

# VITAL SIGNS



MASSACHUSETTS  
MEDICAL SOCIETY

Every physician matters,  
each patient counts.

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## MMS Forums Identify Challenges and Threats

BY ROBERT ISRAEL  
VITAL SIGNS EDITOR

The MMS held two fall forums that identified health challenges and threats facing Massachusetts and the nation. The topics discussed at these forums included raising awareness of the need for medication-assisted treatment for substance use disorders to combat the scourge of heroin, fentanyl, and illicit prescription drugs; controlling rising health costs; and helping providers to meet the demands of the digital age.

### Summit on Opioid Addiction

On October 31, the MMS sponsored a leadership summit on opioid addiction, *Medication Assisted Treatment: Improving Access to Evidence-Based Care*. The summit was attended by nearly 200 health care professionals at MMS Headquarters in Waltham.



Photo by Doug Bradshaw

Gathered for the Opioid Summit: MMS Past President Dennis M. Dimitri, M.D., Monica Bharel, M.D., Middlesex County Sheriff Peter Koutoujian, U.S. Senator Edward J. Markey, MMS President James S. Gessner, M.D., MMS President-Elect Henry Dorkin, M.D., MMS Vice President Alain Chaoui, M.D.

U.S. Senator Edward J. Markey said in his keynote address, “If we are going to reduce the supply for heroin, fentanyl, and illicit prescription opioids, we have to reduce the demand through treatment.”

“I will not stop fighting for legislative support on this issue,” Sen. Markey added, noting that despite his efforts and those of his colleagues, Congress has repeatedly rejected bills in support of addiction recovery programs.

He decried the rising numbers of deaths in Massachusetts due to overdoses — which doubled in just one year — and warned that due to the inundation of fentanyl from China and Mexico, “we are poised to lose even more lives.”

“Fentanyl is like a Class 5 hurricane making landfall,” Sen. Markey said. “It is the Godzilla of opioids. It is trending too quickly. It is so dangerous that first responders insist on wearing hazmat suits when they arrive at a scene of an overdose for fear they will become contaminated if exposed to it. We just don’t know how dangerous it is, and it’s coming to every street in America.”

According to Markey, combating the opioid epidemic requires “aggressive data collection, surveillance, increased prescriber and patient education, and the passage of aggressive new laws,” which would be aimed at

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## MACRA: What Physicians Need to Know

BY ALEX CALCAGNO  
MMS DIRECTOR OF ADVOCACY, GOVERNMENT, AND COMMUNITY RELATIONS

The Medicare Access and CHIP Reauthorization Act (MACRA) represents one of the biggest changes in Medicare since its inception. On October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) released the final rule to implement the law, providing many of the details for implementation. In the final rule, CMS Acting Administrator Andy Slavitt responded to a number of the concerns expressed by the physician community. This article outlines generally what physicians need to know about MACRA and includes resources for more information.

### A Need for Change

There are those who are clamoring for the Sustainable Growth Rate (SGR), the former Medicare physician payment formula. We can tell you unequivocally the SGR was an impending disaster. Anyone even remotely familiar with the SGR knew the unending saga of trying to stop burgeoning (up to 30 percent) cuts in Medicare on an annual, sometimes bi-annual basis. Over time, our ability to stop those cuts was limited.

Leaders in the physician community also believed that creating a new Medicare payment methodology would be important to give increased stability to medical practices and to better reflect the ongoing changes,

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## Trends Impacting Physicians in 2017

BY KERRY ANN HAYON  
PPRC DIRECTOR

While many more changes to health policy are forthcoming in the wake of the national election, several trends will impact physician practices in the New Year:

**1) MACRA** — The October 2016 release of the final Medicare Access and CHIP Reauthorization Act (MACRA) regulations resulted in a year-end hustle to grasp the particulars of the new law and calls for tight decision-making timelines for practices to determine what option for participation they will choose for reporting in 2017. See accompanying article and visit [www.massmed.org/MACRA](http://www.massmed.org/MACRA) for updates about emerging MACRA trends.

### 2) Opioids, Pain Management, Substance Abuse Treatment —

This year in Massachusetts, there remained an intense focus on opioids and controlled substances with the rollout of new opioid legislation and implementation of MassPAT, the state’s prescription monitoring system. Attention at both the state and national levels will continue with a focus on alternative pain management treatments, partial fill legislation, and coverage for substance abuse services. Visit [www.massmed.org/opioids](http://www.massmed.org/opioids) for updates.

**3) Rising Pharmaceutical Costs** — Health care is no stranger to the debate over rising pharmaceutical costs, and in 2016 this debate

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## PRESIDENT'S MESSAGE



### The Strength of MMS

In my last President's Message, I spoke of the importance of advocacy, noting that MMS members consider it as the principle responsibility of the organization. We must view this in context, however, and it is clear that our profession today is quite different from that of years past in many ways. Consider the following:

While independent practice remains strong, more than half of physicians are now employed. Nearly a third of today's physicians are women, a percentage likely to grow, as nearly half of medical students today are female.

Shortages of physicians exist in many specialties, and estimates are that U.S. medical school graduates won't be enough to fill the gaps. Yet international medical school graduates, desirous of practicing in the United States, face challenges in gaining requirements for licensure.

Physician leaders are also looking for ways to increase the number of African-American, Hispanic, and Native American physicians to increase diversity in medicine and reduce disparities. Today's younger physicians, perhaps recognizing the growing impact of physician burnout and stress, seek a work-life balance unknown to previous generations.

These are just some aspects of the changing nature of our profession and are reasons why advocacy is so important. The strength of the MMS depends on advocacy, and the effectiveness of our advocacy depends on the commitment of our members.

To our active members whose efforts make the MMS as strong as it is, I thank you for your willingness to help. To others, especially our younger colleagues, I encourage you to join us. Physicians may differ on selected issues, but the value of organized medicine lies in a unified voice, one representing the spectrum of our membership and advocating for physicians and patients alike.

— James S. Gessner, M.D.

## MMS Forums

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controlling the consumption of opioid drugs.

"The surgeon general's report on opioids will have a great societal impact," Sen. Markey said, "similar to when the former surgeon general years ago released the report about the health hazards of cigarette smoking. History will judge us, because now is our opportunity to respond to the greatest public health crisis in the 21st century." (U.S. Surgeon General Vivek Murthy, M.D., released the report on alcohol, drugs, and health on November 17).

Massachusetts Public Health Commissioner Monica Bharel, M.D., Middlesex County Sheriff Peter J. Koutoujian, and other speakers called for an effort to destigmatize those who struggle with substance abuse.

"Treatment works, recovery is possible," Koutoujian said, citing treatment programs sponsored by the Bay State's criminal justice system that are preparing inmates to return to society after incarceration better able to control their drug habits.

Dr. Bharel reminded the capacity audience to commit to viewing substance abuse addiction through the lens of the #StateWithoutStigMA campaign, launched last year by Governor Charlie Baker's Opioid Working Group, which aims to eradicate the negative stereotype of drug misuse by declaring it to be a treatable illness.

The MMS gathered more than a dozen national and local experts on the topic for this summit to speak on treatment of addiction as a disease, the importance of psychological treatment and behavioral support, models of care, and supporting physicians

and providers in treating opioid use disorders. Hosted by MMS President James S. Gessner, M.D., it was moderated by Dennis M. Dimitri, M.D., immediate past president and chair of the MMS Task Force on Opioid Therapy and Physician Communication.

Presentations at the Summit on Opioid Addiction can be viewed at [www.massmed.org/MAT2016Pres](http://www.massmed.org/MAT2016Pres).

### State of the State's Health Forum

At the MMS 17th annual State of the State's Health Care Leadership Forum on October 19, Ray Campbell, executive director of the Massachusetts Center for Health Information and Analysis



Ray Campbell

(CHIA), reported that unlike the rest of the nation, Massachusetts remains a "bright spot" that has not veered from its commitment to perpetuating state-funded health care programs for all citizens.

"We have bipartisan support for health care in Massachusetts that transcends party lines," Campbell remarked. "There has been no talk during this election year of a repeal or replacement of Massachusetts' health care reform."

Yet these health programs come at an increasingly high cost, Campbell noted. Current state-level discussions are exploring how to rein in costs since 2016 saw a 4.1 percent increase in spending, exceeding 2015's benchmarks.

"We are exploring ways we can do a better job to use data we collect to shed light on spending here, so we ultimately institute statewide cost-savings to better control it," Campbell reported.

Kate Walsh, president and CEO at Boston Medical Center (BMC), remarked that since Massachusetts mandated health coverage for all citizens in 2006, BMC has had to adjust to the



Kate Walsh

strain of patients seeking health services. "We've invested in a rigorous quality improvement agenda," she reported, adding that BMC continually tailors programs to better respond to patients' needs. She pointed to efforts to treat opioid use and abuse — last month BMC launched its Opioid Urgent Care Center — as illustrative of how the hospital is striving to be "part of the solution... because our patients deserve it." Walsh concluded, "We're working hard to remove barriers and to empower patients to take firmer control of their health."

Michael Dowling, president and chief executive officer of Northwell Health, a conglomerate of 21 hospitals and over 450 patient facilities and physician practices in New York and New Jersey, echoed this theme of empowerment, urging attendees to define it as a movement not just for patients but also for providers. "We must ask ourselves what skills, specifically in technology, we will need in the next 5 to 10 years," he said, "since our world is always changing, and health care is in a transformative stage."



Michael Dowling

Presentations of the State of the State's Health Care Leadership Forum can be viewed at [www.massmed.org/SOS2016Pres](http://www.massmed.org/SOS2016Pres).

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# Nondiscrimination in Health Programs and Activities of Affordable Care Act

BY WILLIAM FRANK  
MMS ASSOCIATE COUNSEL

In May, the Department of Health and Human Services (HHS) and the Office of Civil Rights (OCR) issued its final rule implementing Section 1557 of the Affordable Care Act (ACA). This law prohibits any health care provider who receives funding from the federal government from refusing to treat — or otherwise discriminate against — an individual based on race, color, national origin, age, disability, and sex. The rule, which went into effect July 18, 2016, builds on long-standing and familiar federal civil rights laws. It also contains new provisions.

Section 1557 is the first civil rights law to prohibit discrimination on the basis of sex in all health care programs and activities, explicitly extending the protections of Title IX which only apply to educational programs

concerning health care. It requires covered entities to provide equal access to health care programs for individuals regardless of gender. These include pregnancy, false pregnancy, termination of pregnancy, recovering from childbirth, or related medical conditions. Moreover, the final rule extends the definition of *sex discrimination* to include discrimination based on sexual orientation and gender identity.

Although this area of law is evolving, the OCR has provided examples of when a provider's behavior would constitute discrimination on the basis of sex or gender identity. For instance, a provider's persistent and intentional refusal to use a transgender individual's preferred name and pronoun and insistence on using those corresponding to the individual's sex assigned at birth constitutes illegal sex discrimination if such conduct is sufficiently

serious to create a hostile environment. Similarly, a provider using derogatory language against unmarried individuals who are sexually active or pregnant constitutes illegal sex-based harassment, if such conduct is sufficiently serious to create a hostile environment.

In addition, Section 1557 creates a new focus on national origin discrimination by highlighting the language barriers that individuals with limited English proficiency may face. Under the law, providers must take steps to give these individuals meaningful access to health care. These steps include offering those in need of language assistance written translations and interpreter services when requested.

In furtherance of its purpose, the law requires physicians to comply with several administrative requirements. These include the following: posting a notice of

nondiscrimination and taglines in multiple languages, developing and implementing a language access plan, and, for group practices with 15 or more employees, designating a compliance coordinator and adopting grievance procedures.

Physicians should note that violations of this law may result in administrative enforcement actions that could result in a loss of federal financial assistance, as well the potential for aggrieved individuals to bring individual or class action violation claims directly against physicians in federal court.

For additional information on compliance with Section 1557 of the ACA, the OCR has published a summary of the rule, fact sheets on key provisions, frequently asked questions, and sample notices and taglines (translated into 64 languages) on its website: [www.hhs.gov/civil-rights/for-individuals/section-1557](http://www.hhs.gov/civil-rights/for-individuals/section-1557).

## Trends Impacting Physicians

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heated up, as exemplified by the EpiPen cost increase. Physician concern over increased prior authorization requirements for medications and over other mechanisms for control of rising drug costs are expected to intensify in 2017.

### 4) Physician Wellness and

**Burnout** — Discussions on physician burnout and staff wellness gained increased attention in 2016. New administrative requirements in a rapidly changing environment require physicians to be attentive to processes and areas of business not inherent to their training. These tasks serve as system stressors, which may result in non-patient care career changes or early retirement. Data suggest we have an aging physician workforce and a shortage of physicians to meet the impending demand of retiring baby boomers. The MMS and its affiliate Physician Health Services is focused on providing resources and services to aid in promoting wellness and reducing burnout. PPRC is hosting a webinar on physician

burnout on January 25, 2017. Visit [www.massmed.org/PPRC](http://www.massmed.org/PPRC) for information.

**5) Technology** — In 2017, physician practices will be impacted by technological advancements. Telemedicine, in particular, has experienced increased interest as a result of the adoption of payment policies for telemedicine services by a few local health plans. As a result, many practices are exploring how to incorporate telemedicine into their care models. It is anticipated that next year, more practices will pilot telemedicine technology or work toward enhanced care models of integration for telemedicine technologies, while others will explore where and how it may fit in to their practices.

As telemedicine visits increase, the need for accurate, valid, and real-time reporting of patient vitals and other clinical statistics will increase, as well. There are wearable devices and remote diagnostic devices under development that may provide another level of clinical surveillance for physicians. Integrating the information into EMR and care pathways is not without challenges.

The overall desire to improve diagnostic capabilities for patients who may have difficulty getting to the office may add value and augment care for the chronically ill by assisting with early detection of potential issues or by providing more accurately

captured trends on a patient's health. Physicians considering integrating telemedicine into their practices should refer to PPRC's *A Guide to Telemedicine for the Physician Practice* at [www.massmed.org/telemedguide](http://www.massmed.org/telemedguide).

## Running on Empty? Physicians' Path to Enjoying Life and Medicine More

January 25, 2017  
Noon–1:00 p.m.

Featured Speaker:  
Nance Goldstein, PhD, ACC



Register at: [www.massmed.org/phyburnout](http://www.massmed.org/phyburnout)

# MMS Sponsors Symposium on Climate Change, Nuclear War

BY ROBYN ALIE  
HEALTH POLICY AND PUBLIC HEALTH  
MANAGER

On October 15, a legally binding deal signed by more than 170 nations to combat climate change was announced. Under the Kigali Amendment, named after the Rwandan capital where the meeting took place, the countries will phase out hydrofluorocarbons, or HFCs. These chemical coolants used in air conditioners and refrigerators have 1,000 times the heat-trapping potency of carbon dioxide. The move has been praised as the single biggest step to date toward keeping global warming below two degrees Celsius, which was a key commitment of the Paris climate accord.

This news opened the symposium "Climate Change and the Growing Risk of Nuclear War," convened by the Greater Boston Physicians for Social Responsibility and sponsored by the MMS and 10 other groups, including the Boston-area medical schools and schools of public health, among others.

The symposium addressed the public health effects that result from climate change and its role in increasing the potential for nuclear war.

Renowned faculty, including Barry Levy, M.D., of Tufts Medical



Photo by Derek Fawles

Ira Helfand, M.D. (left), co-president, International Physicians for the Prevention of Nuclear War, and Zia Mian, Ph.D., co-director of the Program on Science and Global Security at Princeton University, spoke at the MMS-sponsored October 15 symposium, "Climate Change and the Growing Risk of Nuclear War: A Health Care Perspective."

School; Jennifer Leaning, M.D., of Harvard Medical School; and Susan Solomon, Ph.D., of the Massachusetts Institute of Technology, described the effects of climate change in recent years, noting that 2016 is on track to be the hottest year on record, and global temperatures are expected to increase between one to three degrees by 2100. These warming temperatures and melting ice caps will continue to lead to a rise in the sea level — an average of eight inches in the past 100 years — far more than in the previous two millennia.

The rising sea level will affect the eastern seaboard of the United States, yet coastal areas, including Boston, have plans and resources to adapt to many of these changes. However, many countries, like Tuvalu or Vanuatu (island nations in the South Pacific) and Bangladesh, lack resources and infrastructure and therefore face more dire consequences.

Other effects of climate change include

storm surges, erosion, contamination of aquifers, and drought, leading to food and water instability. These will result in increases in poverty, heat-related disorders, respiratory and allergic disorders, infectious diseases, injuries from weather-related events, mental health problems, and violence.

Zia Mian, Ph.D., codirector of the Program on Science and Global Security at Princeton University, described the very real potential for nuclear conflict over scarce resources with the case of Pakistan and India, neighboring countries with nuclear weapons and a history of disputes. In September, India threatened to dam or divert a major river the two countries share; Pakistan threatened a nuclear response. The impact of even a limited nuclear attack in South Asia would be felt around the world, explained Ira Helfand, M.D., co-president, International Physicians for the Prevention of Nuclear War.



Barry Levy, M.D., and Jennifer Leaning, M.D., discussing the global health and environmental effects of climate change.

## MMS and Alliance Charitable Foundation Announces Health Studies Awards

Health Studies Awards, made by the MMS and Alliance Charitable Foundation, provide grants to residents and medical students studying abroad. Each recipient receives between \$1,000 to \$2,000 to offset travel and lodging expenses. Over the past 16 years, 85 individuals have received awards. Here are this year's recipients:

**Wenqi Feng**, a fourth-year student at Boston University School of Medicine, will assist at hospitals and clinics in Riobamba, Ecuador, performing checkups at local schools and for patients who lack access to physicians.

**Elena Hill**, a fourth-year student at Tufts Medical School, will spend one month at the Christian

Medical Center in Vellore, India, assisting an underserved population at both inpatient care and outpatient primary care facilities.

**Joseph Kahan**, a fourth-year student at Tufts Medical School, will provide assistance at the Albert Schweitzer Hospital in Haiti, assisting with home visits with community health workers and participating in a pilot project to improve surgical care for rural Haitian patients.

**Wilfredo Matia**, a fourth-year student at Harvard Medical School, will spend one month at the Centro de Salud Barbara, a rural outpatient urgent care clinic three hours from Guatemala City that provides programs and educational initiatives for women.

**Leah Wibecan**, a fourth-year student at Harvard Medical School, will work at a hospital in Buenos Aires, Argentina, specializing in neurological disorders.

**Tejumola Adegoke, MD**, a third-year OB/GYN resident at Boston Medical Center, will provide assistance at the Scottish Livingstone Hospital in the Kweneng district of Botswana with a full spectrum of OB/GYN care.

**Daniela Buscariollo, MD**, a fifth-year resident in the Harvard Radiation Oncology Residency Program, will work at Gaborone Private Hospital in Botswana with patients receiving radiation.

**Chelsea McGuire, MD**, a second-year resident in the Boston University

Family Medicine Residency Program, will assist in Africa at the Motebang Hospital in Lesotho. Lesotho Boston Health Alliance is a program between Boston University and Lesotho's Ministry of Health.

**Altaf Saadi, MD**, a fourth-year resident in Partners Neurology Residency Program, will provide assistance in inpatient and outpatient settings at Tanzania's Muhimbili National Hospital.

**Diane Smith, MD**, a second-year resident in the Lawrence Family Medicine Residency Program, will assist at Baptist Medical Center, an African District Health Hospital in Northern Ghana.

**MACRA**

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including the focus on measuring quality and value, and the formation of medical homes, accountable care organizations, and other delivery models.

To that end, the AMA convened a national working group of state and national medical organizations, of which the MMS was a member, charged with creating principles that could guide the development of the new law. These included the following:

1) retain fee for service, 2) physician input and choice in the new program, and 3) creation of a transitional payment methodology that would gradually allow practices to transition to risk, if they so choose, while recognizing those that have already achieved high-quality care while managing costs. These principles were supported by most of the national and state medical groups, many of which are embedded in MACRA.

**MACRA — The Big Picture**

The essence of MACRA is the new Quality Payment Program (QPP), which sets up two payment pathways for physicians and other health care providers. One pathway, the Merit-Based Incentive Payment System (MIPS), creates an enhanced fee-for-service model.

Under MIPS, physicians will receive a MIPS composite score, which is based on their work in four categories: quality, improvement, advancing care information, and cost. Several of the metrics are specialty- and

subspecialty-specific. MIPS reimbursement is based on a physician’s fee for service, multiplied times the conversion factor, times the MIPS composite score. This determines whether the physician will be eligible for a bonus payment or penalty. In 2019, the bonus or penalty will be up to or down to 4 percent. The bonus funds are budget-neutral, meaning they must balance out. There is an additional fund for those who excel; these physicians can receive an additional 10 percent.

The other payment pathway is called advanced payment models (APMs). These groups manage risk of varying degrees. There are different kinds of APMs. Whether a group qualifies as an APM or an advanced APM depends on the amount of financial risk they take, as well as other criteria including EMR utilization and MIPS-type metrics. Those who are in advanced APMs automatically get a 5 percent bonus. Those who perform well above the benchmark are also eligible for an additional bonus.

Three categories of providers are exempted from the MIPS reporting program: 1) providers receiving \$30,000 annually or less in allowable billed Medicare charges or if they treat 100 Medicare patients or less in one year, 2) physicians in their first year of the Part B program, and 3) providers who qualify for the advanced APM. Physicians in the first two exempted categories will be paid on a straight fee-for-service formula.

There are special provisions and protections for small practices, generally defined at 15 and fewer

clinicians, and for “non-patient facing providers” (e.g., anesthesiologists, radiologists, pathologists), and for medical homes. CMS is also working on options for physician-led groups as well as “virtual practices.”

In the final rule, which defines a number of the details of implementation, CMS builds in more flexibility, time, and options for physicians to participate in the new programs. For some practices that have successfully reported metrics in the past or have managed risk and/or are part of the networks or systems with staff, the expectation is that the new law will be less of a challenge. For those practices that have never successfully reported or who do not use an EMR, the new law will be more difficult.

Those who want to find out more about the new law have two options: 1) The MMS has prepared a one-hour presentation that will give you and your staff a general overview of the law, timelines, and requirements, contact Lori DiChiara at [ldichiara@mms.org](mailto:ldichiara@mms.org), for information, and 2) for more personalized help, contact the Physician Practice Resource Center at [pprc@massmed.org](mailto:pprc@massmed.org).

The MMS, as a member of the national team that helped develop and pass the new Medicare law, will continue to help you navigate the new program and choose the best course for you and your patients.

**MACRA Timeline**

While 2017 is a transition year, choices made then will affect your payments in 2019. During this time, CMS also needs to

collect information on your practice to check attribution and allow time for changes. The “Pick your Pace” program is designed to enroll physicians in the program while minimizing penalties for those who were new to reporting quality and other metrics. All physicians in Medicare will receive an annual 0.5 percent update in 2016 through 2019.

Five choices as of January 1, 2017, include the following:

**1) Perform a Test:** You can submit as little as one quality measure, or one clinical improvement activity on one patient, for CMS to test their system. You will not be eligible for any bonus payments in 2019, but you will not be cut.

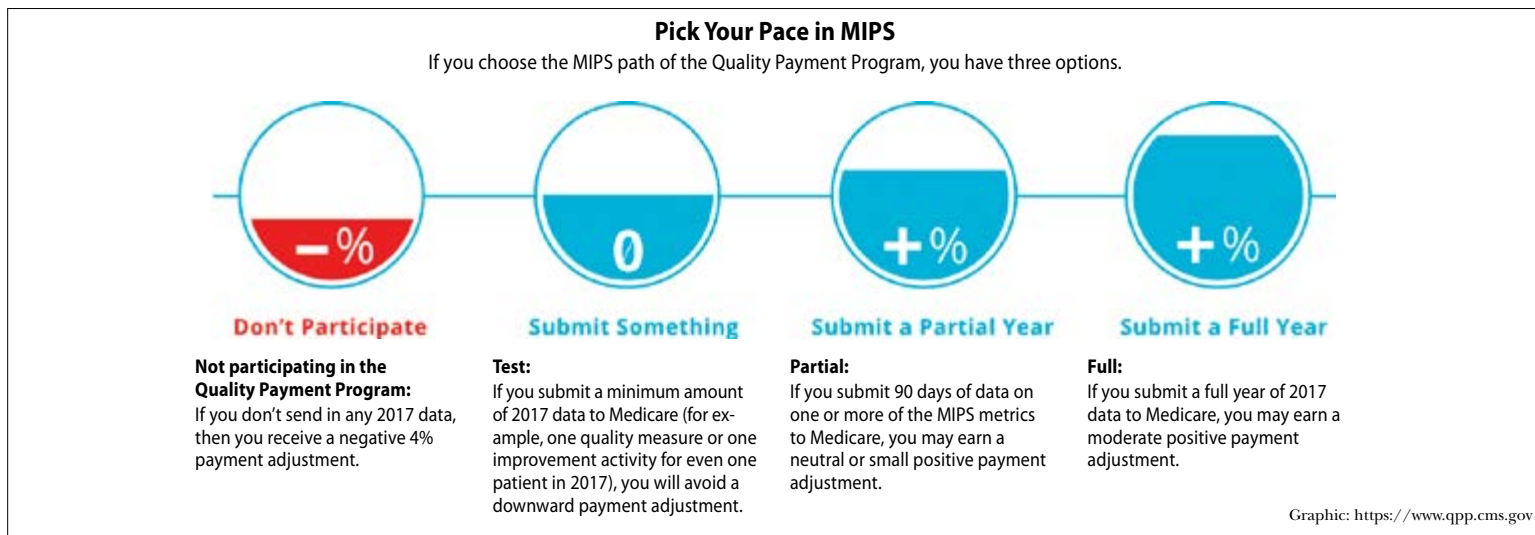
**2) Partial Participation:** You can choose to report on one or several of the MIPS metrics for at least 90 days. You will not be cut and might be eligible for a small bonus update.

**3) Report for the Full Year:** You can report on all the MIPS measurements that will be required. You will be eligible for up to a 4 percent bonus payment in 2019.

**4) Qualify as an Advanced APM:** You don’t need to worry about MIPS. You will receive 5 percent update in 2019. (If you don’t know what this is, you mostly likely aren’t one.)

**5) Do nothing:** You will be cut 4 percent in 2019. The amount of this penalty increases each year. Unless you are exempt you will be cut 4 percent in 2019.

For more information, visit [www.massmed.org/MACRA](http://www.massmed.org/MACRA) or [www.ama-assn.org](http://www.ama-assn.org), or <https://www.qpp.cms.gov>.



PHYSICIAN HEALTH MATTERS

# Restoring the Doctor-Patient Relationship

BY STEVE ADELMAN, M.D.  
PHS DIRECTOR

The contours of the physician burn-out crisis are becoming clearer. In early September, Dr. Christine Sinsky and colleagues reported on the results of a time study in the *Annals of Internal Medicine*. Reading the study, I experienced déjà vu: I once conducted a similar study in a factory in Philadelphia the summer before I started medical school, following assembly line workers with a stopwatch to document how they spent their time. Sinsky and her colleagues clocked the activities of 60 physicians in 16 practices during the course of 430 hours of office practice. It is telling that we are applying to the medical field research techniques practiced in the manufacturing industry.

Attention must be paid to Dr. Sinsky's results: She and her colleagues discovered that during office hours, doctors spent 27 percent of their time with patients. Thirty-seven percent of the time was devoted to electronic health records (EHRs) and desk activity, as opposed to time actively interacting with the patient. When the patient was not in the room, two-thirds of physician's time was spent

on additional EHR activity and desk work. Outside of office hours, the doctors studied spent an additional 1.5 hours per day on EHR and related administrative tasks.

## Strengthening Doctor-Patient Relationship

Let's put the findings in a historical context:

When most of us were in training, the doctor-patient relationship was at the heart of medical practice. Subsidiary administrative activities like record-keeping were a peripheral sideshow. This ratio has since flipped: Electronic record-keeping and other administrative activities have crowded out time spent interacting with patients. In many practice situations, the doctor-patient encounter is now the sideshow. Little wonder that Dr. Colin P. West *et al.*, who performed a comprehensive meta-analysis of "Interventions to prevent and reduce burnout" (published in *The Lancet*), commented that "physician burnout... has reached epidemic levels." It seems clear that the emotional exhaustion, depersonalization, and reduction of personal accomplishment that characterize burnout thrive in the

atmosphere of industrialized administrative tedium that Dr. Sinsky's time study documented.

Dr. West and his colleagues reviewed nearly 3,000 studies on burnout and summarized what they learned from the 52 best studies. Fifteen of them were randomized trials; 37 were cohort studies. They found that interventional strategies that focused on the individual physician reduced burnout. Effective approaches included mindfulness training, stress management training, and small group discussions ("misery loves company"). Although the data for organizational interventions did not include randomized trials, the reviewed cohort studies suggested that duty hour reductions and local clinical process improvement initiatives both reduced burnout. Overall, their review suggested that burnout countermeasures had the potential to move the 2014 overall burnout rate of 54 percent back to the 2011 rate of 44 percent. None of the reviewed studies looked at a combination of individual and organizational interventions, and there were no data on the sustainability of demonstrated improvements. Recently, Dr. Harris

Berman and I surveyed the attitudes of some 450 practicing physicians, medical leaders, and health care executives. We presented our findings at the International Conference on Physician Health. We asked physicians to consider a number of system-level approaches to diminish burnout and enhance joy in practice. Of the eight approaches considered, respondents selected the following as the most important and implementable: "improving and upgrading electronic health record and related technologies to enhance the care experience of patients and their clinicians."

## Preventing Physician Burnout

In order to restore satisfaction in the practice of medicine again, the various stakeholders should prioritize doing everything possible to prevent burnout, to restore the doctor-patient relationship, and to get the current EHR monkeys off the backs of practicing physicians. Revolutionizing electronic medical records to enhance the experience of physicians and other team members so we can put priorities back to where they belong should not be rocket science — let's do it!

Save the Date! 2017 Annual Meeting • April 27–29, 2017 • Seaport Hotel and World Trade Center, Boston

## THE WINDING ROAD OF ADDICTION

### HOPE ON THE HORIZON

#### Thursday, April 27

- House of Delegates Opening Session
- Reference Committee Hearings
- MMS Awards Luncheon
- Ethics Forum
- International Medical Graduates Annual Reception
- President's Reception and Nancy N. Caron Annual Art Exhibit and MMS and Alliance Charitable Foundation Auction

#### Friday, April 28

- Annual Education Program
- Shattuck Luncheon and Lecture
- Presidential Inauguration and Awards Reception and Dinner

#### Saturday, April 29

- House of Delegates Second Session
- Alliance Annual Meeting, Brunch, and Program
- Annual Meeting of the Society Luncheon



MASSACHUSETTS  
MEDICAL SOCIETY

ANNUAL MEETING

Online registration  
opens in mid-February

## Legal Advisory Plan: Peace of Mind for Practices

When the Board of Registration in Medicine (BRM) issues a notification of a complaint or investigation, it can be challenging. While many BRM notifications are resolved with an attorney's letter prior to formal proceedings, hiring an attorney is costly, especially if the initial response does not resolve the issue. The MMS Legal Advisory Plan (LAP) is a members-only, low-cost legal service, designed to effectively respond to BRM issues to the point of formal proceedings. The LAP's counsel is experienced

with BRM procedures and can assist physicians to avoid pitfalls. Attorney representation will also be provided in the event a physician is requested to appear at a BRM conference.

The LAP offers discounts to groups of five or more enrolled MMS physicians. More members are taking advantage of the group LAP membership as a valuable addition to a group's benefit portfolio or to ensure that the licenses of the physicians within the practice are safeguarded with the benefit of legal counsel. To learn more, visit [www.massmed.org/lap](http://www.massmed.org/lap).

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### ACROSS THE COMMONWEALTH

#### District News and Events

##### NORTHEAST REGION

**Charles River — Winter/Scientific Meeting.** Wed., Jan. 25, 6:00 p.m. Location: Wellesley Country Club, Wellesley Hills. Guest Speaker: Joseph Loscalzo, M.D., Ph.D. Topic: The Challenge of Genetic Diagnosis in the Genomic Era.

**Essex North — Membership Jazz Brunch.** Sun., Jan. 29, 11:00 a.m. Location: North Andover Country Club, Andover.

**Essex South — Membership Meeting.** Tues., Jan. 17, 6:00 p.m. Location: Spinelli's Function Facility, Peabody. Speaker: Alex Calcagno, Director, Federal Relations, Massachusetts Medical Society. Topic: MACRA. This activity meets the criteria for the Massachusetts Board of Registration in Medicine for risk management (RM) study.

**Middlesex West — Executive Committee Meeting.** Wed., Jan. 4, 6:00 p.m. Location: MMS Headquarters, Waltham.

For more information or to contribute news, contact Michele Jussame or Linda Howard, Northeast Regional Office at (800) 944-5562 or [mjussame@mms.org](mailto:mjussame@mms.org) or [lhoward@mms.org](mailto:lhoward@mms.org).

##### SOUTHEAST REGION

**Bristol South — Executive Committee Meeting.** Tues., Jan. 24, 6:00 p.m. Location: Corks Restaurant, New Bedford, MA.

**Plymouth — Holiday Event.** Thurs., Dec. 15, 6:00 p.m. Location: Plimoth Plantation, Plymouth. Executive Committee Meeting. Thurs., Jan. 26, 6:00 p.m. Location: MMS Southeast Regional Office, Lakeville.

For more information or to contribute news, contact Sheila Kozlowski, Southeast Regional Office at (800) 322-3301 or [skozlowski@mms.org](mailto:skozlowski@mms.org).

##### WEST CENTRAL REGION

**Berkshire — Executive Committee Meeting.** Mon., Jan. 23, 6:00 p.m. Location: Mazzeo's, Pittsfield.

**Hampden — Executive Committee Meeting.** Tues., Jan. 10, 6:00 p.m. Location: HDMS Office, West Springfield. Winter District Meeting. Tues., Jan. 31, 6:30 p.m. Location: Springfield Marriott, Springfield. Speaker: James Gessner, M.D., MMS President.

For more information or to contribute news, contact Cathy Salas, West Central Regional Office at (800) 522-3112 or [csalas@mms.org](mailto:csalas@mms.org)

##### STATEWIDE NEWS AND EVENTS

**Arts, Humanism, History, and Culture Member Interest Network — Executive Committee Meeting.** Tues., Dec. 6, 6:00 p.m. Teleconference only.

For more information or to contribute news, please contact Cathy Salas, West Central Regional Office at (800) 522-3112 or [csalas@mms.org](mailto:csalas@mms.org).

### IN MEMORIAM

The following deaths of MMS members were recently reported to the Society. We also note member deaths on the MMS website, at [www.massmed.org/memoriam](http://www.massmed.org/memoriam).

**Daniel Colm Armstrong, M.D.,** 85; Quincy, MA; Royal College of Surgeons, Dublin, Ireland, 1955; died December 15, 2015.

**Samuel J. Brendler, M.D.,** 94; Suffield, CT; New York University College of Medicine, Boston, 1946; died September 28, 2016.

**Hugh P. Chandler, M.D.,** 84; Boston, MA; Harvard University Medical School, Boston, 1960; died October 9, 2014.

**Paul P. Dunn, M.D.,** 94; Fall River, MA; Tufts College Medical School, Boston, 1944; died June 8, 2014.

**Fredric D. Frigoletto, Jr., M.D.,** 83; Wellesley Hills, MA; Boston University School of Medicine, Boston, 1962; died October 31, 2016.

**Gregory J. Gallivan, M.D.,** 77; Longmeadow, MA; Tufts University School of Medicine, Boston, 1962; died October 1, 2016.

**Kenneth B. Gordon, M.D.,** 85; Orleans, MA; Boston University Medical School, Boston; died October 4, 2016.

**Andrew D. Guthrie, M.D.,** 87; Winchester, MA; Tufts University School of Medicine, Boston, 1953; died September 13, 2016.

**James H. Hepp, M.D.,** 83; Travelers Rest, SC; Albany Medical College of Union University, Albany, NY, 1965; died October 9, 2016.

**Eduardo C. Leonardo, M.D.,** 82; Somerset, MA; Facultad de Medicina San Fernando, Lima, Peru, 1961; died June 11, 2016.

**John T. Maltzberger, III, M.D.,** 82; Lexington, MA; Harvard University Medical School, Boston, 1959; died October 5, 2016.

**Alan S. Prager, M.D.,** 87; Waban, MA; Boston University School of Medicine, Boston; died August 29, 2013.

**Alan D. Rothstein, M.D.,** 85; Brookline, MA; Tufts University Medical School, Boston, 1956; died May 13, 2016.

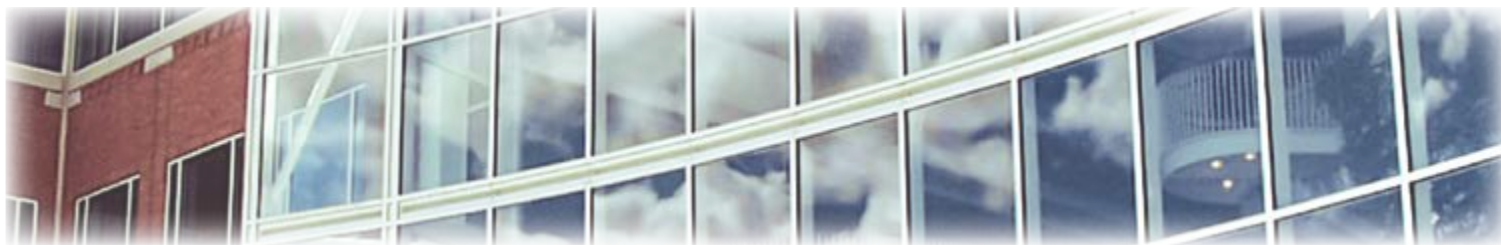
**Daniel S. Sax, M.D.,** 81; Randolph Center, VT; University of Maryland School of Medicine, Baltimore, MD, 1959; died October 27, 2016.

**Walter P. Zmyslowski, M.D.,** 85; Worcester, MA; Tufts University School of Medicine, Boston, 1956; died May 24, 2016.

## MMS Residents and Fellows Receive AMA Membership

The MMS is the first state medical society to provide the MMS Resident and Fellow Section (RFS) with additional benefits by sponsoring their membership in the AMA. The MMS and AMA are strongly allied, from supporting legislation favoring student loan savings accounts, to combating prescription opioid abuse. The MMS will supplement benefits with additional AMA services, including a free JAMA subscription and savings on nine specialty journals. All members can access the broad array of benefits and services from both organizations.

To learn more about the activities of the MMS Resident and Fellow Section, go to [www.facebook.com/amaresidentsandfellows](http://www.facebook.com/amaresidentsandfellows).



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# VITALSIGNS

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## MMS AND JOINTLY PROVIDED CME ACTIVITIES

### LIVE CME ACTIVITIES

Unless otherwise noted, event location will be MMS Headquarters, Waltham. Visit [www.massmed.org/cme/events](http://www.massmed.org/cme/events).

#### Save the Date

#### 2017 Annual Education Program — The Winding Road of Addiction: Hope on the Horizon.

Friday, April 28, 2017 (Seaport Hotel, Boston, MA)

### ONLINE CME ACTIVITIES

Go to [www.massmed.org/cme](http://www.massmed.org/cme)  
**Risk Management CME**

#### Electronic Health Records Education (3 modules)

- Module 1 — EHR Best Practices, Checklists, and Pitfalls
- Module 2 — Making Meaningful Use Meaningful: Stage 1
- Module 3 — Making Meaningful Use Meaningful: Stage 2

#### End-of-Life Care

- End-of-Life Care (3 modules)
- The Importance of Discussing End-of-Life Care with Patients
- Advance Directives (Legal Advisor)
- Principles of Palliative Care and Persistent Pain Management (3 modules)

#### Pain Management and Opioid Prescribing

- Managing Pain Without Overusing Opioids
- The Opioid Epidemic: Policy and Public Health (6 modules)
- Principles of Palliative Care and Persistent Pain Management (2 modules)
- Opioid Prescribing Guidelines in Practice
- Opioid Prescribing Series (6 modules)
- Identifying Potential Drug Dependence and Preventing Abuse (Legal Advisor)
- Managing Risk when Prescribing Narcotic Painkillers for Patients (Legal Advisor)

#### Medical Marijuana (4 modules)

- Module 1 — Medical Marijuana: An Evidence-Based Assessment of Efficacy and Harms
- Module 2 — Medical Marijuana in the Commonwealth: What a Physician Needs to Know
- Module 3 — Medical Marijuana in Oncology
- Module 4 — Dazed and Confused: Medical Marijuana and the Developing Adolescent Brain

#### Additional Risk Management CME Courses

- Initiating a Conversation with Patients on Gun Safety
- Bullies and Victims: Can You Tell the Difference?

- Intimate Partner Violence: The Clinician's Guide to Identification, Assessment, Intervention, and Prevention
- Understanding Clinical Documentation Requirements for ICD-10
- ICD-10: Beyond Implementation
- Prostate Cancer and Primary Care
- Cancer Screening Guidelines (3 modules)
- 2.0: What's New in the New Rules?
- Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
- Effective Chart Review for Quality Improvement

#### Additional CME Courses

- Carbon Monoxide Poisoning
- Genetically Modified Foods: Benefits and Risks
- Just a Spoonful of Medicine Helps the Sugar Go Down: Improve Management of Type 2 Diabetes
- Weighing the Evidence on Obesity
- Aggregating the Evidence on Antiplatelet Drugs: A Review of Recent Clinical Trials
- Acid Suppression Therapy: Neutralizing the Hype
- Preventing Overuse of Antipsychotic Drugs in Nursing Home Care



CME CREDIT: These activities have been approved for *AMA PRA Category 1 Credit™*.

FOR ADDITIONAL INFORMATION AND REGISTRATION DETAILS, GO TO  
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