPAC.

For more information on these programs and applications, please see AMPAC's new online registration form at: www.ampaconline.org/political-education/apply or contact Jim Wilson, Political Education Programs Manager, at jim.wilson@ama-assn.org. ❖

AMA resources for physicians

Practice management
Health IT information and tools, private payer and practice management tips, clinical quality and patient safety, RBRVS, Online Data Collection Center, DoctorFinder, and CPT codes. www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice.shtml

Clinical practice improvement
With a longstanding commitment to clinical quality improvement and patient safety, the AMA works to apply science to medicine in ways that help you ensure patients receive the highest-quality care. www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement.shtml

Continuing medical education (CME)
A physician's continuing medical education and professional development is critical to keeping up with advances in medicine and with changes in the delivery of care. www.ama-assn.org/go/cme

Medical ethics
If you're looking for guidance or insight to ethical issues in medicine today, the AMA Medical Ethics Group offers relevant resources to help you. www.ama-assn.org/ama/pub/physician-resources/medical-ethics.shtml

Medical science
The AMA keeps you in touch with the latest news and information about the science behind the practice of medicine. www.ama-assn.org/ama/pub/physician-resources/medical-science.shtml

Public health
News and updates about H1N1 flu virus, promoting health lifestyles, health disparities, disaster response, geriatric and adolescent health, violence prevention, and obesity. www.ama-assn.org/ama/pub/physician-resources/public-health.shtml

Physician health
Research, news, and resources for physicians pertaining to their own personal health. www.ama-assn.org/ama/pub/physician-resources/physician-health.shtml

Patient Education Materials
Health literacy resources and program patient information about foodborne illnesses, vaccines, driver safety, online health records, visual aids for the human body. www.ama-assn.org/ama/pub/physician-resources/patient-education-materials.shtml

Legal issues
Guidance from the AMA's Office of General Counsel about business and management issues such as physician payment and professional liability insurance (Please note the information provided on this site does not constitute legal advice.) www.ama-assn.org/ama/pub/physician-resources/legal-topics.shtml

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SI-09-072 05/09

RIMS inaugurates new leadership team

GARY BUBLY, MD, was inaugurated President of the Rhode Island Medical Society on Saturday, October 2, in a ceremony and celebration conducted at the Squantum Association in East Providence.

Dr. Bubly is an emergency physician based at The Miriam Hospital. A Boston native, he earned his bachelor's degree *cum laude* at Dartmouth College and his medical degree at the University of Massachusetts. He did his residency at Brown. He is married to Karen Smigel, MD, a family physician employed by the Navy and working in Newport. Dr. Bubly is a Past President of the Rhode Island Chapter of the American College of Emergency Physicians and a Fellow of ACEP.

NITIN S. DAMLE, MD, is President-Elect of the Rhode Island Medical Society and a principal of South County Internal Medicine. A Boston native who grew up in Michigan, Dr. Damle earned a bachelor's degree with high honors and a master's degree in pharmacology, both from the University of Michigan at Ann Arbor. He earned his medical degree at Wayne State University. He did postgraduate training in internal medicine at Brown. Dr. Damle's four year term as Governor of the Rhode Island Chapter of the American College of Physicians will end in April 2011.

ALYN L. ADRAIN, MD, is the new Vice President of the Rhode Island Medical Society. She is a gastroenterologist in private practice in Providence. She earned her medical degree at Brown and did her post-graduate training at Kaiser Permanente/University of California at San Francisco. She served as Secretary of RIMS during 2009–2010.

ELAINE C. JONES, MD, a neurologist practicing in Providence, is the new Secretary of RIMS. **SCOTT E. WANG, MD**, a pathologist practicing in Newport, is a new Councilor at Large. **STEVEN R. FERA, MD**, a cardiologist in private practice in Wakefield, remains RIMS' other Councilor at Large.

JERRY FINGERUT, MD, remains Treasurer of the Medical Society. Rhode Island will continue to be represented in the AMA House of Delegates by **MICHAEL E. MIGLIORI, MD**, Delegate, and **PETER A. HOLLMANN, MD**, Alternate Delegate.

AMA Delegates and Alternates serve two-year terms; all other RIMS office holders serve one-year terms.

Outgoing President of RIMS, **VERA A. DE PALO, MD**, presented the Dr. Charles L. Hill Award for service to **DAVID B. ETTENSOHN, MD**, and the Dr. Herbert Rakatansky Award for professionalism to **CAROLINE A. TROISE, MD**. (Their acceptance remarks are published on pages 10–11) ❖

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For more details on accreditation please visit CMElectures.org.

RIMS 198th Annual Member Banquet

Saturday, October 2, 2010

Squantum Association, East Providence

David B. Ettensohn, MD received the Dr. Charles L. Hill Award in recognition of his energetic and eloquent leadership in a time of particular challenge and stress for the Rhode Island medical community.

Caroline Troise, MD was the third recipient of the Dr. Herbert Rakatansky Award for Professionalism in Medicine. Dr. Troise has served as the medical director of the RI Free Clinic since its inception.

RIMS President Vera A. De Palo, MD presents the Dr. Charles L. Hill Award to Dr. Ettensohn

Remarks of David B. Ettensohn, MD

2010 DR. CHARLES L. HILL AWARD RECIPIENT

Thank you, Vera. And Newell, a.k.a. "wordsmith" Warde, for those carefully crafted descriptors that adorn the individualized document that comprises my Charles Hill Award.

This is an award that celebrates "leadership and service" in the medical community. I am honored to be this year's recipient. In my position as Medical Society President a few years ago, physicians in the state of Rhode Island were immediately confronted with the prospect of a reimbursement cut of 7% on an already very low reimbursement scale of 76% of the Medicare fee schedule. If allowed to pass unchallenged, it would have been the death knell for private practice in the State.

We took up the challenge in the Medical Society and marched on the State House. The amazing thing about this whole experience, in my opinion, was not the concept itself of the march, but the fact that we were able to attract over 700 physicians and other health care workers to participate. In the end, we were successful in stopping the fee reduction, and in fact some fee increases were realized.

The reason to relate this episode is not to revel in our successes, but to point out the possibilities when physicians get together to fight for what is right. If there is a weakness in American medicine, it is not with the education or training of our doctors, nor with insurance companies or hospital administrators, nor with managed pharmaceutical formularies, nor even with tort reform. It is with the lack of input that doctors have in each of these areas and, in fact, with the whole of the medical profession.

It is not that we cannot impact each and every one of the issues in medicine, but rather, more often than not we sit idly on the sidelines while others make decisions for us. We are spectators rather than participants. Each doctor must be a leader in the effort to assure adequate delivery of medical care to every individual who needs it. That not only means caring for the patient who walks through the door, but also caring about every political decision that is before the General Assembly in Rhode Island or in front of Congress on Capitol Hill.

We need every doctor to get involved, and we need a strong Medical Society that can collect, process and funnel our concerns in a united voice.

While I have heard a lot of griping about where medicine is heading these days, I have not seen a lot of participation in shaping the decisions that we gripe about. Every doctor has the necessary intellect to understand the issues, but few have actually voiced their opinions in a manner that could help bring about change.

(M)ore often than not we sit idly on the sidelines while others make decisions for us. We are spectators rather than participants.

We need every doctor to get involved, and we need a strong Medical Society that can collect, process and funnel our concerns in a united voice. I was happy to provide that leadership at a time when it was easy for me to do so. I had a draconian mandate to work with, at a time when doctors' backs were financially against the wall, so it was easy to get folks riled up and focused. The real challenge going forward will be to recognize that there are always important decisions to make on a daily basis and that constant pressure is required of our doctors to assure that every patient gets the best possible care.

The real challenge is to get every doctor to draw on his or her leadership abilities and get involved. If we do not participate where medicine in Rhode Island and, on a bigger stage, the entire country, is going, then it is clear that others will do it for us, and are doing it as we speak. If you like it, then continue to do nothing. If you do not…then LEAD!

Thank you. ❖

Remarks of Caroline A. Troise, MD

2010 DR. HERBERT RAKATANSKY AWARD RECIPIENT

It is a great honor to receive an award named for a physician so respected and beloved in our community. Thank you.

I have truly been blessed over the past 30 years being a member of this community.

Starting with my residency at Rhode Island Hospital, I have been surrounded by wonderful role models who have taught me the difference between patient care and caring for patients.

As William Osler stated; "It is more important to know what sort of patient has the disease, than what sort of disease the patient has."

It is often easy to lose sight of this in our office practices today. We can all attest to the enormous changes in the practice of medicine that have occurred over the past 10 years.

We have had the birth of the hospitalist system, the adoption of the electronic medical record, the devaluation of primary care doctors and the exodus of many medical providers from this state.

"It is more important to know what sort of patient has the disease, than what sort of disease the patient has." —William Osler

In October 1999, after a typical day at the office, I walked into a corner building on Broad Street for the first time to do a volunteer session for the Rhode Island Free Clinic. There were a dozen patients seated in folding chairs against one wall. They had already been waiting hours for a chance to receive medical care. They had no medical insurance.

I was astounded by the numbers of patients with untreated hypertension and diabetes, and overwhelmed by their gratitude at what little we were able to provide at that time.

In the past 10 years, there have been some changes at the Free Clinic as well. We have moved up the street to a state-of-the-art facility, complete with electronic medical record. In the past year, we also now have a pharmacy and are able to dispense generic medications to our patients at no cost to them.

Some things have not changed, however.

We are still fortunate to have the dedicated volunteers and staff who work day after day to deliver quality medical care to these uninsured patients. I am not just referring to the workers at our Broad Street location. What is so gratifying is the generosity of the whole community to keep our facility going. The hospitals, universities, drug companies, state Health Department, medical insurance companies, local businesses, private citizens, students, all have contributed to keeping the free clinic in existence, which has been a challenge in these difficult financial times.

I am especially indebted to the medical community for their volunteerism in meeting the medical needs of our patients. We have been able to provide excellent primary and specialty care in our facility as well as in our virtual network, where doctors have agreed to see our patients in their own offices.

What also has not changed is the growing number of uninsured patients needing basic medical care and the continued shortage of primary care physicians to care for them. This past month over 70 patients showed up for our new patient lottery and only 13 were able to be accepted.

We desperately need primary care doctors. Last week, the free clinic received $99,000 in federal grants to expand our services to provide medical care for more uninsured patients.

To me, a night at the Free Clinic is a reminder of what it means to be a doctor and why I went to medical school in the first place.

Without primary care doctors, the full potential of this money cannot be realized.

To me, a night at the Free Clinic is a reminder of what it means to be a doctor and why I went to medical school in the first place. One does not have to travel to a third world country to care for the needy. Please consider joining our family of providers.

I would like to close by thanking my family, friends and colleagues for supporting my activities over the years.

Thank you for this tremendous honor. I will do my best to remain worthy of it. ❖

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Medicare payments restored through January 1, 2012

In mid-December 2010, President Oba-ma signed legislation to continue the 2.2% increase in Medicare payments established in 2010 and to delay 30% reductions in Medicare's physician fee schedule that were to take effect January 1, 2011. For Rhode Island the averted cuts would have meant $60 million less in physician payments during 2011, an amount that corresponds, on average, to well over $20,000 per practicing Rhode Island physician. The twelve month delay until January 1, 2012, is intended once again to give Congress breathing room to develop an alternative to the catastrophic "Sustainable Growth Rate" (SGR) formula that originated with the Balanced Budget Act of 1997 and has been wreaking havoc with Part B Medicare since 2001. The current one-year reprieve carries a $19 billion price tag. ❖

CMS home health certification now requires a "face-to-face encounter"

Enforcement is delayed until April 1

Effective January 1, Medicare requires that home health care orders must be based on personal examination of the patient performed either by the certifying physician or by a non-physician practitioner who is working for or in collaboration with the physician.

As part of the certification form itself, or as an addendum to it, the physician must document that the physician or non-physician practitioner saw the patient, and document how the patient's clinical condition supports a homebound status and need for skilled services.

The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care.

The new requirement applies only to fee-for-service Medicare, not Medicare Advantage.

While the long-standing requirement for physicians to order and certify the need for home health remains unchanged, this new requirement is supposed to assure that the physician's order is based on current knowledge of the patient's condition. Because the AMA and other physician organizations expressed concern that CMS has not conducted adequate outreach to physicians about this requirement, CMS agreed to delay enforcement until April 1, 2011. ❖

2011 brings enhanced Medicare benefits for preventive services

Effective January 1, Medicare patients no longer pay anything out-of-pocket for most preventive health services, including annual wellness visits, which are being added to the Medicare benefits as of this year. In the past, Medicare beneficiaries were liable for deductibles and/or 20% copayments for their mammograms and colonoscopies. No more, thanks to the sweeping new federal health law.

In addition to the wellness visits (which are distinct from the one-time "welcome to Medicare physical," which is only available to beneficiaries in the first year of their enrollment in Part B), CMS has announced the following list of preventive services that now entail no out-of-pocket cost:

- **Breast cancer screening:** Yearly mammograms will be offered to women age 40 and older with Medicare.
- **Colorectal cancer screening:** This includes a flexible sigmoidoscopy or colonoscopy for all beneficiaries age 50 or older.
- **Cervical cancer screening:** Pap smear and pelvic exams are available every two years, or annually for those at high risk.
- **Cardiovascular screenings:** Free blood test to check cholesterol, lipid and triglyceride levels offered every five years to all Medicare beneficiaries.
- **Diabetes:** Twice-a-year screening for those at risk.
- **Medical Nutrition therapy:** Available to help people manage diabetes or kidney disease.
- **Prostate cancer screening:** An annual digital rectal exam and PSA test for all male beneficiaries age 50 or older.
- **Bone mass measurements:** Available every two years to those at risk, or more often if medically necessary.
- **Abdominal aortic aneurysm screening:** Available to men ages 65 to 75 who have ever smoked.
- HIV **screening:** Available to those Medicare beneficiaries who are at increased risk or who ask for the test.
- **Vaccinations:** Annual flu shot, and vaccinations against pneumococcal pneumonia and hepatitis B.

Beneficiaries covered through a Medicare Advantage plan may have a different mix of benefits, depending upon the plan. Most Medicare Advantage plans already offer Medicare-covered preventive services without cost-sharing. ❖

CMS implementation guide for 2011 Medicare PQRS available online

CMS' 2011 Medicare Physician Quality Reporting System Implementation Guide is available in the "Downloads" section of the CMS physician quality reporting website at www.cms.gov/PQRI/15_MeasuresCodes.

The educational materials are intended to help physicians and medical office staff participate successfully in the 2011 program, which opened January 1, 2011. ❖

Avoid 2012 e-Rx penalties by reporting in 2011

In 2011, Medicare's reward for e-prescribing will begin to phase out; and in 2012, penalties for not e-prescribing will begin to phase in. The e-prescribing bonus payment will be 1 percent in 2011 and 2012, and 0.5 percent in 2013. The penalty for not e-prescribing will be a reduction in Medicare reimbursement by 1 percent in 2012, 1.5 percent in 2013, and 2 percent in 2014.

CMS announced in the final Medicare physician fee schedule rule that it plans to use 2011 data to determine 2012 penalties for e-prescribing (e-Rx). The American Medical Association has opposed this approach. In order to avoid a penalty for e-prescribing in 2012, physicians must now engage in claim-based reporting of G-code G8553 ten times between January 1 and June 30. Penalties will not apply to physicians (or group practices) where less than 10% of their allowed charges for this time frame are comprised of codes in the 2011 e-Rx measure.

Physicians should be cautioned that participating in the electronic health record (EHR) incentive program in 2011 will not protect them from the e-Rx penalty despite the fact that e-prescribing is a component of the EHR program. Individual physicians can avoid the e-Rx penalty if:

1. They are not a physician as of June 30, 2011;
2. They do not have prescribing privileges prior to June 30, 2011 (use G8644 at least once during reporting period);
3. They do not have at least 100 cases containing an encounter code in the measure denominator (2011 e-Rx measure specifications are available in the "Downloads" section of the E-Prescribing Measure section of the CMS website located at: www.cms.gov/ERxIncentive/06_E-Prescribing_Measure; or
4. They become a successful e-prescriber (reporting G8553 at least 10 times during reporting period). Group practices that are participating in the Group Practice Reporting Option (GPRO) I or GPRO II during 2011 must become a successful e-prescriber. Depending on the group's size, they must report the e-Rx measure for 75-2,500 unique e-Rx events for patients in the denominator of the measure.

CMS may, on a case by case basis, exempt an eligible professional from the application of the e-Rx payment adjustment if compliance would result in a significant hardship. This exemption is subject to annual renewal. For the 2012 e-Rx payment adjustment, the following circumstances would constitute a hardship:

1. The eligible professional practices in a rural area with limited high-speed internet access; or
2. The eligible professional practices in a area with limited available pharmacies for electronic prescribing. ❖

Managing adult migraine

The American Medical Association has released Management of Migraine in Adults, the latest in AMA's new series of CME-bearing newsletters called Therapeutic Insights.

Earlier editions of Therapeutic Insights treat hypertension, HIV, Alzheimer's disease, and community acquired pneumonia. All are available online at www.ama-assn.org/go/therapeuticinsights.

Therapeutic Insights offers concise, current treatment-oriented CME that goes a step beyond evidence-based disease management to offer state and national data on actual prescribing patterns for each disease. The data are provided by IMS Health.

Therapeutic Insights is a free online resource that highlights one disease condition per issue and is written by top disease experts in collaboration with the AMA. Each edition carries AMA PRA Category 1 CME Credit. ❖

Behavior That Undermines a Culture of Safety

MARY-LYNN RYAN, RISK MANAGEMENT
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Disruptive behavior by professionals in healthcare settings is well documented as a threat to quality care and patient safety. Managing disruptive behavior requires a coordinated effort based on a written policy and established procedures that cover reporting, confrontation, documentation, response, outside consultation, reprimand, follow-up, and monitoring, as well as support for subject physicians.

Although there is no universally accepted definition of disruptive behavior, the American Medical Association (AMA) defines it as "personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively." It also includes "conduct that interferes with one's ability to work with other members of the health care team."[1] Everyone who behaves inappropriately should be treated in the same manner, including excellent practitioners.[2] This expectation should be clear in the policy.

All members of the health care team should be aware of the policy and the definitions of disruptive behavior it contains. Leaders who are expected to enforce the policy should be trained in the process for addressing disruptive behavior, as well as the legal ramifications of limiting a practitioner's practice and the legal protections available to both parties in such an action.[1]

One goal of a disruptive-behavior policy is to create a safe and supportive environment where everyone knows what is reportable and feels empowered to make a report. Research indicates that many instances of disruptive behaviors are not reported because the would-be reporter is afraid of reprisal.[3] To address this issue, the Joint Commission recommends making the process confidential and including non-retaliation clauses in the policy. Interviewing reporters in confidence assures them that their reports are being taken seriously.[4]

A history of delayed or hesitant responses to disruptive behavior can discourage staff from reporting such behavior in the future. Therefore, it is important to investigate and intervene as quickly as possible. Prompt response reassures witnesses and reporters that the problem is being addressed pursuant to the policy.

When the decision has been made to perform an "intervention," the designated team should plan every step (even rehearsing, if necessary), taking into consideration the effects and consequences of planned actions. The planning, goals and outcomes of an intervention should be carefully documented. If necessary, the resulting report can serve as evidence that the reported practitioner received due process.

An initial intervention without follow-up will generally not put an end to disruptive behavior, which tends to be triggered by ongoing circumstances in the healthcare environment (e.g., lack of equipment, understaffing, fatigue or practitioner health issues). A reported provider should understand that he or she is being monitored for compliance.[3]

Treat the reported behavior as a problem with the physician's behavior, not with the physician. In other words, the physician should not be labeled a "disruptive physician."[4] When it is too difficult to conduct an objective assessment in-house, an outside evaluation can assure the involved parties of the process's fairness and objectivity. In some cases, the most prudent course will be to involve legal counsel for guidance.[4]

Disruptive behavior compromises patient care and increases professional liability risk. Although disciplining a healthcare provider for disruptive behavior can be difficult for a variety of reasons, it must be done in a timely, organized and fair manner. Individual practitioners who struggle with anger/frustration management must also take responsibility for their disruptive behavior and seek help. To create a culture of safety for patients and a supportive and productive environment for all members of the healthcare team, practitioners, Medical Executive Committee (MEC) members and administrators are encouraged to consider the risk management recommendations offered in this article. ❖

Endnotes

1. AMA. Model Medical Staff Code of Conduct. Available on the AMA Web site at: www.ama-assn.org/ama1/pub/upload/mm/21/medicalstaffcodeofconduct.pdf (accessed 1/21/2010).

2. ECRI. Healthcare Risk Control. Executive Summary. Medical Staff 8. Supplement A. March 2009 Disruptive Practitioner Behavior.

3. Weber, DO. Poll results: Doctors' disruptive behavior disturbs physician leaders. The Physician Executive 2004: 30 (4) 6-14. (2004). Available on the ACPE Web site at net.acpe.org/resources/publications/OnTargetDisruptivePhysician.pdf (accessed 1/18/2010).

4. Joint Commission. Sentinel Event Alert. Issue 40, July 9, 2008. Behaviors that undermine a culture of safety. Available on the Joint Commission Web site at: www.jointcommission.org/SentinelEvents/Sentineleventalert/sea_40.htm (accessed 1/21/2010).

Managing Professional Risk is a quarterly feature of NORCAL Mutual Insurance Company and the NORCAL Group. More information on this topic, with continuing medical education (CME) credit, is available to NORCAL Mutual insureds. To learn more, visit www.norcalmutual.com/cme.

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Bicentennial Committee laying plans for RIMS 200th in 2012

On Tuesday, February 25, 1812, the Rhode Island General Assembly voted to incorporate a body of forty-nine Rhode Island physicians as the "Rhode Island Medical Society. " The rationale for this enactment, as stated in the legislation, was as follows: "(t)he Medical Art is important to the health and happiness of society, (and) every institution calculated to further its improvement is entitled to public attention(;)…Medical Societies, formed on liberal principles, and encouraged by the patronage of the laws, have been found conducive to this end."

Undoubtedly present in the chamber at the time of the vote that day was Dr. Amos Throop, 76, who, besides being Rhode Island's most prominent physician at the time, was a former colleague of the legislators who were voting and the president of one of Providence's first banks. Eight weeks later, on April 22, 1812, in the Senate chamber of the Old State House on Benefit Street in Providence, Dr. Throop led the founding organizational meeting of the Rhode Island Medical Society and became the Society's first president.

Early in 2010, RIMS President Vera De Palo, MD, appointed her predecessor, **DIANE R. SIEDLECKI, MD**, to chair a Bicentennial Committee. Dr. De Palo charged the Committee to plan the observance of the two hundredth anniversary of the founding of the Society. Other members of the Committee are **DR. STANLEY ARONSON**, **DR. GARY BUBLY**, **DR. NITIN DAMLE**, **DR. VERA DE PALO**, **DR. ARTHUR FRAZZANO**, **DR. MILTON HAMOLSKY** and **DR. FRANK SULLIVAN**.

A number of commemorative events and activities are being planned for the bicentennial year. The main celebration will be a banquet at Rosecliff Mansion in Newport on Saturday evening, April 21, 2012. Also planned are a symposium to be held in the new facilities of the Warren Alpert Medical School at Brown and other observances to be conducted at the Rhode Island School of Design Museum and the Hay Library at Brown University. RIMS members will receive notices and invitations as the dates approach.