Focusing on Social Determinants to Improve Health

BY ROBYN ALIE, MANAGER, MMS POLICY AND PUBLIC HEALTH

Sofia has poorly controlled diabetes and asthma, obesity, osteoarthritis, and dependence on opioids. At 45 years old, she’s on multiple medications. She is intelligent and industrious, but her life circumstances have limited her academic, employment, and financial opportunities and led to serious health issues. Growing up, she had limited access to nutritious food, physical activity, and school enrichment programs.

This anecdote opens a new book, Well, by Sandro Galea, MD, MPH, DrPH, dean of the Boston University School of Public Health. The book looks at the factors that make us healthy—or not. “Our health is not defined by things like seeing doctors or taking medicines or getting in our 5,000 steps a day,” writes Dr. Galea. “Rather, it’s defined by the full spectrum of our life circumstances, from the families we come from to the neighborhoods where we live to the people we see and the choices we make.”

These life circumstances that influence health, or social determinants of health (SDOH), have become a focus of discussions about health care outcomes and costs in Massachusetts and across the nation. Social determinants, defined by the World Health Organization as “the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness,” refer to factors such as the availability of healthful foods, safe and affordable housing, access to education and job opportunities, transportation options, social support, and exposure to crime, poverty, and discrimination.

How SDOH Affect Health

Social determinants are responsible for 80–90 percent of modifiable contributors to health outcomes, with medical care claiming only 10–20 percent. For example, lack of stable housing contributes to higher rates of tuberculosis, hypertension, asthma, diabetes, and HIV/AIDS, and more frequent hospitalizations.

Children who are food insecure are more likely to have impaired brain development, more hospitalizations, iron-deficiency anemia, and behavioral disorders.

Patients across the Commonwealth

Physicians see the effects of these nonmedical factors every day. According to the 2018 Survey of America’s Physicians, almost 90 percent of physicians say that “some,” “many,” or “all” of their patients are affected by a social condition that presents a serious impediment to their health. “Social determinants of health affect all persons regardless of type of insurance coverage,” said MMS President Maryanne C. Bombaugh, MD, MSc, MBA, FACOG. Payers are increasingly exploring how to address SDOH as a way to control skyrocketing health care costs. MassHealth is at the forefront of this effort (see story below).

The AMA and United Healthcare recently announced a collaboration to standardize data collection of social determinants of health to help address individuals’ unique needs. They’re supporting the creation of 23 new ICD-10 codes to capture, among other things, patients’ access to nutritious food, adequate and safe housing, and transportation as well as their ability to pay for medications and utilities. The codes would trigger referrals to social service organizations and other community resources.

MassHealth ACOs Beginning to Address Food, Shelter, and Safety as Part of Health Care Delivery

VICKI RITTERBAND, INTERIM VITAL SIGNS EDITOR

It’s challenging to maintain good control of your diabetes when you have limited access to fresh fruits and vegetables and no place to refrigerate your insulin. And if you’re worried about where you’ll sleep on any given night, getting an annual mammogram is probably low on your to-do list.

In an effort to encourage caregivers to address patients’ social needs in tandem with their medical ones, MassHealth has undergone one of its most ambitious restructuring in decades. As of spring 2018, more than 850,000 members are now enrolled in one of 17 MassHealth accountable care organizations (ACOs) — groups of physicians, hospitals, and other health care providers that collaborate to deliver coordinated, high-quality care to their patients, with reimbursement based on value, not volume. Under the new model, ACOs contract with MassHealth to provide members with medical and behavioral health care and addiction treatment. MassHealth also launched the Community Partners (CP) program in July 2018. CPs are community-based organizations with expertise in working with members with severe behavioral health and social challenges, as well as long-term support needs. CPs partner with ACOs and managed care organizations to provide intensive care coordination for these members. “The ACO model we have rolled out asks for an unprecedented level of joint care planning, coordination, and integration among primary care, behavioral health providers, and community partners. It’s a big paradigm shift,” said Daniel Tsai, assistant secretary for MassHealth and Medicaid director for the Commonwealth.

continued on page 4

continued on page 5
Rob Restuccia: Visionary and Advocate for Affordable Health Care for All

The Massachusetts Medical Society mourns the loss of Rob Restuccia, a great friend and fierce health care advocate.

Restuccia was brilliant at navigating our complex health care system and passionate about ensuring that every citizen has access to high-quality, affordable care, making him a force to be reckoned with in Massachusetts and beyond.

While at the helm of Health Care for All and later, Community Catalyst — two organizations he was instrumental in building — Rob demonstrated a genius for rallying and uniting disparate stakeholders and moving mountains.

Some of his greatest health care reform triumphs in the Commonwealth were scaled to meet national needs, including the Children’s Health Insurance Program (CHIP). In 2010, the landmark Affordable Care Act was passed, in large part because of the work of Community Catalyst, the national consumer advocacy organization Restuccia led until his illness forced him to step down in September 2018. Restuccia’s passing leaves a large void in the health care community and in our collective heart. The Massachusetts Medical Society is grateful for his service and dedication to every patient and for the lasting impact his quest for health care equity will have on patients for many years to come.

Massachusetts Consultation Service for Addiction and Pain Treatment Is Free to Physicians

BY AMY ROSENSTEIN, ASSISTANT VICE PRESIDENT OF OPERATIONS, MASS BEHAVIORAL HEALTH PARTNERSHIP

The Massachusetts Consultation Service for Treatment of Addiction and Pain (MCSTAP) offers phone consultations to primary care providers on safe prescribing as well as managing care for adults with chronic pain and/or substance use disorder (SUD). MCSTAP also provides referral information about community-based providers and services to support patients with these conditions.

MCSTAP provides expertise and information on a wide range of topics, including medication management related to medication-assisted treatment, opioids, and non-opioid pain medications; pain management strategies, including non-pharmaceutical treatment of pain; and community-based resources for people living with chronic pain and/or SUD.

The Grayken Center for Addiction at Boston Medical Center provides medical leadership for MCSTAP. MCSTAP’s physician consultants, who practice in health systems across Massachusetts, have extensive academic and clinical expertise in safe prescribing and management of patients with chronic pain and/or SUD.

“MCSTAP is like having a trusted colleague who not only understands where you are coming from and what you are facing, but also has experience and knows how to help you right there on the spot — just when you need it most,” said MCSTAP Medical Director Christopher Shanahan, MD, MPH, FACP.

MCSTAP’s services are free to Massachusetts providers. The service supports the care of all adults with chronic pain and/or SUD, regardless of insurance coverage. MCSTAP is funded by the Massachusetts Executive Office of Health and Human Services.

For a consult, call 1-833-PAIN-SUD (1-833-724-0783), Monday through Friday, 9 a.m. – 5 p.m. For more information, visit mcstap.com.
Multiple health issues are associated with poor oral health, especially among elderly patients. Despite the relative affluence of Americans, 70 percent of retirees do not have dental insurance — Medicare does not include dental benefits — and one in four adults age 60 and older no longer has any natural teeth. The risks of poor oral health include heart disease, stroke, diabetes, hypertension, aspiration pneumonia, and sepsis, leading to medical complications and possible hospitalization. Missing teeth can affect nutrition, since people without teeth often lean toward soft, easily chewed foods.

Normal aging has an impact on the oral cavity, potentially affecting speech, mastication, swallowing, and digestion, as well as appearance. Elders may have decreased oral sensation, changes in taste sensitivity, decreased saliva, and lingual strength, and mandibular/gum changes. Despite these challenges, medical providers are well-positioned to support elderly patients’ oral health in several ways and should do the following:

- **Ask patients about oral health issues**: Query them about pain, ability to chew, oral lesions, dry mouth, and dentures.
- **Determine patients’ routine oral care**: Recommend that they brush twice daily and floss once a day, and store dentures in water overnight. Ask them whether they need assistance with oral care.
- **Examine the oral cavity**: Have patients remove dentures. Look for food impaction, plaque, inflamed gums, decay, and lesions.
- **Limit anti-cholinergic medications**: These can cause dry mouth and accelerate caries, so it’s worth limiting them if possible.
- **Make a dental referral**: This is especially important if your patient has diabetes or acute oral needs. For those without MassHealth or private dental insurance, inform them of these options:
  - Dental hygiene and dental schools, which offer reduced fees for preventive and chronic needs.
  - Federally qualified health centers with dental practices, which offer graduated payments based on income.
  - The AARP, which offers dental insurance packages.
  - PACE (Program of All-inclusive Care for the Elderly), which is administered by MassHealth and Medicare and provides a wide array of medical, social, recreational, and other services to eligible seniors.
  - Dentists who offer payment plans or pro bono care on a case-by-case basis. Inquire about which dentists in the community do either or both.
- **Lend your voice and support to advocating for Medicare dental coverage**: Watch for statewide efforts and learn more about national efforts by the Santa Fe Group and the Center for Medicare Advocacy. Act now to make a difference.

**Accountable Care Model Encourages Integration of Oral and Medical Care**

**BY NEETU SINGH, DMD, MPH, AND HUGH SILK, MD, MPH**

Oral Health has been recognized by the Institute of Medicine, the US Department of Health and Human Services, and others as having a profound effect on overall health, from heart disease to diabetes. Accountable care organizations (ACOs) across the country are now including oral health services in their value-based care delivery and payment models, or at least considering it. MassHealth ACOs are participating in this effort by including an oral health quality measure, presenting an opportunity for the state to generate a strategic plan for oral health integration (OHI). Under the ACO model, reimbursement is based on the ACO’s performance on quality measures, so ACOs have a powerful incentive to integrate dental and medical care. The initial stages of OHI will unfold over the next several years, with a goal of identifying and evaluating promising strategies within the current MassHealth ACO program structure. Strategies that prove most effective will be pitched for integration into MassHealth ACOs in 2022, the year the state renegotiates its Medicaid contract with the federal government.

Initiatives being considered to achieve OHI in MassHealth ACOs include the following:

- Integrating health care data, such as medical and dental electronic health records (EHRs), to facilitate interdisciplinary provider communication and ensure continuity of care.
- Establishing a formal bi-directional e-referral pathway between MassHealth ACOs and oral health providers.
- Implementing evidence-based oral health metrics that will help incentivize the provision of oral health care, measure performance, and guide quality improvement.
- Reimbursement oral health providers based on the quality of their care, not the quantity.
- Utilizing community health workers and dental coordinators to support cooperation among physicians, dental providers, allied health professionals, and patients.
- Using dental hygienists and other mid-level providers to create interdisciplinary services for patients.

Admittedly, challenges remain, including implementation costs, evolving payment systems for oral health providers, and the difficult task of integrating dental and medical care systems that have long operated on separate tracks. However, given the overwhelming potential for long-term cost savings as well as improved patient outcomes, every effort will be made to achieve OHI in MassHealth ACOs. Stay tuned for more updates as this important health initiative evolves.

Dr. Neetu Singh is an advisor to the MMS Committee on Oral Health, and Dr. Hugh Silk is chair of the MMS Committee on Oral Health. UMass Medical School’s medical and nursing students on the Oral Health Population Health Clerkship assisted with this article.
State Focuses on Improving Health, Lowering Costs through Nutrition Interventions

BY KRISTIN SUKYS, POLICY ANALYST, HARVARD LAW SCHOOL’S CENTER FOR HEALTH LAW & POLICY INNOVATION

Lack of reliable access to nutritious food is a key driver of poor health outcomes, health care utilization, and costs. Food insecurity costs Massachusetts $1.9 billion in avoidable medical expenses each year. Research has shown that Food is Medicine (FIM) interventions, such as medically tailored meals and produce prescriptions, can address the nutritional needs of individuals coping with or at risk for diet-related chronic illnesses, resulting in improved health outcomes and lower health care costs. However, access to FIM interventions remains limited.

Over the past two years, the Massachusetts Food is Medicine State Plan, an initiative of Community Servings and Harvard Law School’s Center for Health Law and Policy Innovation, has brought together stakeholders from across the state to develop a blueprint for scaling access to FIM services. The state plan evaluates the need for, access to, and barriers associated with FIM across the Commonwealth. Using data from surveys, listening sessions, consumer interviews, and geographic information system mapping, the plan outlines 15 policy recommendations spanning five areas: provider knowledge and screening; patient referral and connection; high-quality, appropriate services available in the community; sustainable funding for Food is Medicine interventions; and leadership engagement and system transformation.

Recognizing the role that physicians and other clinicians play in identifying and responding to food insecurity among their patients, the state plan offers several recommendations, including the creation of a provider nutrition education and referral task force. The task force, which will be co-chaired by the Massachusetts Medical Society, will be charged with working to improve physician and clinician nutrition knowledge by creating nutrition-oriented continuing education modules and supporting ongoing efforts to strengthen the role of nutrition in curricula and licensing exams.

Addressing SDOH continued from page 1

The Physician’s Role

But is assessing patients’ SDOH really the physician’s role? Many physicians find themselves already overburdened, unable to spend as much time with patients as they would like and lacking the resources to identify, let alone address, these social challenges. In reality, many physicians are already trying to address SDOH with patients, finding alternate solutions, for example, when patients cannot afford their medications or have no transportation to fill a prescription.

Resources are ramping up across the state to support patients. Boston Medical Center has committed $6.5 million to initiatives to help patients find and maintain affordable housing. Physician organizations like Atrius Health employ care facilitators and community health workers to link patients to social services. Hospitals, the state, and community organizations are providing web- and app-based tools to help patients and providers find community resources to address non-medical needs.

Advocating for Social Policy Solutions

However, these health care system-based tools don’t solve the larger problems. In a January Health Affairs blog, Brian Castrucci of the de Beaumont Foundation and John Auerbach of Trust for America’s Health wrote that while “health providers’ efforts to meet individuals’ nonmedical needs are praiseworthy and potentially life-saving,” policy changes that get at the root causes are needed. “Health care navigators and similar enhancements to health care can’t actually change the availability of resources in the community. They can’t raise the minimum wage, increase the availability of paid sick leave, or improve the quality of our educational system. These are the systemic changes that are necessary to truly address the root causes of poor health.”

Physicians can play an important role in helping to effect systemic change, according to Dr. Bombaugh. “I view advocacy as a form of patient care. These social determinants have a profound effect on health, so addressing them is in our lane. We have a voice, we can influence decisions, we can make change happen through advocacy. We can offer the medical expertise regarding the effects of these social determinants of health.”

She added, “How do we accomplish the most we can? We do that by taking a holistic view of what it means to have health, to have well-being. Clinical care is important, but if we want to truly impact the health and well-being of patients, we need to consider everything that may be affecting them.”

Expert Resources for Physicians

Five premium articles and expert resources to keep you at the forefront of your profession.

1. The New England Journal of Medicine Notable Articles of 2018
3. Ethical Dilemmas: Terminating a Patient-Physician Relationship
4. Guide to Telemedicine for the Physician Practice
5. A Crisis in Health Care: A Call to Action on Physician Burnout

To learn more visit massmed.org/topresources.
MassHealth ACOs
continued from page 1

Health-Related Social Needs
As part of their MassHealth contracts, ACOs must query patients about those needs — called health-related social needs in MassHealth parlance — that could have a profound impact on their health, including housing, nutrition, safety and security, and transportation. "You can’t address issues from a cost, quality, and care standpoint for our most complex members without addressing gaps in their behavioral health care and health-related social needs," explains Tsai. "We’re hearing anecdotally that the ACOs are uncovering a lot of unmet needs and that’s exciting and terrifying. Now they have to figure out how to meet those needs." ACOs are already collaborating with community partners — including addiction treatment programs, elder services, and housing organizations — to address their patients’ challenges.

MassHealth applied for and received an infusion of $1.8 billion in federal funds, called Delivery System Reform Incentive Payments (DSRIP), to support its redesign to an ACO-centered system. Beginning in 2020, MassHealth ACOs will be eligible to use some of that money to assist patients with their housing and nutritional needs.

Vital Signs recently sat down with Sarika Aggarwal, MD, former chief medical officer of Beth Israel Deaconess Care Organization (BIDCO). BIDCO, recently renamed Beth Israel Lahey Performance Network, created an ACO plan called Tufts Health Together with BIDCO — one of the state’s 17 MassHealth ACOs. We asked Dr. Aggarwal about how Tufts Health Together with BIDCO will use its DSRIP funds as well as other aspects of creating an ACO that addresses patients’ social determinants of health.

VS Can you tell us a little about the Tufts Health Together with BIDCO ACO?

Aggarwal Tufts Health Together with BIDCO is a partnership plan in which the ACO providers and hospitals work together to provide an integrated multidisciplinary approach to the care of MassHealth members. Our strategy is to leverage existing infrastructure and use Delivery System Reform Incentive Payments to make targeted investments to improve health outcomes and bend the cost of care curve for this population. Our investment priorities included four main categories: care management and population health management resources and services, information technology and workforce development, integration of behavioral health and social determinants of health into primary care, and the development and integration of data and analytic reporting functionality across the payer and provider systems. Like the other MassHealth ACOs, we’ve been up and running since March 1, 2018. Our membership numbers fluctuate, but we generally care for between 35,000 and 38,000 people.

VS MassHealth ACOs are required to screen patients for their health-related social needs. Which tool are you using to gather the data and how are you doing it?

Aggarwal Tufts Health Together with BIDCO is required to screen patients for social determinants of health as a quality metric. We are also committed to screening based on our belief in the whole person care model as well as the increasing body of evidence showing the impact of social determinants on health outcomes. Our health plan partner began offering screening to the ACO members at the start of the program. In order to improve screening and referral, it was important that this was incorporated into the practice workflow.

As part of our DSRIP strategy, we implemented the electronic medical record (EMR) build of the PRAPARE (Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences), a state-validated screening tool. This tool was chosen because it used national and regional core measures, it was informed by research, and PRAPARE templates existed for several of the BIDCO EMRs. BIDCO primary care physicians use six different EMRs, and this number increases significantly when you include multiple versions as well as our specialists’ EMRs. Since PRAPARE EMR templates already existed for two of our three main primary care EMRs, our strategy was to use this tool to automate the screening and build the training and referral processes in the primary care practices in the initial phase, while incorporating screening at other sites in subsequent years.

Part of the automation was to ensure this structured data was incorporated into our data warehouse, which already integrated claims and clinical data, in order to enhance future risk stratification models for our clinical programs.

Our EMR build started in 2018 and we began the first pilot at our South Cove Community Health Center, which has multiple sites in and around Boston. About 99 percent of the Massachusetts population there is Asian. The tool was translated into traditional Chinese and the center began the screening and referral process manually, inputting the information into the EMR tool. Subsequently, we began other pilots and have started disseminating the training to other primary care sites using lessons learned from our pilot sites.

VS What does the tool ask about?

Aggarwal The original tool has several national core measures, including questions on race, language, ethnicity, education, employment, housing and food stability, transportation, social supports, and safety. It also includes optional measures such as incarceration and refugee status. The tool included all the MassHealth key focus areas.

VS Have there been any implementation challenges?

Aggarwal A major initial challenge was staffs’ hesitation to ask certain questions as well as patients’ reluctance to answer them — about things such as refugee and incarceration status. Other challenges included the length of the original PRAPARE tool and some practice sites’ difficulty making referrals because of lack of knowledge or time. This was a challenge particularly for smaller practices. We also found that not all the patients accepted an action plan by the practice if a need was determined.

To respond to some of these challenges, we decided to focus on questions in the PRAPARE that aligned with the key areas determined by MassHealth. Our workaround included re-training the practices to ask only those questions that we determined were the MassHealth focus domains. We also incorporated a patient question at the end of the tool allowing the patient to determine whether he or she needed help with any of the areas determined as a need. In addition to screening education for all practice staff, we have built community resource directories and training programs and expanded existing resources to meet patient referral needs.

VS Can you tell us about Tufts Health Together with BIDCO’s plans for the DSRIP funds?

Aggarwal MassHealth has begun to give us guidelines on the flexible service DSRIP program starting in 2020. This program will fund solutions to food and housing insecurity in high-risk patients. Along with our health plan partner, we have begun the process of analyzing our patient cost, utilization, disease co-morbidity, and social determinant of health data to figure out where we will have maximum impact, which cohort of patients will be eligible, and which programs on housing and food insecurity will best serve our patients’ needs. We are having discussions with community service organizations as well as our community partners to build our strategy around these funds.

Potentially we are looking at patients in the community partner program who are high utilizers and have concomitant chronic medical and behavioral diseases such as diabetes, asthma, COPD, and bipolar disorder as our cohort for this program. Our plan is to implement disease management education in addition to serving the patients’ food and housing needs. We have also planned in-house training to address gaps in these areas for all our clinical and non-clinical staff.

VS What is your vision of success for Tufts Health Together with BIDCO?

Aggarwal Our vision is to create communities of care across BIDCO where the providers, health plan, and community partners work collaboratively to improve access, communication, data integration, coordination of processes and resources, and integration of medical, behavioral, and social care to improve patient health outcomes.
District News and Events

NORTHEAST REGION

MIDDLESEX — Legislative Breakfast. Fri., May 17, 7:30–9:00 a.m. Mount Auburn Hospital, Cambridge.

MIDDLESEX CENTRAL — Executive Committee/Delegates Meeting. Thurs., May 16, 7:45 a.m. Emerson Hospital, Concord. Executive Committee/Delegates Meeting. Thurs., June 20, 7:45 a.m. Emerson Hospital, Concord.

NORFOLK/SUFFOLK — Legislative Breakfast. Fri., June 14, 7:30 a.m. Faulkner Hospital, 1153 Centre Street, Boston (Mary Ann Tynan Conference Room 1 & 2). Contact Michele Jussaume or Linda Howard at (800) 944-5562 or mjussaume@mms.org or lhoward@mms.org.

SOUTHEAST REGION

BARNSTABLE — Legislative Breakfast. Fri., June 7, 7:30–9:00 a.m. Falmouth Hospital, Falmouth. Contact Sheila Kozlowski at (800) 322-3301 or skozlowski@mms.org.

WEST CENTRAL REGION

WORCESTER — Meet the Author Series. Thurs., May 16, 5:30 p.m. UMass Medical School, Worcester. Author: Ronald Epstein, MD, professor of family medicine, University of Rochester School of Medicine and Dentistry. Author of Attending: Medicine, Mindfulness, and Humanity. Co-sponsored by WDMS and Humanities in Medicine Committee of the Lamar Soutter Library, UMass 225th Anniversary Gala. Fri., Sept. 27, 5:30 p.m. Beechwood Hotel, Worcester. For more information, contact WDMS at (508) 753-1579.

WORCESTER NORTH — Executive Committee Meeting. Wed., June 5, 6:00 p.m. The 1761 Old Mill, Westminster. Contact Cathy Salas, West Central Regional Office at (800) 522-3112 or csalas@mms.org.

In Memoriam

We also note member deaths on the MMS website at massmed.org/memoriam.

Russell S. Boles Jr., MD, 96; Osterville, MA; Columbia University College of Physicians and Surgeons, New York; died February 4, 2019.

William J. Daly, MD, 79; Falmouth, MA; New York Medical College, Valhalla; died November 19, 2015.

Paul M. Epstein, MD, 70; East Falmouth, MA; George Washington University School of Medicine, Washington, DC; died December 9, 2017.

Manfred M. Ernesti, MD, 89; Milton, MA; University of Buenos Aires Faculty of Medicine, Argentina; died March 17, 2019.

Gilbert H. Friedell, MD, 91; Charleston, SC; University of Minnesota Medical School, Minneapolis; died September 23, 2018.

Herbert F. Haberman, MD, 84; Toronto, Canada; University of Toronto Faculty of Medicine, Canada; died January 1, 2019.

Harold E. Harris Jr., MD, 80; South Hadley, MA; Northwestern University School of Medicine, Evanston; died February 19, 2019.

Thomas Jakobovits, MD, 92; Needham, MA; Semmelweis University, Hungary; died March 11, 2019.

Robert A. Lebow, MD, 74; Sturbridge, MA; SUNY Downstate Medical Center, Brooklyn; died March 15, 2019.

Ellen M. Maher, MD, 89; Pittsburgh, PA; National University of Ireland; died August 15, 2018.

Robert Ramsdell, MD, 93; North Hampton, NH; Tufts University School of Medicine, Boston; died January 20, 2019.

James A. Robinson, MD, 95; South Orleans, MA; University of Rochester School of Medicine; died March 11, 2010.

David R. Williams, MD, 70; Yarmouth Port, MA; College of Medicine and Dentistry of New Jersey, Newark; died October 20, 2018.

Philip A. Wood, MD, 82; Harvard, MA; Tufts University School of Medicine, Boston; died February 17, 2019.

Interested in Learning More about Social Determinants of Health (SDOH)?

Social Determinants of Health: Improving Population Health through Prevention-Based Care is a four-module online CME course offered by the Medical Society.

Modules 1 and 2
These two modules describe how socioeconomic factors affect health and wellness, outline the correlation between US health care spending and health outcomes, and explain why caregivers must address SDOH during their clinical interactions.

Module 3
This module discusses the difference between fundamental redesign and incrementalism in health care reform and misconceptions about individuals with unmet social needs.

Module 4
This module describes the role of physicians in addressing SDOH, explains the importance of identifying unmet social needs through screening, and discusses the barriers to addressing the social determinants of health in clinical practice.

For additional information, including CME credits and registration details, call (800) 843-6356 or visit massmed.org/socialdeterminants.
Jehan Alladina, MD (Baylor College of Medicine, 2012; residency: MGH), received a first place Basic Science Research Award at the 14th Annual Respiratory Disease Young Investigators’ Forum. Dr. Alladina’s winning project, “CD141+ Dendritic Cells Distinguish Allergic Asthmatics from Allergic Controls,” studied the role of dendritic cells in allergic asthma. Dr. Alladina is a pulmonologist in the Division of Pulmonary and Critical Care Medicine at MGH.

Sameer Hirji, MD (Duke University School of Medicine, 2015; general surgery residency: Brigham and Women’s Hospital), received the J. Maxwell Chamberlain Memorial Award from the Society of Thoracic Surgeons at its 55th annual meeting. The Chamberlain award, which is given to the meeting’s top-ranked abstract, recognized Dr. Hirji’s project, “Relationship Between Hospital Surgical Aortic Valve Replacement (SAVR) Volume and Transcatheter Aortic Valve Replacement (TAVR) Outcomes.” The award was shared with Tsuyoshi Kaneko, MD, the project’s senior principal investigator and attending cardiac surgeon at Brigham and Women’s Hospital. Dr. Hirji is a resident in the department of surgery at BWH in the joint general and cardiothoracic surgery program.

Philicia Moonsamy, MD (Jefferson Medical College, 2015; residency: MGH), received the Nina Starr Braunwald Research Fellowship Award from the Society of Thoracic Surgeons and the Thoracic Surgery Foundation. The award, which is given annually to promising women surgical residents, will support Dr. Moonsamy’s work on the NEW-AF clinical trial in cardiac surgery. Dr. Moonsamy is a clinical fellow in surgery at MGH.

Motaz Qadan, MD, PhD (University of Edinburgh, 2003; residency: Stanford University Medical Center; fellowship: Memorial Sloan Kettering Cancer Center), was named the inaugural incumbent of the Gapontsev Family Endowed Chair in Surgical Oncology at MGH. The chair is responsible for advancing research, care, and education in surgical oncology. Dr. Qadan is a liver and pancreas surgeon at MGH.

John A. Renner Jr., MD (Case Western Reserve University School of Medicine, 1964; residency: Tufts New England Medical Center), was the 2019 recipient of the Massachusetts Medical Society’s Special Award for Excellence in Medical Service. The award honors a physician who has made a distinguished demonstration of compassion and dedication to the medical needs of his or her patients and the public. Dr. Renner is renowned for his treatment of adults and adolescents with substance use disorder (SUD) and his work reducing the stigma around SUD. Dr. Renner is a professor of psychiatry at Boston University School of Medicine, director of the BMC Addiction Psychiatry Residency, and associate chief of psychiatry of the VA Boston Healthcare System.

Hyun-Sik Yang, MD (Seoul National University, 2009; residency: BWH/MGH), was selected for the 2019 Robert W. Katzman, MD, Clinical Research Training Scholarship in Alzheimer’s and Dementia Research. Dr. Yang’s research seeks to reveal how genetic variants affecting immune cell function are involved in the progression of Alzheimer’s disease. The scholarship will support his project, “Immunogenetic Alzheimer’s Disease Risk and the Progression of Preclinical Alzheimer’s Disease.” Dr. Yang is an instructor in neurology at BWH.

Please send your news to vitalsigns@mms.org. Learn about MMS membership at massmed.org/benefits.

Talking to Legislators 101

Alex Calcagno, the MMS’s director of advocacy, government, and community relations, was a featured speaker at the American College of Physicians’ (ACP) Advocacy Day at the statehouse. Calcagno spoke to ACP members about effective ways to educate legislators about issues important to physicians. Brendan Abel, the Medical Society’s legal and regulatory affairs counsel, updated members on key legislative issues.
Social Determinants of Health Issue

1 Focusing on Social Determinants to Improve Health
How and why physicians are beginning to go beyond dealing solely with patients’ medical needs.

1 MassHealth ACOs Now “Treating” Social Needs
First step is assessing patients’ challenges

Also in the Issue
2 Rob Restuccia: Visionary and Advocate for Affordable Health Care for All
3 Pay Attention to the Oral Health of Your Elderly Patients
3 Accountable Care Model Encourages Integration of Oral and Medical Care

Plus
2 President’s Message: Improving Care for Our Most Vulnerable
2 Massachusetts Consultation Service for Addiction and Pain Treatment Is Free to Physicians
4 State Focuses on Improving Health, Lowering Costs through Nutrition Interventions

Inside MMS
7 Member News and Notes
7 Talking to Legislators