

VITAL SIGNS



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MEDICAL SOCIETY

*Every physician matters,
each patient counts.*

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Mass. Planned Parenthood Welcomes M.D. as New CEO

First Physician to Lead a State Planned Parenthood Office

BY ROBYN ALIE
MMS PUBLIC HEALTH MANAGER

Jennifer Childs-Roshak, M.D., M.B.A., was named president and CEO of Planned Parenthood League of Massachusetts last fall, becoming the first physician to direct a Planned Parenthood in the United States. The position brings Childs-Roshak full circle in her career: it was her experience after college working for the U.N. Fund for Population Activities and volunteering for Planned Parenthood



Jennifer Childs-Roshak,
M.D., M.B.A.

that inspired her to go to medical school and become a family physician. Childs-Roshak spoke with *Vital Signs* about her new role.

You are the first physician to lead a Planned Parenthood organization. What do you think you, as a physician, bring to the role?

One advantage for me is having trained as a family physician, where a lot of the training is very systems-based, and around the health of the family unit. It's a perspective that really resonates with our population and our work in family planning.

One of my priorities for the organization is to connect the dots between the health care, education, and advocacy work. It's a lot of what physicians are doing every day on a one-on-one basis — we provide medical expertise and often advocate for patients to get the care that they need.

What are the challenges for Planned Parenthood?

One of our biggest challenges is the perception that we're a one-trick pony, only providing abortion services. While that is critical

for women's health, [as is] having the ability to make decisions about your own reproductive health, people are not aware that we provide the wide breadth of services and great access. We have terrific patient experience scores,

and are looking for ways to collaborate to help physicians manage their patient population.

Most people are unaware of the majority of the services we provide. We see over 30,000 patients per year for well women exams, sexually transmitted infection testing and treatment, and overall access to family planning.

We're the experts in birth control. We provide long acting reversible contraceptives (LARC). These are the best way to prevent a pregnancy, short of abstinence. The American Academy of Pediatrics has recommended LARC as first line birth control option for teenagers. They're safe, very cost effective, and super effective for preventing pregnancy. We talk about family planning.

If you have a chronic medical illness, LARC are more reliable than a birth control pill and interact with medications less

New Opioid Limits Law Passes

Governor Charlie Baker has signed a law that limits first-time prescriptions of opioids to seven days, requiring verbal screenings of all public school students, and passing a host of other provisions related to education, treatment, and prevention of drug addiction. The seven-day limit provides exemptions for patients with cancer or chronic pain, or those who are in palliative care.

MMS President Dennis M. Dimitri, M.D., said, "The MMS commends the work of the legislature and Gov. Baker in crafting a bill that offers a number of helpful measures to address a complex problem."

He said, "The seven-day limit on prescription drugs is particularly

noteworthy, as this provision in the law should reduce the amount of prescription drugs that can be diverted to abuse or misuse, and at the same time allow a reasonable time for prescriptions for those patients who truly need pain relief."

"This law is another step forward in attacking the problem of opioid abuse," he said. "Physicians will continue to work with leaders in state government, public health officials, and health care providers in reducing prescription drug and opioid abuse in the Commonwealth." More details on the new law are available at www.massmed.org/opioidbill2016.

[More Opioids Coverage, page 3](#)

Cornell Named New MMS EVP

The Massachusetts Medical Society Board of Trustees has selected Lois Dehls Cornell as the Society's new executive vice president. Cornell will assume leadership of the organization on June 1, succeeding Corinne Broderick who will retire in May after serving as executive vice president for 15 years.



Lois Dehls Cornell, J.D.

"I am honored to have been selected as the next executive vice president for the Medical Society," said Ms. Cornell. "I look forward to partnering with the Society's physician leaders to continue its proud tradition of advocacy for Massachusetts' physicians and

the advancement of medical knowledge."

Cornell was employed for more than two decades at Tufts Health Plan where most recently, she served as chief administrative officer and general counsel. She earned her law

degree from Northeastern University School of Law, and prior to joining Tufts, she was an associate at Goodwin Procter in Boston.

In addition, she serves on many association and nonprofit boards, including the American Health Lawyers Association and the Pan-Mass Challenge. She resides in Natick, MA.

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PRESIDENT'S MESSAGE



Welcoming Change

We are very pleased to welcome Lois Dehls Cornell as our new executive vice president.

She will assume leadership on June 1, succeeding Corinne Broderick who has served this society for an amazing 32 years. Ms. Cornell comes to us after two decades in leadership at Tufts Health Plan, and serves as president of the American Health Lawyers Association.

As chair of the Board of Trustees's search committee, I can tell you that Ms. Cornell's abilities are impressive. She is passionate about health care and superbly qualified to lead our organization into the future.

Another piece of news that came as we were preparing this month's edition of *Vital Signs* was the passage of the state's new comprehensive opioid addiction legislation.

This law mandates a seven-day supply limit on first-time opioid prescriptions for adults, with exceptions for patients with cancer and chronic pain. It also requires that patients presenting to an emergency department with a possible overdose be evaluated for substance abuse disorders within 24 hours before discharge.

We commend the work of the legislature and Gov. Charlie Baker in hammering out a bill that offers a number of helpful measures to address a complex problem. The new limits on opioid prescriptions should reduce the amount of drugs diverted to abuse or misuse, and at the same time allow patients who truly need pain relief to get it.

This is a strong step in the right direction and the MMS will continue to work to further reduce prescription drug abuse in Massachusetts.

— Dennis M. Dimitri, M.D.

Meaningful Use Hardship Exemption Deadline Extended to July 1, 2016

All Physicians Encouraged to Apply, Avoid Penalties

The Centers for Medicare and Medicaid Services has again extended the deadline by which physicians may apply for a hardship exemption from the 2015 Medicare Meaningful Use requirements.

The new deadline is **July 1, 2016**. All applications from eligible professionals must be received by CMS by 11:59 p.m. EST on that date.

CMS has stated that it will broadly accept hardship exemptions because of the delayed publication of the program regulations.

The exemption process was created because of long delays in the promulgation of program requirements. Successful applications for the hardship exemption



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will allow physicians to avoid a Meaningful Use penalty in 2017.

The American Medical Association is encouraging all physicians subject to the 2015 Medicare Meaningful Use program to apply for the

hardship exemption.

Applying for the hardship will not prevent a physician from earning an incentive. It simply protects a physician from receiving a Meaningful Use penalty. Therefore, physicians who believe that they met the Meaningful Use requirements for the 2015 reporting period are encouraged to apply for the hardship protection to avoid financial penalty in 2017.

Letter to the Editor: MMS Position on Aid in Dying

Adding my thoughts to the subject ("Reconsider Opposition to Aid in Dying," March 2016), I have noticed that as my physician friends age with me into our 80s, they have less objection to doctor-assisted death and more interest in having this option for themselves and their spouses when the time comes.

Personally, in my younger days, I was firmly opposed to the

"slippery slope" of assisted dying then practiced by Dr. (Jack) Kevoorkian. Now, to the contrary, I would like to make the decision for myself, and have no fears that my physicians will abuse this privilege if allowed.

I urge the Society to reconsider its opposition.

Sincerely,

— Mayo Johnson, M.D., Beverly, MA

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MMS Members Confirm Your Website Password

In order to serve you better, the MMS plans to upgrade our member database system on or about April 20.

In order to complete this upgrade, we must limit some functionality on the MMS website for several days before launch. For example, during this time you will not be able view members-only documents or take online CME courses.

Also, the first time you visit the MMS website after the upgrade, you will be asked to confirm your password. You will only have to do this once.

For more details about this transition period, visit www.massmed.org/transition or contact MMS Customer Service at (800) 843-6356.

Your Two Cents

Vital Signs welcomes letters to the editor. Letters should be 200 words or fewer, and all are subject to editing. Send to the MMS Department of Communications, 860 Winter Street, Waltham, MA 02451-1411; vitalsigns@mms.org; or fax to (781) 642-0976.

Incorporating Telemedicine Services into Your Practice

BY JAMES DZIOBEK III AND RYAN MARLING
PPRC STAFF

Patients are looking for convenient ways to access health care services when they are unable to be physically present for a traditional office exam. Over the past couple of years, some physician practices across the country have started using telemedicine technologies in innovative ways to increase patients' access to services.

A successfully implemented telemedicine service can increase access to care, and may also improve the operational efficiency of the practice and patient experience. The Physician Practice Resource Center's recent webinar, *Integrating Telemedicine into Practice* (presented by Adam Licurse, M.D., M.H.S., and Jasdeep Sahota, MBA, M.S.) discussed contributing factors leading to the spread of telemedicine. These factors include a greater demand for convenient health care, improved technology to facilitate virtual visits, and the need for a focus on care coordination in many emerging payment models.

Telemedicine may serve as a mechanism to help bridge the gap between patient demand and managing population health by providing improved access and convenient care. While many interesting use cases exist, there have been a number of concerns



raised about telemedicine. These include reimbursement, identifying appropriate patients for telemedicine visits, the ease of use of the technology, maintaining continuity of care, and concerns about providing care for patients across state lines. If you are considering implementing telemedicine in your practice, a few key considerations and best practices shared during the webinar include the following:

- Target your patient populations**
Consider which patients in your practice may be candidates for use of the technology. Consider the clinical and demographic factors that may make video visits a practical solution.
- Be sure to designate a virtual visit champion**
Having a clinical and administrative champion is important in developing your practice's strategy for telemedicine. Champions would strategize and monitor the processes both administratively and clinically to ensure the health care needs of participating patients and physicians are met.
- Ensure a smooth virtual visit**
Consider what the process and responsible person will be to ensure that requisite logistics are set up and a test run is completed prior to the virtual visit. Make sure that the patient is able to use the technology and that all systems are working properly in advance.
- Determine how virtual visits are incorporated into physician schedules**
Will virtual visits be scheduled during a virtual visit block or will they be handled at certain points during the day? Advance consideration in this area may help with enhanced efficiencies for both virtual and in-person encounters.
Although it might not be perfect for all patients, telemedicine could help boost patient satisfaction and allow patients to be seen sooner during some routine follow-up visits. Telemedicine may also help physicians connect to patients in new ways outside of traditional care settings.

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LAW AND ETHICS

Clarifying Privacy Law: Opioids, HIPAA, and the PMP

BY WILLIAM FRANK, ESQ
MMS ASSOCIATE COUNSEL

The new opioid legislation signed this month into law includes a new requirement that, as of October 2016, all Massachusetts prescribers must query the prescription monitoring program, or PMP, prior to issuing every Schedule II or III narcotic.

There is often confusion as to whether federal privacy laws, including HIPAA, may limit discussions about patients with potential substance use disorders without prior patient consent.

In this context, the physicians involved in these communications would fall under the definition of *covered entities* and thus be subject to HIPAA privacy regulations. The content of these discussions — patient identifying information, prescriptions, concerning behavior — would fall under HIPAA's definition of *protected health*

information, again making these discussions subject to HIPAA rules. HIPAA generally allows for communication with an outside physician pertaining to the treatment of the patient without prior patient consent, so long as several precautions are taken including limiting personal health information disclosures to the minimum necessary.

Psychotherapy Notes

While HIPAA generally provides equal protection to health information regardless of the nature of the content, the regulations have a specific provision for psychotherapy notes. HIPAA requires authorization from the patient prior to the use or disclosure of psychotherapy notes, except where required by law in "duty to report" or "duty to warn" situations. HIPAA defines psychotherapy notes as "notes recorded by a

health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record."

For the purpose of this PMP-prompted discussion, it should be noted that psychotherapy notes do not include any information about medication prescription and monitoring, nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. While physicians must remain mindful of this limitation to patient consent-free communication about treatment, the psychotherapy notes provision is relatively narrow in its definition.

Separate Provisions

In addition to HIPAA's confidentiality requirements, there are separate federal drug and alcohol confidentiality regulations, often referred to by its citation, 42 CFR Part 2.

The applicability of who is covered by the provisions of 42 CFR Part 2 is much narrower than HIPAA. Also, 42 CFR Part 2 applies to "programs," other than general medical care facilities, which is defined as any person or organization that "holds itself out as providing and provides, alcohol or drug abuse diagnosis, treatment, referral for treatment or prevention." Importantly, the Substance Abuse and Mental Health Services Administration (SAMHSA) has provided some clarification about this broad definition, particularly to primary care practices that may

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Planned Parenthood

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often. We also have same day and walk-in access. If you see your rheumatologist and you're going on an immunosuppressant and need birth control, you can get the IUD the same day. It's a real value-add for patients, and for physicians who want to refer their patients for easy access and affordable care.

What is the population you serve?

We definitely have a total cross-section of society. Different ethnic and socioeconomic mixes. We have seven health centers across the state. At [one of our facilities], up to 20 percent of our patients are men. We have a lot of patients who as identify as LGBTQ. I'm proud that patients do feel comfortable coming to see us, to get the preventive care they may otherwise avoid. This is a nice complementary service [for PCPs].

We take commercial and public insurance, self-pay, and sliding scale. And for those who can't

afford it, we have Title X funding that covers birth control at no charge for women. This is what's being fought in the national arena.

We do not turn people away who come in looking for preventive services, reproductive and sexual health care. We're not in the primary care business; we want to collaborate with primary care. We're there for their patients when they need us, but certainly are sending people back to their primary care physicians.

What kind of advocacy and education do you do?

We do a lot of advocacy work. The Healthy Use Act would require, in schools that choose to have sex education, the sex education class be age appropriate, medically accurate, and comprehensive.

There's a patient confidentiality bill that impacts all clinical practices, and requires insurance companies to minimize the amount of information on the explanation of benefits. And we're really trying to get some traction around a telemedicine bill.

Education is very important. We have a number of award-winning programs around sex education, a lot of which pull in parents to talk to their kids about sexual health.

What else should physicians know?

As a physician, I've seen what happens when people can't access care. If there's anything that is a barrier to fellow physicians' patients, they should think of us as a partner, and as an expert in family planning, providing nonjudgmental, compassionate care. No question is too sensitive for our staff. They're very well trained. Our confidential consultation and referral hotline is open to anyone with any question about sexual or reproductive health.

To the extent that clinicians have a voice in their kids' schools, patients' schools, and can advocate for age appropriate, medically correct, comprehensive sex education programs, there's a lot of need for that. Sex education is not mandatory. Some school systems have nothing, some have abstinence-

only programs — some of those schools have the highest rates of teen pregnancy.

Physicians are leaders in their communities and can be advocates for smart public health policies by helping connect the dots between personal health and public health. We have the power as clinicians to make a difference.

Were security issues a consideration in accepting this position?

The safety of the patients and staff are a top priority. We have some of the highest security — a lot is a result of the 1994 shootings at Planned Parenthood in Brookline. Unfortunately, all practices have to think about this. It's an unfortunate reality for society in general. I'm not worried about it personally, I'm confident in our security measures. On our patient surveys, we never have comments about security. It looks and feels just like any other medical office. It's always comments about how well cared for they are.

Sitting Less, Moving More Can Make Major Health Differences

Combating "the New Smoking"

BY GREG GOULD
MMS PUBLIC HEALTH STAFF

What if the difference between health and chronic illness was something as simple as a five-minute walk? Recent research suggests that sitting less and moving more throughout the day can make a major difference in overall health.

"Americans are engaging in sedentary behavior for 17 hours a day," said Beth Frates, M.D., member of the MMS's Committee on Nutrition and Physical Activity and a lifestyle medicine specialist. "Sitting is considered to be the new smoking."

Sedentary behavior is associated with many diseases and disorders such as heart disease, stroke, osteoporosis, obesity, diabetes, hypertension, depression, anxiety,

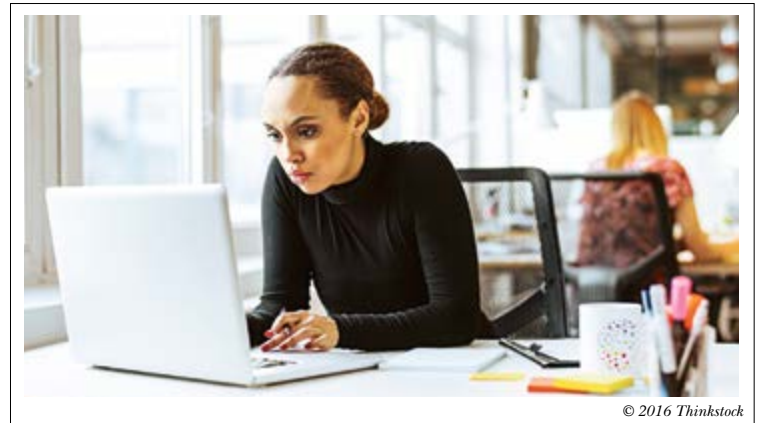
and even some cancers such as colon and breast, she said. Recent research has even connected sitting with decreased metabolism, decreased HDL levels, and improved creativity, she added.

"Even if people are meeting the guidelines, they still need to be aware of the dangers of sitting," said Dr. Frates. "Exercising a half-hour

every day for five days a week does not give you permission to sit for extended periods during the rest of the day." Long work days sitting, followed by long commutes, and time on social media contribute to this sedentary time, according to Dr. Frates. Physicians and their patients should find creative ways to build activity into their day, such as incorporating a standing or walking

"Even if people are meeting the guidelines, they still need to be aware of the dangers of sitting"

— Beth Frates, M.D.



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break every hour for a few minutes, she added. These activities will help to change body position, wake up the body and muscles, and allow for some movement each hour.

For references about sedentary behavior, and resources on increasing physical activity, visit www.massmed.org/healthyweight.



Link In with MMS

Connect with your peers by joining our members-only LinkedIn group at www.massmed.org/linkedin.

Beacon Hill Victories: No Indoor Tanning for Minors, New Protections for Diabetic Students

BY RONNA WALLACE
MMS LEGISLATIVE CONSULTANT

No one under 18 years of age will be allowed to use a tanning facility in Massachusetts, under a new law recently signed by Massachusetts Governor Charlie Baker. Chapter 31 of the Acts of 2016 is the culmination of 10 years of advocacy to reduce the prevalence of skin cancer in young people.

Until now, Massachusetts law allowed young people under 14 years of age to use indoor tanning facilities if accompanied by a parent or guardian; those 14 to 17 years of age would have needed a parent or guardian's consent. The MMS is a strong proponent of the new law, and it has long been on the record in support of limiting access to tanning facilities for young people.

Also nearing Gov. Baker's desk is legislation that would create an Office of Health Equity to coordinate activities to eliminate racial and ethnic health and health care disparities.

The Office of Health Equity would be charged with evaluating

the effectiveness of programs and interventions to eliminate health disparities, identifying best practices and model programs, and preparing an annual plan for the Commonwealth to eliminate disparities. The bill has already cleared the House and is currently pending before the Senate Ways and Means. The MMS presented written testimony in support of the bill at the public hearing last summer.

Another win for public health is the recent ad-

vancement of legislation to protect students with diabetes. H.417, "An Act Improving Students' Access to Life Saving Treatments," was reported out of the Joint Committee on Public Health and is now pending before the Health Care Financing Committee. The bill, sponsored by Louis L. Kafka (D-Stoughton) at the request of the MMS and the



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American Diabetes Association, would allow students to possess and self-administer glucose testing strips and insulin; it would also allow others to administer glucagon to diabetic students in emergency situations when the school nurse is unavailable. Parents would be required to give written permission that would

allow their student to self-manage.

Lastly, the MMS is pushing for action on legislation to reduce tobacco use. Currently pending

before the Public Health Committee are the following bills that are strongly supported by the MMS as positive steps to strengthen Massachusetts' commitment to a smoke-free Commonwealth:

- **H.2021, "An Act Further Regulating the Sale of Tobacco Products to Teenagers,"** would ban the sale of tobacco products, including electronic

cigarettes and vaporizers, to any person under 21 years of age.

- **HB2050/SB1119, "An Act Further Modernizing Tobacco Control and Protecting the Health of Minors,"** would prohibit the use of electronic cigarettes, vaporizing devices, and related products anywhere smoking is prohibited.
- **H.1954/S.1137, "An Act Restricting the Sale of Tobacco Products at Health Care Institutions,"** would ban the sale of tobacco products by health care institutions and pharmacies, and bar licensed health professionals from working in a professional capacity in locations where tobacco products are sold.

These important bills would go a long way towards reducing tobacco use by young people and ensuring that all individuals live free of secondhand smoke exposure. The MMS supports each of these bills individually and supports the advancement of a comprehensive bill that includes all the above provisions.

Clarifying Privacy Law

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occasionally provide such treatments and referrals.

Important Exceptions

According to SAMSHA, primary providers who do not work in general medical care facilities meet 42 CFR Part 2's definition of program only if their *principle* practice consists of providing alcohol or drug abuse diagnosis, treatment, or referral for treatment, *and* they hold themselves out as such." Lastly, 42 CFR Part 2 only applies to programs that are federally assisted, though the law provides a broad definition of this including receiving federal funds in any way, receiving tax exempt status, having DEA licensure, being a Medicare provider, etc.

Providers subject to 42 CFR Part 2 must adhere to important restrictions on their

communications about a patient. Specifically, they are prohibited from unlawful disclosures, defined as any communication of information that directly or indirectly identifies someone as being in, or having been in, or having applied for treatment in a substance abuse program. The scope of protected information that can be considered to identify a patient as an alcohol or drug patient or having a drug or alcohol problem is also quite broad and includes written or oral information about a patient's status as a current patient, information about a patient's identity, medical or treatment information, as well as "impressions of program staff."

There are several important exceptions to the disclosure prohibition in 42 CFR Part 2. The primary exception is prior patient consent. In fact, 42 CFR Part 2 has several specific, important

requirements to the consent process that must be reviewed before any signed document is considered valid. These requirements are detailed in the statute, but include the need for an explanation of the need for and scope of the consent, as well as indication of the expiration of the consent, among others. These consent forms do not have to be specific to each given request, so practices subject to these rules should consider drafting blanket consent forms that incorporate the specified consent factors.

Also, 42 CFR Part 2 has an exception for communication pertaining to medical emergencies. Under this provision, patient identifying information may be disclosed to medical personnel who have a need for information about the patient for the purposes of treating a condition which poses an immediate threat to the health

of any individual and which requires immediate medical intervention. It is important to note that this exception limits emergency disclosure to medical personnel, which is a narrower take than HIPAA.

While the inclusion requirements for practitioners subject to 42 CFR Part 2 are narrow, the disclosure prohibitions are substantial. It should be noted that SAMSHA and the Department of Health and Human Services are currently working to update and modernize these regulations to make the rule more understandable and less burdensome.

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

Helping One Another: Physician Peer Support Group for Burnout and Stress Is Effective and Empowering

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. The following article by Linda Bresnahan, M.S., PHS director of program operations, describes a recent study that delineates the effectiveness of this important resource.

— PHS Director Steve Adelman, M.D.

BY LINDA BRESNAHAN
PHS PROGRAM OPERATIONS DIRECTOR

At times when burnout and stress are overwhelming physicians, a newly published study demonstrates that peer support for behavioral health challenges in the physician population is effective and impactful. The concept of peer support is not new. Addiction support models such as Alcoholics Anonymous and Narcotics Anonymous set the stage for the benefits of peer support, which were soon followed by such groups as Overeaters Anonymous and Gambling Anonymous. But even outside the realm of addictive disorders, the benefits of sharing with, learning from, and supporting one's peers can present as a valuable resource. Physician



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Health Services recognized the potential for the therapeutic benefits of physicians helping one another beyond the challenges of addiction, and 13 years ago it created the PHS Behavioral Health Support Group.

Facilitated by an experienced social worker, the group welcomes all physicians, residents, and medical students in Massachusetts interested in sharing personal concerns, helpful insights, and affirmation. In an effort to measure the success of this venture, retired PHS Director Luis Sanchez, M.D., and other researchers have studied the effectiveness of this group since its inception in 2001. Respondents evaluated the group's impact on their quality of life in four domains: family and friends, wellness, professional relationships, and career.

Consistent with the findings in the addictions setting, participants' experience in this support group was meaningful, constructive, and consistent with improvement in personal and professional functioning. One survey participant summarized, "I was made to feel that my input was helpful. [I] learned that I was not alone and that all members truly wanted to help one another." Overall, 72 percent of attendees regarded their participation in the support group as positive. While many of the participants attended the group as an adjunct to other PHS support services and/or monitoring, 33 percent of respondents had attended the group on their own, independent of other supportive interventions, according to the study, published this year in *Journal of Psychiatric Practice*.

Respondents identified the role of the facilitator as particularly important, underscoring the facilitator's capacity to welcome new participants, manage interactions, set limits, and maintain a supportive emotional tone. As one participant described, "the facilitator provided everyone with a chance to have a say — but was able to detect those in need of more help and gave them more of a platform for expression." The challenges for such a group include the fact that the variety of problems, experiences, and interactive styles can be much more diverse than in a more targeted or homogeneous support group model such as AA. This makes the role of an experienced facilitator all the more essential. However, with the benefit of a skilled facilitator, this unique treatment intervention may become a model for a broader application of similar peer support in a workplace setting, to help address some of the more global themes of stress and burnout in current day medicine.

The study results encourage physician health programs, hospitals, medical practices and physician groups to consider implementing a facilitated support group as an additional source of support for physician well-being.

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.

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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.

Brian H. Gross, M.D., 76; Peabody, MA; Washington University School of Medicine, 1965; died November 24, 2015.

Robert G. Knight, M.D., 86; Athol, MA; Georgetown University School of Medicine, 1954; died October 22, 2015.

Herbert J. Levine, M.D., 85; Newton, MA; Johns Hopkins University School of Medicine, 1954; died July 11, 2014.

Paul A. Levine, M.D., 71; Stevenson Ranch, CA; Boston University School of Medicine, 1968; died December 27, 2015.

Shelia B. Nemser, M.D., 69; Needham, MA; New York Medical College, 1969; died May 9, 2015.

Bernard Portnoy, M.D., 87; New Bedford, MA; Northwestern University Medical School, 1953; died December 9, 2015.

George M. Sanger, M.D., 91; Coronado, CA; University of Toronto Faculty of Medicine, 1946; died January 2, 2015.

Richard Sens, M.D., 80; Cambridge, MA; Albert Einstein College of Medicine, 1961; died November 20, 2015.

James J. Shula, M.D., 73; Londonderry, NH; Case Western Reserve University School of Medicine, 1964; died October 5, 2012.

Wendell E. Smith, M.D., 88; Glen Allen, VA; University of Vermont College of Medicine, 1954; died February 12, 2016.

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

Charles River — Annual District Meeting. Thurs., Apr. 7, 6:00 p.m. Location: Gore Estates, Waltham. Tours of the mansion will be conducted at 7:15 p.m. **Delegates Resolution Review.** Thurs., Apr. 6, 6:00 p.m. Location: MMS Headquarters, Waltham.

Essex North — Annual District Meeting. Wed., Apr. 13, 6:00 p.m. Location: Diburro's Function Facility, Haverhill. Marylou Sudders, Secretary, Executive Office of Health and Human Services.

Essex South — Annual District Meeting. Tues., Apr. 12, 6:00 p.m. Location: Danversport Yacht Club, Danvers. Speaker: James Gessner, M.D., MMS president-elect.

Essex South/Essex North — Joint Delegates Meeting. Tues., Apr. 26, 6:00 p.m. Location: Beverly Depot, Beverly. Topic: Resolution Review.

Middlesex Central — Delegates Meeting. Thurs. Apr. 21, 7:45 a.m. Location: Emerson Hospital, Concord.

Middlesex North — Annual District Meeting. Thurs. Apr. 28, 6:00 p.m. Location: Stonehedge, Tyngsboro.

Middlesex West — Annual District Meeting. Wed., Apr. 6, 6:00 p.m. Location: Marlborough Country Club. Guest Speaker: Gail Gazelle, M.D., professional coach for physicians. **Delegates Resolution Review.** Thurs., Apr. 28, 6:00 p.m. Location: MacPherson Hall, Framingham Union Hospital. Delegates will meet to review and discuss the resolutions for the Annual 2016 Meeting.

Norfolk — Annual District Meeting. Tues., Apr. 12, 6:00 p.m. Location: Sheraton Needham Hotel. Guest Speaker: Dennis Dimitri, M.D., MMS president, and Alex Calcagno, MMS director of federal and community relations. **Resolution Review.** Wed., Apr. 20, 6:00 p.m. Location: MMS Headquarters, Waltham. Delegates will meet to review and discuss the resolutions for the Annual 2016 Meeting.

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

SOUTHEAST REGION

Barnstable — Annual Spring Meeting. Fri., Apr. 1, 6:00 p.m. Location: New Seabury Country Club, Mashpee. Guest Speaker: Dennis Dimitri, M.D., MMS president.

Plymouth and Norfolk South — Joint Annual Spring Meeting. Weds., Apr. 6, 6:00 p.m. Location: Neighborhood Club, Quincy. Guest Speaker: Dennis Dimitri, M.D., MMS president.

Bristol North and South — Annual District Meeting. Tues., Apr. 19, 6:00 p.m. Location: Venus de Milo, Swansea. Speaker: Jeffrey Drazen, M.D., NEJM editor-in-chief. **Southeast Regional Caucus.** Thurs., Apr. 28, 8:00 p.m. Location: LeBaron Hills Country Club, Lakeville.

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

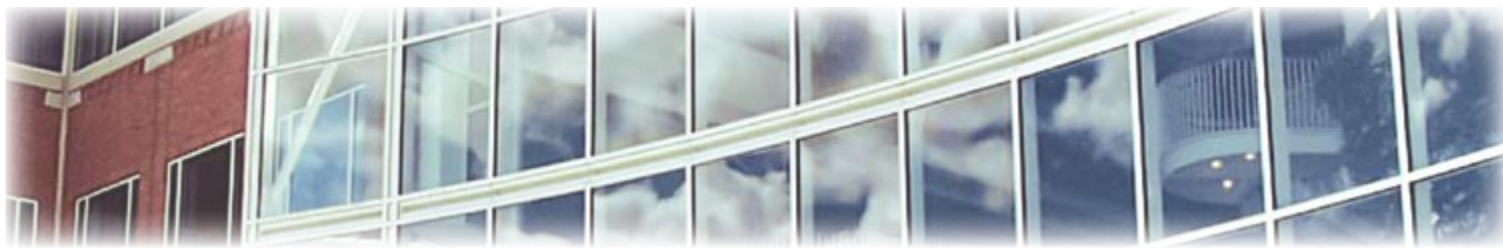
Berkshire — Annual District Meeting. Tues., Apr. 26, 6:00 p.m. Location: Crowne Plaza, Pittsfield. Guest Speaker: Dennis Dimitri, M.D., MMS president. Topic: Doing No Harm: The Opioid Epidemic and Physicians in 2016.

Hampden — Annual District Meeting. Tues., Apr. 19, 6:00 p.m. Location: Delaney House, Holyoke. Guest Speaker: Chelsea Gardner, D.O. Topic: Identification and Management of Gender Identity and Transgender Health Issues in our Pediatric Population. **Executive/Delegate Caucus Meeting.** Tues., Apr. 26, 6:00 p.m. Location: Executive Office, West Springfield. **High School Doctor for a Day Program.** Thurs., Apr. 28, 7:30 a.m. Orientation Breakfast, 5:00 p.m. Debriefing Dinner. Location: Baystate Conference/Learning Center, Holyoke.

Worcester — Annual Business Meeting. Wed., Apr. 13, 5:30 p.m. Location: Beechwood Hotel, Worcester. Meeting includes presentation of the 2016 Community Clinician of the Year Award.

Worcester North — Annual District Meeting. Thurs., Apr. 7, 6:00 p.m. Location: Chocksett Inn, Sterling. Guest Speaker: Dennis Dimitri, M.D., MMS president. Topic: Doing No Harm: The Opioid Epidemic and Physicians in 2016.

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.



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MASSACHUSETTS
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VITALSIGNS

VOLUME 21, ISSUE 4, APRIL 2016

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MMS AND JOINTLY PROVIDED CME ACTIVITIES

LIVE CME ACTIVITIES

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

12th Annual Public Health Leadership Forum — Firearm Violence: Policy, Prevention, and Public Health

Tues., April 5, 2016

Ethics Forum: Patient Satisfaction Surveys — Utility and Unintended Consequences

Thurs., May 5, 2016, Boston

Annual Education Program — Sustaining Joy in the Practice of Medicine: Compassion, Innovation, and Transformation

Fri., May 6, 2016, Boston or via live webinar

2016 Shattuck Lecture — Lost in Translation? Turning Scientific Discoveries into Medical Progress

Fri., May 6, 2016, Boston

Being Prepared for the Unexpected: Building Resilient Communities

Wed., May 18, 2016

MMS and RIMS Directors of Medical Education Conference

Thurs., May 19, 2016

14th Annual Symposium on Men's Health

Thurs., June 16, 2016

ONLINE CME ACTIVITIES

Go to 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 Series (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

- New Opioid Prescribing Guidelines in Practice
- Managing Pain Without Overusing Opioids
- The Opioid Epidemic (6 modules) — MMS 11th Annual Public Health Leadership Forum

- Principles of Palliative Care and Persistent Pain Management (2 modules)
- Opioid Prescribing Series (6 modules)
- Identifying Drug Dependence (*Legal Advisor*)
- Managing Risk When Prescribing Narcotic Painkillers (*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
- Intimate Partner Violence
- Payer Audits and Payment Recoupments
- Understanding Clinical Documentation Requirements for ICD-10
- ICD-10: Beyond Implementation



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

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