

VITAL SIGNS



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each patient counts.*

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Ten Mobile Apps Physicians Should Know

BY DEBRA BEAULIEU-VOLK
VITAL SIGNS STAFF WRITER

You've probably heard the phrase "There's an app for that." But as medical professionals, which apps do you really need to know about?

Mobile health experts offered *Vital Signs* the following short list of apps to be aware of spanning various areas of physician work and life.

Wearables/Activity Trackers

"You have to have lived under a rock to not appreciate the deafening hype around wearables right now," said Joseph Kvedar, M.D., director of Partners Center for Connected Health at Massachusetts General Hospital. The conversation has even risen to grace the pages of the *Journal of the American Medical Association*, as a research letter published Feb. 10 noted that wearable devices and tracking apps may not only have greater appeal to the public than older devices such as pedometers, but also that their step-counting capabilities were pretty accurate. With nearly two-thirds of the population now using smartphones, the authors

suggested, this technology holds promise to foster more physical activity.

This power is important for improving health, noted Kvedar, as awareness increases that "sitting is the new smoking." But because an activity tracker is only useful if actually used, Kvedar and colleagues launched Wellocracy, a website designed to help people learn about and compare various apps.

"It's meant to give people a resource to help make decisions wisely so they don't purchase something and use it for a week and then throw it in a drawer because it doesn't fit their personality," he said.

Nonetheless, he recommended physicians take some time to learn about the most popular options:

- **Fitbit:** Arguably the Kleenex of the wearables industry, Fitbit offers an array of products,

mostly centered around a series of wristbands that can track a user's steps, distance, calories burned, and even sleep quality. These devices all integrate with associated smartphone apps.

- **Jawbone:** Jawbone also offers smart wristbands and other accessories to track activity and stillness (i.e., deep sleep). These days, patients are particularly interested in sleep tracking, Kvedar noted.

However, there's a challenge for doctors in knowing what to do about a report revealing a patient's poor sleep patterns. "Activity is cleaner. Sleep is much more complex," he said.

- **MyFitnessPal:** This mobile app can be used alone for users to input their activity and food intake manually, or in conjunction with wearables or tracking

apps. According to Kvedar, nothing really comes close to having the number of users as MyFitnessPal, which had close to 60 million users when it was acquired by Under Armour earlier this year.

Physician Wellness/Social Support

Physicians can benefit from activity trackers as well, according to Dike Drummond, M.D., an expert in physician burnout prevention and CEO of TheHappyMD.com. Drummond said he is in the final stages of building his own burnout-busting mobile app, which will be loaded with short burnout-prevention training videos and audios on meditation, chair yoga, and more.

Other options physicians can use include the following:

- **Doximity:** All of the apps discussed so far include a social networking component. MyFitnessPal, for example, allows users to connect with "friends" to view one another's accomplishments to help share inspiration and encouragement. But when physicians

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Illustration by
Chris Twichell

White House Drug Policy Director: 'Cautiously Optimistic'

More Treatment Access, Prescriber Awareness Needed

BY ROBYN ALIE
MMS PUBLIC HEALTH MANAGER



Michael Botticelli

This is part two of a Vital Signs interview with Michael Botticelli, director of the White House Office of National Drug Policy

about strategies to combat the problem of opioid abuse. Mr. Botticelli will keynote the Massachusetts Medical

Society's April 8 Public Health Leadership Forum on opioids.

Part one of the interview can be found at www.massmed.org/botticelli.

VS How would you characterize the availability of treatment for opioid abuse?

Botticelli This is always really challenging. If you look at national data, only about 19 percent of people that meet diagnostic criteria

for a substance use disorder get care and treatment for their disorder.

The prevalence of substance use disorders is probably on par with the prevalence of diabetes... but the treatment rate for diabetes is about 85 to 90 percent versus 19 percent for substance use disorders. One of the most significant reasons why we know people don't get care and treatment is, one, not having insurance or,

two, that they have insurance but they're underinsured. They have insurance that doesn't have an adequate benefit for substance use disorders. And this is where the Affordable Care Act, and Massachusetts' leading role nationally in implementing health care reform, can really have a profound impact.

Historically, insurance companies have used a variety of

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PRESIDENT'S MESSAGE



There's an App for That

This month we explore mobile health applications useful for physician work and life. Many of us are reluctant to spend too much time buried in the screens of our smartphones and tablet, but Joseph Kvedar, M.D., director of the Partners Center for Connected Health at MGH, shares his thoughts on 10 mobile apps with which all physicians should be familiar.

We are also pleased to feature the second installment of our two-part *Vital Signs* interview with White House Drug Policy Director Michael Botticelli. Mr. Botticelli is a former director of the Bureau of Substance Abuse Services at the Massachusetts DPH, and we are delighted to welcome him back to Boston on April 8 as the keynote speaker for the MMS Public Health Leadership Forum on opioid addiction. For more on the battle against opioid abuse and addiction in Massachusetts, see our State Update in this issue to learn about continued broad-based efforts by state agencies and physician groups, including the MMS.

Many physicians have called our Physician Practice Resource Center in recent months with concerns about payer audits, which seem to be on the rise. This month, we feature stories on steps your practice can take to prepare for an audit and protect itself from payment recoupment.

We look forward to seeing you at our upcoming 2015 Annual Meeting April 30–May 2 at the Seaport Hotel and World Trade Center, Boston. The theme, *Physicianship and Teamwork: Leadership Opportunities in the Era of Population-Based Care*, promises to be timely and stimulating.

— Richard S. Pieters, M.D.

Mobile Apps

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simply want to connect with other physicians about issues related to their profession, many turn to Doximity. Through its mobile and web platforms, physicians can also use Doximity's tools for HIPAA-secure communication, electronic faxing, reading custom-curated medical news, and even earning CME. "They seem to be getting it right," Kvedar said, "in contrast to some others that kind of were a flash in the pan."

Reference/Decision Support

- **Epocrates:** One of the most widely known medical apps, Epocrates offers physicians drug-reference information along with a host of other decision-support tools. Physicians gave the app the highest rating in a 2013 survey by American EHR Partners.
- **Medscape:** This free app from WebMD offers integrated medical information and educational tools, organized by medical specialty. With more than four million users, Medscape offers drug information, medical calculations, CME, and offline access.
- **NEJM Mobile:** Physicians have multiple options for accessing content from the world-renowned *New England Journal of Medicine* on the go, including NEJM This Week, NEJM CareerCenter, NEJM Image Challenge, and the new NEJM iPad Edition.

Productivity

- **Cozi:** Cozi is a calendar app designed to keep busy schedules organized. A family or organization can assign each person a color, so they can

create a clear display showing who needs to be where and when. Gail Cetto, R.N., office manager at a primary care practice in Auburn, learned about the app from one of the group's doctors, who used it to keep track of his children's various sports and activities. She now uses it to manage the practice employees' work schedules.

- **Google:** For those that use Google calendar, maps, and contacts managers on their smartphones, the technology can act like a virtual assistant or secretary, said Kvedar. "It measures all these things about you while you're not thinking about it. With the knowledge of all the digital breadcrumbs you leave throughout the day, it can detect when you're running late for a meeting, for example, and ask while you're sitting in traffic if you want to call the organizer to reschedule."
- **DocbookMD:** A HIPAA-secure messaging application free to all MMS members, DocbookMD allows physicians to send text messages bundled with images. A searchable directory of MMS physicians and national pharmacies is also built in.

Physicians who wish to communicate with patients via encrypted text messaging can consider a service like TigerText. Some electronic health record vendors are now offering patient-facing functionality on mobile devices, Kvedar noted.

A Note of Caution

Despite the usefulness of many mobile apps, there are also a handful of offerings physicians should know about for negative reasons. Apps that could actually be harmful to patients include, for example, those that invite users to take a photo of a mole and have a computer analyze whether they should see a dermatologist, Kvedar warned. Other dangerous apps include those that claim to determine from a user's food diary whether they're diabetic and how to dose insulin.

"This is not just about patients adopting healthy things and physicians adopting productivity tools," he said. "There's a level of scrutiny that's important too. There's stuff out there that shouldn't be and we want to keep our eyes and ears open for it."

Don't Miss This!

Apps Invade Health Care: Why You Should Care

Thursday, May 7, 2015, 6:00 p.m. to 9:00 p.m.

Harvard Martin Conference Center, 77 Avenue Louis Pasteur, Boston, MA

Panelists include:

- Ricky Bloomfield, M.D., director, Mobile Technology Strategy, Duke Medicine
- Charles Safran, M.D., chief, Division of Clinical Informatics, Beth Israel Deaconess Medical Center
- Kenneth Mandl, M.D., professor, Harvard Medical School
- Adrian Gropper, M.D., chief technology officer, Patient Privacy Rights
- Glenn Tucker, M.D., chair, MMS Committee on Information Technology

Register at www.massmed.org/apps2015

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Three Action Steps for Physicians Facing Payer Audits or Recoupment

BY TALIA GOLDSMITH
PPRC ADVISOR

Physicians are more vulnerable to payer audits and payment recoupments than ever. Public and commercial payers audit physician practices of all sizes, and physicians can minimize the impact by being prepared and thoroughly documenting each patient encounter. If the service is not documented appropriately, the auditor or investigator may find that the service provided or the level of service billed was not justified, therefore resulting in a payment recoupment, or takeback.

Assessing your practice's risk and knowing what steps to take in the case of an audit or payment recoupment request, is extremely important. The Physician Practice Resource Center has identified three important action steps that can be taken today to prepare your practice should you face a payer audits and/or takeback in the future.

1. Assess your practice's risk.

Taking a proactive approach by

assessing your practice's risk will minimize the risk of future audits and takebacks. You may consider engaging an expert coder to conduct an internal mock audit that will verify that your documentation supports the levels of services billed and make suggestions where you may be able to tighten up your process or add more detail to your notes. Best practices indicate that conducting a mock audit annually is a great way to be prepared and aware of your practice's level of risk.

2. Understand which entity is auditing your practice. It is important to understand which entity is conducting the audit and the reason for which you are being audited before responding to the audit request. There are quite a few entities that conduct billing/coding audits and investigations. Some examples include the following: private health plan fraud investigation units, the Centers for Medicare and Medicaid Services Recovery Audit Contractors (RAC), CMS Zone Program Integrity Contractors (ZPIC),

among others. There may be specific limits on the number of records that may be requested by governmental auditors and those rules may vary depending on the auditing entity. For example, RAC limits the number of medical records to review based on the size of the physician practice and requires a three-year "look back" period. Conversely, ZPIC audits have no record request limits. Understanding these requirements will help your practice properly assess the amount of time it will take to properly respond to the request.

Contact your malpractice insurer or risk management department. Consider reaching out to your malpractice insurer or risk management department to see if your current coverage contains a rider for audit response and what steps are required to enact this coverage benefit. Processes vary and in most cases carriers have very defined mechanisms to access this benefit. Responding to an audit or recoupment request can take a considerable

amount of time and resources and your coverage may provide some reimbursement for the cost associated with responding to an audit or defending yourself against a payment recoupment. In some cases, malpractice insurers will reimburse you directly for expenses related to your case (e.g., legal advice, chart review, etc.). In other cases, the malpractice insurance plan will take care of the management of your case and will provide the lawyers and other experts.

Join us for the Payer Audits and Payment Recoupments live webinar on May 13. Details at www.massmed.org/payeraudits2015.

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Protect Yourself from Payment Recoupment Protection

BY KATHLEEN FINNERTY-SCHROTH
PIAM PRESIDENT

Medical associations say private health plan recoupment is an increasing source of complaints from physicians. It is important that providers be aware of the availability of insurance protection that responds when a physician or practice faces an audit followed by a demand for return of previous reimbursement payments emanating from the Centers for Medicare and Medicaid Services or a private insurer.

Many of the traditional indemnity insurance companies here in Massachusetts have developed an addendum to the professional liability insurance policy that includes a measure of protection or reimbursement of expenses incurred when defending against allegations of billing fraud and the threat of payment recoupment. In addition, companies

have recognized the risk of a privacy breach incurred in the practice setting and now include basic limits of coverage for some of the associated costs at no charge.

Key Considerations

- Alert your liability insurance company or institution as soon as you have received the notice of an audit finding with payment demand, as the trigger for coverage is often subject to the date you are notified.
- If you believe a breach of personal health information has occurred, immediately contact your insurer, as they may have partnered with experts in forensic review who will be able to walk you through the reporting steps, investigation, and notification requirements.
- Speak first to your liability insurance provider before contacting

an attorney. Sometimes, reimbursement of legal expenses is predicated on the insured using the insurance company's own panel of specialized attorneys or experts. Companies may not reimburse legal expenses, if an attorney has not been vetted by the insurer or the hourly rate exceeds their own negotiated rates.

- Membership in an accountable care organization or similar health care group may require that you maintain insurance coverage for fraud and abuse or a privacy breach at a very high limit. Check your contract language.
- If a practice is insured under a "captive insurance plan" associated with an institution, the presence of this coverage varies widely, but we note that some of the self-insured groups allow

for a basic limit, where others have no identified coverage but may assist you or even require that they manage the claim through their own institutional coverage plan.

Some of the insurance carriers will allow you to increase the limit of liability, and practices with a need for higher limits due to their size or annual revenues may also purchase separate insurance policies from other carriers to supplement the basic coverage.

Prepared by Physicians Insurance Agency of Massachusetts (PIAM), the insurance agency of the Massachusetts Medical Society.

PIAM
a subsidiary of the Massachusetts Medical Society

Michael Botticelli
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discriminatory practices to limit access of substance use disorder treatment.... So what the Affordable Care Act did was not only make sure that exchange programs and Medicaid programs offered a substance use disorder benefit but that those had to be offered on par with other medical-surgical benefits.

The second piece that I think is also really important: At the same time that we have this huge increase in opioid use disorders, we have a building armamentarium of highly effective medications that should be the standard of care for people with opiate use disorder. We now have buprenorphine and vivitrol, [which] are two highly effective medications for opiate use disorders that can be done through a physician in a primary care practice. That's huge, because it significantly diminishes the stigma of having to go to a treatment program to get it, which is the other main factor

that people talk about in what prevents them from seeking care. What's been disappointing nationally is that even though we have these effective medications, only a very, very small number of physicians have opted to get the training and look at utilization of these medications in their practice. Increasing access to treatment and increasing access to medication-assisted treatment are really part of our national strategy.

VS What is the patient's responsibility?

Botticelli I'm pretty public that I've been in recovery for a long, long time. A provider who knew I was in recovery, who knew I was the person in Massachusetts in charge of treatment services, after a procedure, asked me if I wanted a prescription for Percocet. I really liked this guy, he was a great provider. [I thought] it should not be my responsibility to educate my prescriber and my practitioner on safe and effective opioid prescribing.... I was able to say to him, "We have a major

problem with prescription drugs, and this is part of the reason why. I know you didn't want to see me in pain, but also, understand that I am a person at high risk for abuse of this medication." And, knowing that I was in recovery, and if he had some level of education around addiction in general or about recovery, wouldn't it have been more beneficial if we had some discussion about what my pain plan should have been in advance?

This is not coming from a blame perspective: I think we understand that physicians and other prescribers don't get a lot of training in medical school about substance use disorders. For a long time we had two separate systems of care. We've had primary medical care on one side, and behavioral health care on the other. We are now coming to clearly understand... that we need to do a better job at integrating someone's medical care with someone's behavioral health care.

VS Physicians should be asking every patient about a pain management plan and talking to them about the risks when they prescribe that Percocet?

Botticelli Correct. When you look at the safe and effective opioid prescribing curricula, that's exactly what it promotes. This is not just about pain prescribing. This is really an opportunity for a prescriber to have the conversation about what someone's history is, to do a good job screening about their substance use patterns, to ask them about not only their personal history but family history around addiction.

VS Who else has a role in the solution to the opioid problem?

Botticelli There are other players that need to be a part of this. For instance, insurance companies, in terms of making sure they're providing good treatment benefits and that they are meeting the requirements of parity. State government folks have a responsibility to make sure that their Medicaid benefit has good treatment coverage. Law enforcement has a role to play here in terms of making sure that we don't have state laws [which] continue to promote pill mills and that we're focusing on these issues.

VS What do you see happening over the next couple of years? Is it going to get better or worse?

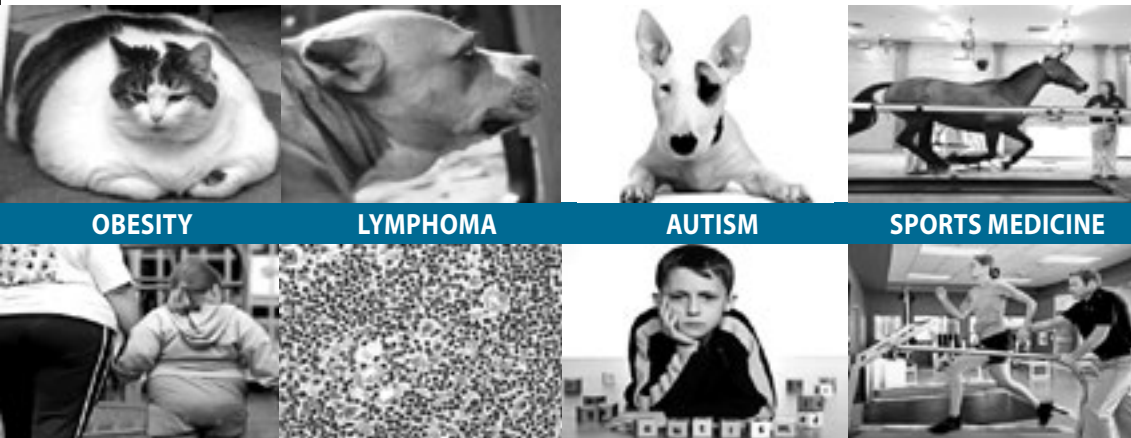
Botticelli I am cautiously optimistic that we are going to continue to make progress. I think that we are seeing some preliminary signs that we are making progress when you look at some of the data around reductions in misuse of pain medications. I think that the heroin overdoses continue to be a challenge and is something that we need to focus on.... I think our challenges are to make sure that we take all of the things that we are doing to scale. We didn't talk about overdose prevention and Naloxone but there is a really good example where Massachusetts has really been a leading example of overdose prevention. I think that we want to make sure that where we have seen success that everybody is implementing those strategies in a comprehensive way.

Zoobiquity Boston

April 25, 2015, 7:50 a.m. to 6:00 p.m.

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STATE UPDATE

2015 Brings Continued Response to Opioid Abuse

BY WILLIAM RYDER, ESQ
MMS LEGISLATIVE COUNSEL

We saw an unprecedented amount of legislation, regulation, legal action, and commission reports attempting to address opioid addiction and overdose in 2014. This year appears to continue that trend of focus on opioid abuse prevention efforts. The AMA has a task force to reduce opiate abuse, which includes MMS President Richard Pieters, M.D., as a member. The MMS has its own task force on opiate therapy and physician communication, led by MMS Vice President James Gessner, M.D., which is working to identify ways to help physicians and other prescribers share information about their shared patients' histories and treatment plans.

The MMS group includes 13 physician members and staff from several departments. Initial discussions have focused on ways to help physicians communicate about the opioid treatments of shared patients. The focus includes both referrals for pain management and addiction issues as well as situations where

review of the prescription monitoring program identifies other prescribers for patients. It is anticipated this group will continue its work throughout 2015 and into 2016.

The MMS sees a need to help educate prescribers on how to assess data in the state's prescription monitoring program (PMP) and to work with the Massachusetts DPH to improve the system as both a clinical tool for prescribers and a source of good data on the scope of opioid abuse in Massachusetts.

Statistics indicate that the majority of individuals using prescription drugs for non-clinical use did not have a personal prescription, but they obtained the drugs from other sources such as friends and family who did have prescriptions. The MMS is seeking to increase awareness among patients and prescribers on safe storage and disposal of opioids.

The MMS is also working in concert with state and federal authorities. Gov. Charlie Baker and Attorney General Maura Healey have both identified opiate abuse and addiction as a key area of

focus for their new administrations. MMS Director of Public Health Susan Webb represented the MMS at a February invitation-only event at Hope House in Boston where Gov. Baker and Executive Office of Health and Human Services Secretary Marylou Sudders presented detailed data on opioid overdoses and PMP data on patients with multiple prescribers and pharmacies.

The governor has said he intends to hold a series of public meetings in early spring and come up with a plan by May. Secretary Sudders and new DPH Commissioner, Monica Bharel, M.D., have both reached out to the MMS staff for our input. The MMS hopes to help expand access to addiction treatment, preserve access to opioids for patients in need, improve the PMP as a clinical and research tool, and reduce diversion of prescription drugs.

As a physician, Dr. Bharel has had experience using the PMP as a tool in treatment. Her experience with the system should help in improvements to its efficiency, accuracy, and value as a clinical tool.

Last year, the legislature mandated a task force to look at the practices of Blue Cross Blue Shield in setting up best practices and review criteria for coverage of opioid prescriptions. The MMS found the initial approach to be data-based and have great potential for improved clinical outcomes. Current reports indicate that the program has reduced opioid use. The legislature is very interested in this program, and it is hoped that the state's task force will review the data comprehensively to get a sense of the impact on patients of the changes.

The MMS Committee on Legislation will review new legislation on opioids as we move into public hearings this spring. As always, the best interests of patients will inform our testimony and advocacy.

We are pleased with the collaborative relationships we have formed with the Baker administration and the positive attitude of all interested parties in trying to work together on solutions to this enormous public health issue.

LAW AND ETHICS

How to Protect Your Attorney-Client Privilege

BY WILLIAM FRANK, ESQ
MMS ASSOCIATE COUNSEL

Whether retaining an attorney for malpractice or criminal defense, for an action to collect unpaid patient fees, or to pursue a potential business venture, your confidential communications with the attorney are generally protected from disclosure in the course of any legal proceeding. This means neither you nor your attorney can be compelled to testify about what was discussed, even when those discussions include violations of various laws. The attorney-client privilege serves both the immediate needs of the physician and public ends by ensuring sound and fully-informed legal advice and advocacy.

The attorney-client privilege protects confidential communications

between a physician and his/her attorney or prospective attorney made for the primary purpose of obtaining legal advice or assistance.

For this privilege to apply, a physician needs to seek advice or assistance from an attorney that pertains to matters within his or her professional competence. In turn, the attorney must agree to give — either implicitly or explicitly — the desired advice or assistance.

Once in place, the attorney-client privilege is a very strong one, but physicians need to be careful to avoid waiving it by sharing information with a third party. Assuming the physician and attorney have used reasonable efforts to protect the information from disclosure, the privilege can remain intact if a third party overhears their conversation without

their knowledge, or intercepts an email or fax without their permission.

However, as a general rule, a knowing and voluntary release of privileged information outside the confines of a "special relations" (e.g., with your spouse, clergy person, therapist, etc.) will waive your privilege. For example, over dinner one night you tell a friend what your attorney said about expert reviews that did not support you in a malpractice suit. By knowingly and voluntarily releasing this information, you have waived your attorney-client privilege. While your attorney can still not be compelled to disclose this information, the opposing attorney can legitimately ask you whether you discussed this case with anyone other than your attorney, and what you said to them. By having the outside

discussion, you may have to testify at a deposition or in court that you told a friend that you were worried about the case because several respected experts in your field told your lawyer that you had breached the standard of care.

Protecting the attorney-client privilege is essential to defending your case. Privileged information should be carefully guarded, and no matter how good it may feel to vent about an ongoing legal matter, doing so may ultimately undermine your case.

The "Law and Ethics" column is provided for educational purposes and should not be construed as legal advice. Readers with specific legal questions should consult with a private attorney.

PHYSICIAN HEALTH MATTERS

PHS Support Groups: Unique Atmosphere of Support and Trust for Physicians

Physician Health Services sponsors a number of confidential support groups that provide doctors with a safe place to discuss significant personal and professional concerns. The Behavioral Health and Workplace Stress Support Group is held three times per month at MMS Headquarters in Waltham. This free group is ably facilitated by Diana Barnes Blood, L.I.C.S.W., a wise and experienced social worker who is exceptionally skilled at empathic listening. You can attend the group once or twice, intermittently, or frequently — whatever meets your needs.
— PHS Director Steve Adelman, M.D.

BY DIANA BARNES BLOOD, L.I.C.S.W.

Beyond statistics, which provide good data but not meaningful description, the PHS support group is officially described as an opportunity for doctors who are experiencing the rigor of medicine to support one another. Three times a month they have an opportunity to develop and strengthen coping skills to deal with others, as physicians and as people. Participants, either self-referred or referred by PHS, are invited by a facilitator to become group members, provided that they make a commitment to maintaining total confidentiality and to doing their best to help both themselves and other members.

From this vantage point, I have asked a group of members to speak about our peer support group in their own words. They have graciously agreed to do so.

“We give our name, or medical specialty, what we need, and we start where we are. It’s the only place I can be a doctor and a human being safely. It’s where I’m most comfortable, where I get to talk about issues that matter to me, that I can’t think about most of the time. I won’t get laughed at or pushed around. In medicine we can get caught up in our doctor role — expectations, time, and energy. So confidentiality is a huge issue. The structure helps me focus, too.”

“The trust we place in our facilitator keeps people from talking too much or too little. She tries to get to everyone involved, interpreting, checking in, taking the temperature of the room frequently. We don’t have to feel rushed or pressured. If the atmosphere is supportive enough, there can be the kind of honesty that may even sting a little bit but helps us, doesn’t make us feel criticized. A catalyst is helpful.”

“The range of topics is extensive and exhaustive. Whether work-related or personal, we know they

are symbolically much the same and they all affect our feelings and our performance as physicians.”

“Outside of here we are isolated. Getting to know each other — the continuity — is very important. We have great respect for what people here have been through and have surmounted. I’ve learned from people in this group; each person has great value to the others no matter how much he talks, no matter what the situation. We develop respect, affection, and acceptance for others, and they share our values. Even if we start with a negative attitude toward ourselves (like many), others’ compassion for us

turns into self-compassion. In turn, ‘Hope animates courage.’ It’s not just what we bring to the group: the value is what everybody brings — mutual support, respect, hope, and honesty.”

One person used the following image:

“It’s like the feeling that you’re drowning, and you don’t know how far it is to the shore. Then you see all the hands reaching out to you, to pull you in. And suddenly you’re no longer drowning.”

If you are interested in attending a PHS support group, please contact Physician Health Services at (781) 434-7404, or visit our website at www.physicianhealth.org.

Position Available

PART-TIME ASSOCIATE DIRECTOR, PHYSICIAN HEALTH SERVICES, INC.

PHS staff and associate directors have a common mission — to help heal doctors and promote patient safety. We provide confidential support to physicians with substance use and behavioral health concerns/disorders, mental or physical illness, and occupational stress.

The part-time associate director role involves a 20 to 30 percent time commitment, including a day a week at our Waltham office. Work on other days may be performed in Waltham or at an office north of Boston.

Please send a letter of interest and CV to: Steven Adelman, M.D., Physician Health Services, Inc., 860 Winter Street, Waltham, MA 02451

Or email them to: lbresnahan@mms.org

More information at www.massmed.org/phsposition

Graduating Medical Students



- If you are staying in Massachusetts, talk with your residents-fellows program director about FREE MMS Membership or simply ask your program coordinator to submit a 2015 program roster to activate the MMS benefits for you and your colleagues.
- Beginning your training out of state? Maintain your membership through December 2016 at no cost. Watch your mail for more information.

Questions?

groups@massmed.org | 800-322-2303, ext. 7748

Women Physicians: Share Your Story

The Massachusetts Medical Society’s Committee on Women in Medicine is compiling a new book of transformational stories as told by women physicians.



In addition to providing a historical perspective, this collection of candid stories will address turning points in women physician’s careers, the difficult career decisions they made, and lessons learned along the way.

The book aims to serve as continued inspiration and a source of motivation to current and future women physicians as they navigate the journey to create their own unique lives.

**What is your transformational story?
Let us learn from your experience!**

For more information about this project, please contact Erin Tally at (781) 434-7413 or etally@mms.org, or Dr. Helen Cajigas at (617) 596-3680 or heca2013@gmail.com.

NEJM Group Launches NEJM Knowledge+ Family Medicine Board Review

Following the success of NEJM Knowledge+ Internal Medicine Board Review, NEJM Group announces the addition of NEJM Knowledge+ Family Medicine Board Review to its growing portfolio of educational products.

NEJM Knowledge+ Family Medicine Board Review includes the same adaptive learning technologies to increase learning efficiency and knowledge retention as NEJM Knowledge+ Internal Medicine Board Review, but this new product is designed expressly for family medicine physicians, residents, and physician assistants (PAs).

NEJM Knowledge+ Family Medicine Board Review includes:

- A comprehensive question bank comprising 1,500 case-based questions, along with derivative short multiple-choice, and fill-in-the-blank formats for a total of more than 4,000 questions — all guided by the ABFM blueprint and designed to reflect the topics, clinical settings, and problems primary care clinicians face in their practices.
- A key learning point, detailed feedback, and links to further reading, with each question.
- Two timed practice exams with performance assessment and links to question review
- A robust reporting system that details the user's progress and performance along several facets such as by topic, clinical setting, or patient age. Reports also demonstrate how the learner's reported confidence in each answer stacks up against her actual performance.
- An Accreditation Center that tracks CME credits earned, including AAPA Self-Assessment and AAFP Prescribed credits and *AMA PRA Category 1 Credits™*
- Desktop, iPad, iPhone, and Android options

Selecting from and building on the Internal Medicine Board Review question bank and leading the ongoing effort to ensure the relevance of the content in NEJM Knowledge+ Family Medicine Board Review are Mark T. Nadeau, M.D., M.B.A., FAAFP, senior reviewer, and Christie Lucente, M.S., PA-C, physician assistant reviewer. Dr. Nadeau is professor of Family and Community Medicine at University of Texas, San Antonio, where he also directs the family medicine residency



program. Ms. Lucente is an Emergency Medicine PA at Brigham and Women's Hospital, where she has also served as coordinator of PA education.

Thousands of clinicians from around the world have already selected NEJM Knowledge+ Internal Medicine Board Review to help them meet their continuous learning needs. Additionally, the program has already been adopted by internal medicine residency programs worldwide, including Brigham and Women's Hospital, UT Southwestern Medical Center, and Turku University Hospital in Finland.

Visit <http://knowledgeplus.nejm.org/our-products/family-medicine-board-review> to learn more.

MMS Members receive a 25% discount on purchase here: <http://kpl.us/massmed>.

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

Charles River — Annual Meeting. Tues., April 7, 6:00 p.m. Location: Wellesley Country Club, Wellesley. Entertainment by the Blake Newman Group. **Delegates Meeting.** Thurs., Apr. 23, 6:00 p.m. Location: MMS Headquarters, Waltham. Resolution Review.

Essex North/Essex South — Joint Annual Meeting. Wed., April 1, 6:00 p.m. Location: Spinelli's Function Facility, Peabody. Guest Speaker: MMS President-Elect Dennis Dimitri, M.D. **Delegates Meeting.** Wed., April 15, 6:00 p.m. Location: Beverly Depot, Beverly. Resolution Review.

Middlesex — Annual Meeting. Sat., April 11, 6:00 p.m. Location: Museum of Science, Boston. Movie: *Jerusalem*. **Legislative Breakfast.** Fri., April 17, 7:30 a.m. Location: Mount Auburn Hospital, Cambridge.

Middlesex West — Delegates Meeting. Tues., April 21, 6:00 p.m. Location: MacPherson Hall, Framingham Union Hospital, Framingham. Resolution Review.

Norfolk — Annual Meeting. Wed., April 8, 6:00 p.m. Location: Sheraton Needham Hotel, Needham. Guest Speaker: Grant Rodkey, M.D. Topic: Our Pilgrimage.

Suffolk — Delegates Meeting. Thurs., April 23, 6:00 p.m. Location: East Garden Room, Massachusetts General Hospital, Boston.

For more information on these events, or if you have Northeast District news to contribute, please contact Michele Jussame or Linda Howard, Northeast Regional Office at (800) 944-5562 or mjussame@mms.org or lhoward@mms.org.

SOUTHEAST REGION

Bristol North/Plymouth — Joint Spring Meeting. Tues., April 21, 6:00 p.m. Location: Boston Tavern Restaurant, Middleboro. Guest Speaker: MMS President Richard Pieters, M.D.

Southeast Regional Caucus. Wed., April 15, 6:00 p.m. Location: LeBaron Hills Country Club, Lakeville. Resolution Review.

For more information, or if you have Southeast District news to contribute, please contact Sheila Kozlowski, Southeast Regional Office at (800) 322-3301 or skozlowski@mms.org

WEST CENTRAL REGION

Hampden — High School Doctor for a Day. Thurs., April 2. Orientation 7:30 to 8:30 a.m. Debriefing 5:00 to 6:30 p.m. Location: Mercy Medical Center, Deliso Conference Center, Springfield. **Delegate/Executive Board Caucus Meeting.** Tues., April 21, 6:30 p.m. Location: HDMS office, West Springfield. **Annual Meeting.** Tues., April 28, 5:30 p.m. Location: Delaney House, Holyoke. Topic: Suicide.

Worcester — Annual Meeting. Wed., April 8, 5:30 p.m. Location: Beechwood Hotel, Worcester. Guest Speaker: Carol Ann Small. Topic: Laughter with a Lesson.

Worcester North — Annual Meeting. Thurs., April 2, 6:00 p.m. Location: Fay Club, Fitchburg. Guest Speaker: MMS President Richard Pieters, M.D. Topic: Physicians and Medical Professionalism: Opportunities and Challenges. CME Available.

For more information, or if you have West Central news to contribute, please contact Cathy Salas, West Central Regional Office at (800) 522-3112 or 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.

Robert W. Carey, M.D., 80; Westwood, MA; Harvard Medical School, 1959; died February 27, 2015.

Eugene A. Doherty, M.D., 86; Norwood, MA; New York Medical College, 1959; died February 3, 2015.

Donald B. Darling, M.D., 85; Belmont, MA; Georgetown University School of Medicine, 1950; died November 16, 2014.

Roy A. Johnson, M.D., 81; Bristol, RI; Boston University School of Medicine, 1959; died February 3, 2015.

Richard J. Mirabile, M.D., 66; Hingham, MA; Boston University School of Medicine, 1972; died April 28, 2014.



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MASSACHUSETTS
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VITALSIGNS

VOLUME 20, ISSUE 4, APRIL 2015

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MMS AND JOINTLY PROVIDED CME ACTIVITIES

LIVE CME ACTIVITIES

Unless otherwise noted, event location is MMS Headquarters, Waltham.

Public Health Leadership Forum — The Opioid Epidemic: Policy and Public Health
Wed., April 8, 2015

Payer Audits and Payment Recoupments — Webinar
Wed., May 13, 2015

MMS and Rhode Island Medical Society Directors of Medical Education Conference
Thurs., May 14, 2015

Preparing for Infectious Disease in a Disaster and Beyond
Wed., May 27, 2015

13th Annual Symposium on Men's Health
Thurs., June 18, 2015

ONLINE CME ACTIVITIES

Go to www.massmed.org/cme **Risk Management CME**

Electronic Health Records Education (3 modules)

- Module 1 — Guide to Health Information Technology
- Module 2 — Making Meaningful Use Meaningful
- Module 3 — Meaningful Use Stage 2

End-of-Life Care

- End-of-Life Care (3 modules)
- The Importance of Discussing End-of-Life Care with Patients
- *Legal Advisor*: Advance Directives

Pain Management

- Principles of Palliative Care and Persistent Pain Management (5 modules)
- Opioid Prescribing, Risk Management of Opioid Therapy, and the Opioid Abuse Epidemic (6 modules)
- *Legal Advisor*: Identifying Potential Drug Dependence and Preventing Abuse
- Managing Risk When Prescribing Narcotic Painkillers for Patients

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

Other Risk Management CME

- Preventing Falls in Older Patients: A Provider Toolkit
- Guide to Accountable Care Organizations: What Physicians Need to Know
- HIPAA 2.0: What's New in the New Rules?

- Cancer Screening Guidelines (3 modules)
- Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
- Effective Chart Review for Quality Improvement

Other CME

- Genetically Modified Foods: Benefits and Risks
- Physician Employment Options in the Health Care Environment
- Contracting with an ACO
- Finance 101 for Physicians and Practice Administrators
- A Roadmap to Bring an End to HIV and STDs in Massachusetts (3 modules)
- Using Data Wisely
- 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
WWW.MASSMED.ORG/CMECENTER, OR CALL (800) 843-6356.