BACKBONE

Volume 11 *a publication of the Connecticut Orthopedic Society* *Summer 2006*

President's Corner *Robert A. Green, M.D. - President*

(Editor's Note: The following is excerpted from Dr. Robert Green's President's Address to the members at the Society's Annual Meeting held on May 19, 2006.)

It is again my pleasure to welcome you to the Connecticut Orthopedic Society's 2006 Annual Meeting. Your board of directors has been actively working to defend the interests of the orthopedic surgeons of the State of Connecticut. Unfortunately, the main issues have not changed and there are new challenges confronting us.

The podiatrists want to operate on the ankle joint with potential aspirations on the knee. They would like to perform open fracture care and arthroscopy of the ankle. However, we view them as a group of practitioners with diverse, non-standardized levels of training which are not equivalent to that of an orthopedic surgeon with or without a fellowship in foot and ankle surgery. Physician members, Michael Aronow, Bill Cimino, Ross Benthein, Jay Kleeman, Larry Berson, and others have contributed many hours working with a legislative committee to better define the ankle joint and establish reasonable limits for podiatric care. The scope of practice bill passed. It does not allow the podiatrists to perform surgical treatment of the ankle. Our goal was to protect the public and we believe that we were successful!

The second issue was direct patient access for physical therapy. The physical therapists have continued to lobby for direct patient access without pre-treatment medical assessment. Legally, physical therapists are not allowed to diagnose, instead they are allowed to "evaluate". I really don't understand the difference. When you evaluate, you have to determine the origin of the problem –the cause. What is the source of the patients sciatica? disc herniation, tumor, infection, etc. This bill also passed, however, there are stipulations with regard to Workers' Compensation and limits on number of visits and duration of treatment. I want to especially thank physician member Bill Cimino who spent an extraordinary amount of time in meetings and testifying at the Capitol. Again, our goal is to protect the public.

The third issue was standards in contracts. This is a bill that was brought in order to level the playing field when we contract with the insurers. Initially, this bill was raised to give us access to contracted fee schedules, remove the standard contract language permitting insurers to unilaterally reduce fees simply by advanced notice and giving us access to the "book of rules". The "book of rules" are those nasty little unknown clauses that permit the insurers to change the rules in midstream. What did we get? The two major elements are (1) that the insurer must establish a procedure so that physicians can view the fee-for-service dollar amount reimbursed for the 50 most common CPT codes performed and (2) permits a physician to request and view any fee-for-service dollar amounts the insurer reimburses to current CPT codes for what we might actually bill. This bill passed and, by some physicians, is not considered a victory.

The fourth issue was professional liability insurance reform. This issue appears to be a joke in Connecticut. Just this week the Pacific Research Institute reported the U.S. tort liability index for 2006 and Connecticut ranked 44th of the 50 states in PLI issues reform. Our only hope this year was for the success of the Republican national liability reform bill entitled "The Medical Care and Access Protection Act of 2006". Unfortunately, this bill was blocked when supporters were unable to break a Senate filibuster. Over 35,000 people signed the petitions. How did our State Senators do

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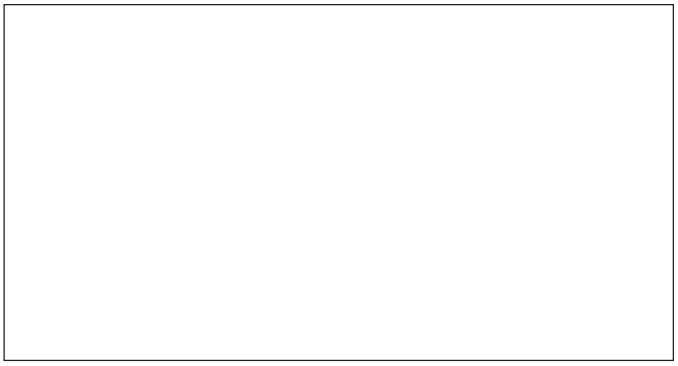
Annual Meeting Highlights

Orthopedist of the Year

John Raycroft, M.D., received the Connecticut Orthopedic Society's highest honor, Orthopedist of the Year, at a luncheon presentation held during the Society's Annual Meeting on May 19, 2006, at the Farmington Marriott in Farmington, Connecticut. He was nominated by his peers for the Society's prestigious honor and the Society's Secretary/Treasurer, Ted Collins, M.D. presented him with the award.



John Raycroft, M.D., (second from left) celebrates with his family and friends after receiving the Society's 2006 Orthopedist of the Year Award at the awards luncheon during the Society's Annual Meeting.

Dr. Raycroft was recognized for his significant contributions and dedication to the practice of orthopedic surgery and the education and training of orthopedic surgeons in Connecticut. Many orthopedic surgeons in Connecticut have had the pleasure and privilege of training with Dr. Raycroft at the Newington Children's Hospital (now the Connecticut Children's Medical Center).

Dr. Raycroft practices in the Hartford area and is a Senior Staff member at Hartford Hospital in Hartford, Connecticut. He is an Assistant Clinical Professor in Orthopedics and Rehabilitation at Yale University and Associate Clinical Professor of Orthopedic Surgery at the University of Connecticut in Farmington, Connecticut. He is active in numerous professional organizations and is the President of the Yale Orthopedic Association.

Dr. Raycroft received his medical degree from SUNY Medicine and completed his orthopedic residency at Yale New Haven Hospital and Newington Children's Hospital. He served in the United States Naval Reserve. He was honored by his peers and the Society for his many achievements and leadership in the education and training of orthopedic surgeons.

Society Hosts Dynamic Speakers

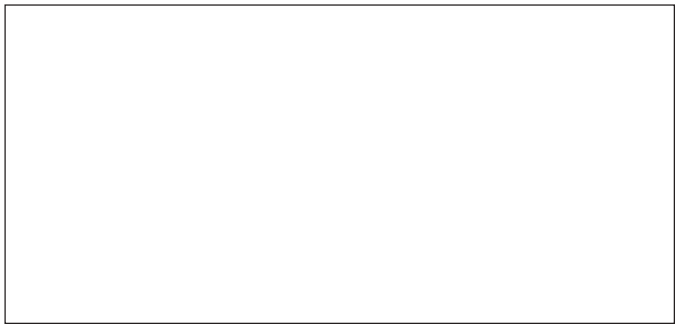
More than 130 physicians, physician assistants, physical and occupation therapists throughout the state attended the Society's Annual Meeting on May 19th, at the Farmington Marriott in Farmington, Connecticut. They took part in an impressive educational program organized by Michael Kaplan, M.D., Society Board member from Waterbury, Connecticut.

Those attending heard about the latest techniques from some of the top names in orthopedic medicine including Drs. Roger Emerson, Tracy Watson, Bruce Browner and Edward McPherson. Dr. Robert Bucholz, AAOS Past President, was on hand to present the latest news from the national association. In addition, Dr. Bernard Pfeifer discussed coding and reimbursement updates for orthopedic practices.

Editor's Note: For those attending that would like a copy of Dr. Edward McPherson's presentation on "Periprosthetic Total Knee Infection," simply email Susan Schaffman at sasshops@aol.com with your request.

Honorary Member of Society

The Board inducted a new honarary member at the Society's Annual Meeting held on May 19, 2006 in Farmington, Connecticut. Honorary membership is conferred by the Board of Directors to any individual who serves or contributes to the advancement of orthopedic practice in Connecticut.



Robert A. Green, M.D., Society President(right), presented Connecticut Workers' Compensation Commission Chairman John Mastropietro with honorary membership to the Society.

Dr. Robert Green, President, presented the membership to Workers Compensation Commission Chairman John Mastropietro. Chairman Mastropietro was recognized for his objective approach and open dialogue with orthopedic surgeons in Connecticut as it relates to patient care of the injured worker. His insights and willingness to meet with the Society to discuss vital issues continues to provide orthopedists in the State with a valuable resource in our mutual objective to provide quality patient care to Connecticut's injured workers.

in supporting our cause? They voted against reform and have continually voted against any type of liability protection. As Dr. Bob Bucholz (past-president of the AAOS) has reminded us, there are lawyers making substantial donations to the trial lawyers PAC. It is our responsibility to help ourselves. Please consider making a donation to "Doctors for Medical Liability Reform".

The fifth issue is the plight of the uninsured and the under-insured which has recently made much news. Three major insurers were given State contracts and $600 million dollars to offer HMO-style insurance plans to cover this patient population, however, most physicians, especially the specialists, have refused to participate secondary to low reimbursement. In fact, as most of you know the issue has attracted the attention of the Governor and the Legislature which is now looking into the malfeasance of the insurers. There is no free health care; you get what you pay for! But guess who gets paid the best for health care? The insurance company CEOs. In addition, the risk of treating what appears to be a litigious group seems to be, at least, partially responsible for physicians seeking reimbursement for emergency room coverage. In recent issues of the BACKBONE, Dr. Ron Ripps wrote a series of articles regarding the stress on physicians covering the emergency room. He identified the major orthopedic stressors as time rage, outcome stress and taking call.

The Board of Directors has been looking into proposing legislation, similar to that in Maryland, where a surcharge is placed on automobile registration renewal that would be directed to physicians, through the hospital, who cover emergency room trauma.

Now that we have looked at all of the good news, what were our accomplishments for 2006?

The AAOS State Orthopedic Society Health Policy Action fund awarded us a $6,000 grant to help our lobbying efforts on the podiatry scope of practice and physical therapy direct access issues.

Membership increased from 169 to slightly over 200 in the last year.

The annual coding course was the most successful to date, with over 125 attendees. We will run this course again next year and into the future as long as it serves the needs of our membership.

Our most satisfying accomplishment was winning the AAOS "State Society of the Year Award" for small states. This included a check for $1,000 to our Society.

The Society's Foundation made charitable donations this year to:

OREF - William Tipton, MD Award - $2,000
Mississippi Playground Rebuild- $1,000
Uconn Orthopedic Residency – $5,000
Yale University Orthopedic Residency- $5,000

This year the Board of Directors added four new members to the board – two residents from the Uconn Orthopedic Residency Program and two from Yale Orthopedic Residency Program. Our goal was to introduce these future orthopedists to the political and practical problems facing practitioners.

These four young people are representatives of the future of orthopedic surgery in Connecticut and throughout the country. They deserve to have a future and, therefore, we feel it is incumbent upon us, the practicing orthopedic surgeons of the State of Connecticut, to help support their future. Each year we have been fortunate to make donations to the Yale and Uconn orthopedic programs which are directed solely to resident research and education. Continuing this as well as supporting the other society activities puts a tremendous strain on our budgets.

I would again ask you to reach into your pockets, pull out cash or your checkbook and make a tax-deductible donation (see p.11) to the Connecticut Orthopedic Society Foundation. Joe DeAngelis, one of the Uconn residents, did it because he recognized the investment in his future and that of his colleagues.

I would like to thank all of the members of the Board who have supported me and this organization throughout the year. These members travel great distances after a long day at work, spend 3 hours at a meeting then travel home, at late hours, to defend and to promote our collective interests.

Where are we going next year? We still have battles to fight and your orthopedic society needs your support financially, politically and personally. Please speak to your legislators, become their friends, attend meetings, make calls and support legislators who support us. Speak to your colleagues to make sure they are society members and ask them to support the profession be becoming an active participant in the Society.

Annual Meeting Highlights

Bylaws Amendment Passed

Members attending the Society's Annual Meeting on May 19, 2006, unanimously approved a bylaw amendment that will allow physician assistants with orthopedic specialty to become affiliate members of the Society.

ARTICLE III-MEMBERSHIP - SECTION 7: Affiliate Membership

A. Affiliate Membership is available to licensed, Physician Assistants of Orthopedic Practices.

B. Affiliate Membership requires application to the Society and annual dues payment of $150.00.

C. Affiliate Members may attend the Society's Annual Meeting free of charge with current year dues payment.

D. Affiliate members are not allowed to vote, hold office or serve on committees with the exception of serving as guests on committees.

Please contact Susan Schaffman at (860)690-1146 or email sasshops@aol.com to obtain additional information and application material.

Resident Papers Presented

This year the Society invited residents from each of Connecticut's orthopedic residency program to present Resident Papers. Residents were selected by the heads of each residency program and each participant received a $500.00 contribution to their respective programs for education and research.

Special thanks to the following participating residents.

Mariam Hakim-Zargar, M.D., from UConn presented, ***"In Vitro Analysis of Engineered Silks Effects on Human Osteoblast Proliferation, Mineralization and Integrin Mediated Signaling Pathways."***

Andrew White, M.D., Yale Resident, presented, ***"Utility of Flexion – Extension Radiographs in Evaluating the Degenerative Cervical Spine."***

Save the Date
2007 Annual Meeting
May 18, 2007
Farmington, CT

Connecticut ORTHOPEDIC Society

Administrative Office
26 Riggs Avenue
West Hartford, CT 06107

Orthopedic Stress *Contributing Editor* - Ron Ripps,MD

Orthopedic Stress: The Dark Side of Perfectionism

In his autobiography, *Geno- In Pursuit of Perfection*, UConn's Women's Basketball coach Geno Auriemma starts by discussing his scars. "The emotional scars aren't easy to see. I've got plenty of them, but there isn't a person that knows all my scars. I've acquired them from a life of questioning myself, of constantly trying to prove myself."

Geno notes that nothing is ever "as good as it could have been." "I have never coached the perfect game, and my players have never played the perfect game. And when that flawed game is over, I am convinced it is my fault, even if we win big. It's like the pitcher who throws a perfect game in nine innings. If he doesn't strike out every guy, he is going to talk about the line drive fly caught by the third baseman. If he's a perfectionist, even after that amazing accomplishment, he's going to be ticked off about that slider that just missed the strike zone."

Dr. John Henry Pfifferling of the Center for Professional Well-Being has found that disabling perfectionism can rule the personal and professional lives of physicians. He noted that internalization of the relentless drive for perfection in our profession (and lives) is charged by our rigorous and competitive training and sustained by cultural pressures to perform to the highest standards. Perfectionist standards are systematically nurtured and rewarded by medical educators, litigators, accreditation groups, risk managers, the media, our patients, and our community. Simply put, Society demands perfection from physicians as a *minimum* standard, and the physician is both the victim and perpetrator of that mindset.

Dr. Pfifferling noted that every practice has at least one perfectionist to contend with…often the rainmaker. Although he is generally perceived as obnoxious by other members of the group, the rainmaker's substantial contribution to covering the overhead mitigates against confrontation. You all know who he is. He is the one who takes feedback (which he regards as criticism) very poorly, and who violates office policy (like rearranging patient sessions) at his whim- because he feels his status excuses him. These individuals often do not take time off, and we know of one practice that had to fine a member for not taking his allotted vacation time. As the individual becomes more consumed by his perfectionism, distrust, hypercriticism of others, stubbornness, sarcasm, wealth hoarding, and need for control all become magnified.

Geno writes, "Okay, we are 39-0, we won a national championship. And what? That means you're good? I guess. The problem is you start looking at other things. You start saying, " I wish I could have influenced this kid this way", or "I wish I could have taken this kid." After the Villanova loss, I remember asking,"Why didn't I prepare better?" You do that enough and it probably isn't healthy."

There is in fact a connection between perfectionism and serious interpersonal and bio-emotional problems. The perfectionist physician, instead of being comfortable with himself, senses he is constantly under surveillance by a highly evolved critical "judge". He wrestles with decision-making, as his internal conversations foment brooding and doubt. Even positive comments are refuted, and the perfectionist becomes exhausted under the scrutiny of his own constant internal observer.

John Henry: "The greater the hyper-criticality of the physician, the more apt he is to be unable to receive or know how to dispense civil and constructive criticism." Despite being highly intelligent and having insight into others' behavior, the perfectionist is incapable of seeing his own perfectionism as the source of his unhappiness. He may suffer from peer sabotage as those upon whom he expresses derision fail to cooperate. He has trouble collaborating and is often the subject of complaints alleging a "hostile work environment." Perfectionism reinforces workaholism, while at the same time it creates self-doubting, denial, and low self esteem.

Geno: "I can't get past the Duke game. All we have to do is inbound the ball, get it across half-court, and we win going away. Well, we can't do it. Why? Because we get sloppy. Well, isn't it the coach's job to make sure that doesn't happen? …The game is supposed to be played a certain way, and we can't do it. We should play the game perfectly. You hear that and you figure, "Geez, this must be coming from a guy who is incredibly disciplined, who has all his ducks in a row, who is a stickler for detail." Well bullshit. This is from a person who wishes he could be that way. This is from a person who is trying to get his players to see the value of being that way."

Perfectionists are rarely satisfied with what they have

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The Backbone is a publication of the **Connecticut Orthopedic Society.** *Comments and suggestions should be directed to:* **Susan Schaffman,** *Executive Director*
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done. They appear to be overly harsh on themselves, and each successive project becomes more taxing, difficult and unattainable. They get caught in their own self-fulling prophecy, always having more work to do. They feel it is their duty to set goals higher than those of their peers and coworkers, and it is their obsession to exceed them. People often call them arrogant or aloof. They relentlessly find imperfection in their work and the work of others. They have trouble laughing at themselves.

Geno: "I'm always amused when I hear people who don't know me describe me as arrogant, insensitive, and overconfident. They have no idea how wrong they are. They don't understand that even after winning five national championships here in Connecticut, I still doubt myself all the time."

John Henry: In the world of medicine, perfectionism relies on the cultural concept of accomplishment as equivalent to self-image. It is the cultural environment that imprints the constant internal judge. It is a common kind of adaptation in families where the parents bestow a preponderance of conditional approval. Children emerge with the sense that "whatever I do won't ever be good enough." When among peers shame impairs honest and timely feedback, it is presumed that everyone in the group expects nothing less than outstanding results. The costs of this model are high. The interpersonal ramifications of perfectionism can lead to an unyielding individual who is emotionally inhibited, obsessively obedient, and unable to relax.

Proposals:

Once the perfectionist understands there is a need to reduce the harmful effects of this style, he will have to learn to let go of guilt, to freely make choices, and to move forward knowing he does not always have to prove himself. He must learn to accept the uncertainty of things and to become comfortable soliciting other's opinions. He needs to appreciate the solace one can enjoy in the words,"I don't know." He will be required to disassociate his self esteem from "results" and to appreciate and to praise the contributions of others. He will have to learn to accept harmless mistakes and to take time to "smell the flowers". He must accept that laughing at oneself is not a sign of weakness.

Geno:" When Mets pitcher Pedro Martinez throws a one-hitter and strikes out fourteen batters, that doesn't make him the best pitcher there is. That doesn't make him the sure-fire Cy Young winner. Treat the event for what it is. What it means is that when Pedro Martinez has his stuff he's as good as anybody."

If the perfectionist is your partner, try to refocus the group's attention on the "big picture." Try not to feel vulnerable or defensive when he indicates you are flawed or deficient, or that the practice is sorely in need of corrective action. Affirm that no one partner can please everyone, that we are all fallible, and the "God's role is already filled." Helping the perfectionist rebalance his life is crucial for collaborative functioning. Societal pressure for perfectionism will not change. That's why the group needs to maintain that equanimity is a higher priority. Ultimately the perfectionist has to acknowledge that refraining from workaholism is an act of freedom.

Geno: " I spent the last ten years finding out from players what it really means to be successful… Every day they force me to look at things in a different way…As we go along we develop our own signature touches. Before every game we come together in the center of our locker room, join hands, and yell, "Together!" When we have a home game, our fans stand and clap in unison until we score a basket."

Dr. Pfifferling may be reached at the Institute for Professional Well-Being in Durham, NC at (919) 489 9167. Geno is published by Wagner Books.

Annual Meeting Highlights

Thanks to Our Sponsors

The Connecticut Orthopedic Society gratefully acknowledges the support of the following companies who took part in the 2006 Annual Meeting on May 19, 2006.

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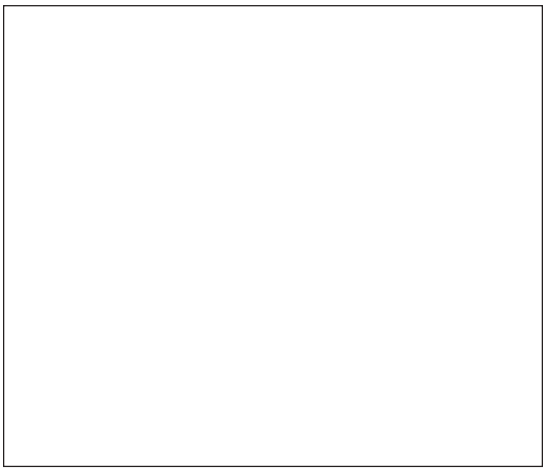
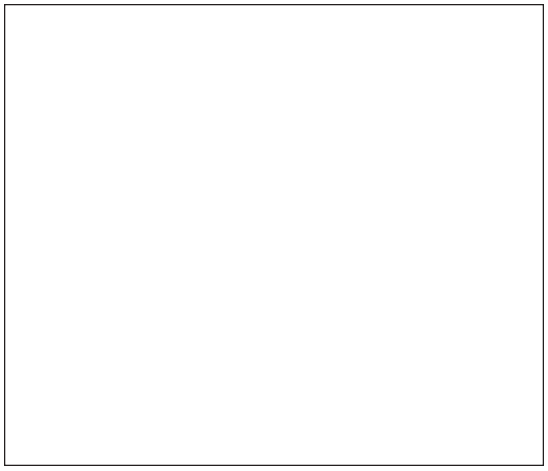
Special thanks to representatives from D. J. Orthopedics for their significant sponsorship.

Stryker Orthopedics and its' representatives were a major contributor to the meeting.





Special thanks to Biomet and its' representatives for their meeting sponsorship and supporting two of the meeting's speakers.

Legislative Wrap Up 2006

The Society and its representatives had an active legislative session for 2006 and a summary of key issues is listed below. In addition, we worked with other medical societies on issues that impacted all of Connecticut physicians and a copy of the Connecticut State Medical Society's legislative summary is also included in this article for your information.

Senate Bill 651 AAC Podiatric Medicine

The Connecticut Orthopedic Society worked diligently on this bill. With special thanks to Drs. Mike Aronow and William Cimino for representing the Society during 7 meetings throughout the year with the Department of Public Health and representatives from the Podiatry Society to attempt to reach a consensus. In lieu of one, the podiatrists introduced the bill seeking an expansion of scope of practice to include ankle surgery. The original bill was amended based on testimony provided by Drs. Mike Aronow, William Cimino, Ross Benthien and Larry Berson, and further discussions and meetings with representatives from the House and the Podiatric Society and lobbying efforts. As a result, the bill passed and awaiting the Governor's signature is one that only gives podiatrists who are board-qualified or certified the ability to engage in the medical and **nonsurgical** treatment of the ankle and anatomical structures of the ankle and the nonsurgical treatment of manifestations of systemic diseases as they appear on the ankle. The ankle is now defined in the statutes as, "ankle" means the distal metaphysis and epiphysis of the tibia and fibula, the articular cartilage of the distal tibia and distal fibula, the ligaments that connect the distal metaphysis and epiphysis of the tibia and fibula and the talus, and the portions of skin, subcutaneous tissue, fascia, muscles, tendons and nerves at or below the level of the myotendinous junction of the triceps surae In addition, qualified podiatrists will restrict treatment of displaced ankle fractures to the initial diagnosis and the initial attempt at closed reduction. No treatment of tibial pilon fractures is allowed under this bill. The Society and its representatives will be entering into an arbitration period during the year to further discuss podiatric scope of practice issues as they relate to surgical treatment. This bill does NOT ALLOW for surgical treatment of the ankle which the Society's representatives and lobbyist vehemently opposed.

Senate Bill 164 AAC Concerning Patient Access to Physical Therapy

Your Society, lobbyist and physician member, Dr. William Cimino worked on your behalf to oppose the direct access legislative request by the physical therapist for direct access for 30 days or six visits. Our main concern was, and continues to be, direct access without a medical diagnosis. Dr. Cimino spent many days at the Capitol in meetings and testifying against direct access without a medical diagnosis. The legislature passed Senate Bill 164 with language not supported by CSOS or CSMS. The bill allows physical therapists with a master's degree or those who earned a bachelors degree prior to 1998 to see patients without a physician referral to provide treatment for 30 days or six visits (whichever is first) provided the patient must disclose their primary care physician; requires the physical therapist to provide information to any self-referred patient regarding the need to consult with their primary care physician or healthcare provider; and mandates that any person seeking physical therapy that does not demonstrate improvement during the period of 30 days or six visits be referred to an appropriate, licensed practitioner. In addition, conditions arising from injuries related to a patient's employment can only be treated with a referral.

House Bill 5477 An Act Concerning The Supervision Of Physician Assistants

This bill clarifies a potential conflict concerning physician supervision in settings outside of the hospital and clarifies that supervision in settings outside the hospital include, but is not limited to: availability of direct communication either in person or by radio, telephone or telecommunications between the PA and supervising physician. There are additional requirements of monitoring by the supervising physician including personal review, face-to-face on a weekly basis, review of charts and records of the PA at the facility and delineation of a plan for emergency situations.

(Editor's Note: The following an excerpt of the Connecticut State Medical Society's 2006 legislative summary.)

Health Insurance Contracting and Negotiations

Although several bills were introduced and heard on these issues, one bill became a vehicle that traveled through committees during the session and ultimately passed the legislature. In what can be considered only the first step toward accomplishing our goal to establish standards, transparency, and equity in contracts between physicians and insurers ***House Bill 5189 AAC Standards in Contracts Between Insurers and Physicians*** passed both chambers unanimously.

As amended, the legislation will finally establish transparency in fee schedules established by insurers. By October 1, 2007 each insurer must provide to physicians, physician

(cont. on p. 8)

groups or physician organizations the top 50 billed codes within the physician's specialty. In addition, the insurer will be required to provide upon request, **ANY fee** for a code the physician bills or intends to bill the insurer.

The bill also includes the establishment of a process for the Chairmen of the Insurance and Real Estate Committee to discuss on a regular basis with physicians and insurers contracting issues and issues related to compliance with the national settlements.

Senate Bill 425 An Act Ensuring Payment for Health Care Services Rendered to Connecticut Residents with an Elevated Blood Alcohol Content.- CSMS worked with State Senator Joe Crisco to pass this legislation to prevent insurers from denying health care services to patients injured while under the influence of alcohol. Current State Statute is silent on the issue and the potential to be denied payment in these situations has impacted the screening for and identification of substance abuse. This legislation, which passed both chambers with no opposition, should be considered a big victory for medicine. Many states throughout the country have been seeking similar legislation unsuccessfully.

Senate Bill 621 An Act Concerning Outpatient Surgical Facilities- This legislation was the result of years of CSMS efforts to ensure that recently enacted licensure requirements for office-based surgery were appropriate for single discipline facilities. Current DPH licensure regulations were originally drafted for hospitals and larger, multi-discipline facilities. Physician offices would be unable to meet many of the requirements such as physical plant and staffing levels. In addition, new language technically making these offices "health care facilities" would change their fire-code requirements. Most offices would be unable to meet them.

As a result of reluctance on the part of DPH to categorically waive any requirements, CSMS draft legislation requiring them to do so. This legislation was originally amended in to a larger DPH bill and successfully passed out of Committee. However, an amendment; passed late in the session removed this language. CSMS will continue to work with appropriate legislators and regulators to ensure that physicians are not harmed by the new licensing requirements.

House Bill 5468 An Act Concerning Certificate of Need Capital Expenditure Thresholds. This legislation raises, from $1 million to $3 million, the threshold that would trigger a CON on capital expenditures to expand or upgrade facilities or purchase major medical equipment.

House Bill 5371 An Act Concerning Extended Reporting Period Coverage Under Medical Malpractice Insurance Policies-This legislation strengthens a CSMS pushed bill from last session. This bill requires any medical liability insurer that ceases to write policies in the state, to provide extended reporting period coverage (tail) to any physician who has held a policy with the insurer for 5 consecutive years regardless of the age of the physician. CSMS also has the support of the Department of Insurance on this issue.

House Bill 5721 An Act Concerning Consultations Between Hospitalists and Primary Care Physicians and Banning Non-Profit Hospital Advertisements- This legislation would have mandated the Department of Public Health to draft regulations to place requirements on communications between hospitalists and primary care physicians. While CSMS offered to work with Legislators to educate them on the growing use of hospitalists, we opposed the legislation that would have hastily regulated a growing specialty that would stifle its growth. Although we successfully stopped the bill in the Public Health Committee, we continue to work on the issue. To stave off any inappropriate regulation over the practice, CSMS worked with the Connecticut Hospital Association and legislators interested in the issue to place language in a Public Health bill to allow the Best Practice Subcommittee of the State's Quality of Care Advisory Committee to review the use of hospitalists and make any appropriate_recommendations to DPH regarding their use.

Senate Bill 54 An Act Making Adjustments to the Budget for the Biennium Ending June 30, 2007- Legislation to implement the Governor's Budget Recommendations, it contained language that would have changed the definition of medical necessity in Medicaid and General Assistance Plans. The current definition in statute allows for a less costly substitution of a physicians prescribed treatment ***only*** if an ***equally effective alternative*** exists. The proposed language would have lowered the threshold to allow substitutions of a prescribed treatment ***merely*** if a ***similarly effective alternative*** exists. Physicians would have to prove "scientific evidence" that a requested alternative is "safe and effective and the least costly among similarly effective alternatives" and to demonstrate "on the basis of the best available scientific evidence," that a treatment is "likely to produce benefit. . . ."

Working with a coalition of other groups, this change was stripped by the Appropriations Committee.

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Legislative Wrap Up 2006

Senate Bill 505 AAC the Establishment of an Electronic Prescription Program and Work Group- This legislation requires the Department of Consumer Protection to establish a program to monitor and collect information from pharmacies on controlled substances. Over the past years, CSMS has worked with DCP to ensure that any proposal does not negatively impact the appropriate prescribing of controlled substances. To ensure that an appropriate program is developed the bill requires DCP to establish a working group with the following members: an internal medicine specialist, a board-certified oncologist, an advanced practice registered nurse, a representative from an acute care hospital, a state police officer, a local police chief, a representative from the Division of Criminal Justice, a representative from a hospice, a pain management specialist, a pharmacist, and a representative from the Department of Mental Health and Addiction Services.

Senate Bill 160 AAC Hospital Acquired Infections- This bill creates an 11-member Committee on "Healthcare Associated Infections" responsible for developing, operating, and monitoring a mandatory reporting system for healthcare associated infections.

The bill defines a "healthcare associated infection" as any localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent or its toxin that (1) occurs in a patient in a healthcare setting; (2) was not found present or incubating at the time of admission unless the infection was related to a previous admission to the same setting; and (3) if the setting is a hospital, meets the criteria for a specific infection site, as defined by the National Centers for Disease Control.

The bill requires the Department of Public Health (DPH) to implement the committee's recommendations concerning a mandatory reporting system for infections and standardized data reporting measures. It also establishes reporting requirements.

House Bill 5372 AAC Access to Radiological and Imaging Services- This bill limits the co-payments that can be imposed on a person for all magnetic resonance imaging (MRI), computed axial tomography (CAT scan), and positron emission tomography (PET scan) services performed in-network. It limits the co-payments for MRIs and CAT scans to no more than (1) $ 375 for all such services annually and (2) $75 for each one. It limits the co-payments for PET scans to no more than (1) $400 for all such scans annually and (2) $100 for each one.

These co-payment limits apply provided the physician ordering the imaging service is not the same physician performing it or in the same practice group as him. The limits do not apply to high deductible health plans designed to be compatible with federally-qualified health savings accounts.

The bill applies to health insurers, HMOs, hospital service corporations, medical service corporations, and fraternal benefit societies providing group or individual coverage for such imaging services.

House Bill 5617 AAC the Prescriptive Authority of Advanced Practice Registered Nurses-Allows APRNs to receive, request and dispense sample medication.

Regulatory Update

Connecticut General Statutes Section 19a-493(b) requires State Licensure of entities performing surgical procedures requiring moderate or deep analgesia or general anesthesia (primary physician offices) to be licensed as an Outpatient Surgical Facility effective March 30, 2007, by the Department of Public Health.

The Department strongly recommends that any entity defined in this statute begin the Licensure process immediately. Many of the existing entities may not be able to meet the physical environment requirements; therefore, it will be necessary for the Department to consider waivers for these facilities. If a license is applied for and renovations to the existing facility are necessary, licenses may not be granted within the timeframe identified in Connecticut General Statutes Section 19a-493(b).

In accordance with Connecticut General Statutes Section 19a-491(d), a biennial licensing and inspection fee is required for the issuance of the facility's license. The licensing fee is $500.00. Acceptable forms of payment include a check, draft or money order made payable to the Treasurer, State of Connecticut.

Please be advised that the referenced statute prohibits continuance of such services without a license. If there are any programmatic questions, please do not hesitate to contact Ann Marie Montemerlo, R.N., DPH at (860) 509-7400. If there are any questions on completing the licensure applications, please feel free to contact Rose McLellan at (860) 509-7444.

Society Members Visit Washington

The 2006 National Orthopaedic Leadership Conference (NOLC) was held May 3-6 in Washington, DC, and was attended by the AAOS Board of Directors, Board of Councilors, Board of Specialty Societies, state orthopaedic society representatives and other orthopaedic leaders. Representatives from the Connecticut Orthopedic Society who met with Connecticut's House of Represenatives and Senators were Drs. Ted Collins (AAOS Councilor & Society Secretary/Treasurer), Frank Gerratana (AAOS Councilor and Society Board Member) and Michael Connair (Society Board Member). Meeting discussions focused on Medicare cuts in physician reimbursement and liability reform. The highlights below are from the AAOS.

Meeting Representative Rob Simmons were (from left) Dr. Michael Connair, Dr. Frank Gerratana, Rep. Simmons, Dr. Ted Collins and Susan Schaffman, Society Executive Director(front).

Once again, the centerpiece of this year's visits to Capitol Hill included medical liability reform, which was especially timely as the Senate had just introduced a bill on the issue that included a cap on non-economic damages. Participants also talked to Members of Congress about the problems with the annual Medicare payment update formula and the projected 2007 4.7% overall pay cut for Medicare services. Also discussed were proposed Medicare payment cuts for imaging services, starting in 2007.

But the NOLC was about more than meeting with elected officials. The Board of Councilors also considered proposed new AAOS standards of professionalism and proposed amendments to AAOS bylaws.

All NOLC participants provided feedback on the rising issue of physicians and hospitals sharing cost savings from their combined efforts to reduce hospital expenditures. A special AAOS Board Team, headed by Dr. David Halsey, gave background information on the "gainsharing" issue, and brought up a number of key questions regarding it. Participants expressed their concerns about the possible negative public perception of such arrangements, ethical considerations, the impact of this issue on clinical practice and the difference between arrangements where cost savings are not shared directly with the physicians but are used to improve hospital operations or the hospital's bottom line.

Meeting Representative Nancy Johnson were (from left) Dr. Ted Collins, Rep. Johnson, Dr. Frank Gerratana and Dr. Michael Connair.

Also discussed were methods for resolving patient discontentment regarding unanticipated events. Richert Quinn, MD, Physician Risk Manager, COPIC Insurance Company spoke about his company's 3Rs program which stands for: *R*ecognize an unanticipated event, *R*espond immediately, and *R*esolve the patient's issues. Thomas Barber, MD, also talked about the Kaiser Permanente Alternative Dispute Resolution System.

To prepare NOLC participants to help the AAOS Coding, Coverage & Reimbursement Committee manage coding and Medicare payment activities, Dr. Brad Henley, Committee chair, described the CPT Editorial Panel and AMA Relative Value Update Committee (RUC) processes. He emphasized the need for orthopaedists to become knowledgeable about how to develop coding proposals and how to complete RUC surveys.

Participants provided feedback on a proposal to expand the scope of practice of hand surgeons, after hearing a panel discussion by representatives of several interested musculoskeletal specialty societies.

Meeting Representative Rosa Delauro were (from left) Dr. Frank Gerratana, Dr. Ted Collins, Rep. Delauro, Susan Schaffman, Society Executive Director and Dr. Michael Connair.

Foundation Contributions

As a member of the Connecticut Orthopedic Society, your involvement and support of the Society has been instrumental in our ability to fund key education, training and research initiatives in Connecticut for future orthopedic surgeons and the practice of medicine.

Through the Connecticut Orthopedic Foundation, Inc., we continue our commitment to the training and education of orthopedic surgeons and to this end have donated $20,000.00 over the past few years to both the Yale and University of Connecticut School of Medicine Orthopedic residency programs.

Since beginning the campaign for contributions late last year, the following members generously answered our request to support the Foundation and the future of orthopedics by contributing over $5,000.00 to the Foundation.

T. Jay Kleeman, M.D. - Wilton, CT

Ted Collins, M.D. - Willimantic, CT

Robert A. Green, M.D. - West Hartford, CT

Murray Morrison, M.D. - Westport, CT

R. J. Sullivan, M.D. - Simsbury, CT

John Mara, M.D. - Avon, CT

John Fulkerson, M.D. - Hartford, CT

Michael Kaplan, M.D. - Waterbury, CT

Tim McLaughlin, M.D. - Farmington, CT

Anthony Spinella, M.D. – Wethersfield, CT

Ken Kramer, M.D. – Woodbridge, CT

Jesse Eisler, M.D. – West Hartford, CT

Michael Marks, M.D., MBA – Weston, CT

Brian Smith, M.D. - Avon, CT

Gary Friedlaender, M.D. - Woodbridge, CT

Michael Aronow, M.D. - West Hartford, CT

Alfredo Axtmayer, M.D. – Wallingford, CT

Please join your colleagues in supporting the future training of the next generations of orthopedic surgeons by making a contribution to the Connecticut Orthopedic Foundation. Your tax-deductible gift will help make a difference.

Connecticut Orthopedic Foundation 2006 Contribution Form

Enclosed is my contribution, made payable to the "Connecticut Orthopedic Foundation, Inc."

(Please Print)

Name_____

Home Address_____

City_____

Zip _____

Phone_____

Email_____

I am pleased to support the Connecticut Orthopedic Foundation with a gift of

(check one)

____$500.00

____$250.00

____$125.00

____$ ____(other)

Please send to the Connecticut Orthopedic Foundation, 26 Riggs Avenue, West Hartford, CT 06107. Your cancelled check is your receipt.

Thank you!