Thinking About Tomorrow’s Medicine
Patients Are Physicians’ “Biggest Untapped Resource”

With the long-anticipated rollout of the Affordable Care Act now underway, 2014 will be a year of major transition for the national health care landscape. But how will these changes and trends filter down to affect us locally? Vital Signs spoke with two experts on Massachusetts and national health care. Joseph C. Kvedar, M.D., is the founder and director of the Center for Connected Health, a division of Partners HealthCare; a board-certified dermatologist; and associate professor of dermatology at Harvard Medical School in Boston. Ian Morrison, Ph.D., is an internationally known author, consultant, and health care futurist. In 2011, Morrison authored Leading Change in Health Care: Building a Viable System for Today and Tomorrow.

VS: What’s the significance of being a Massachusetts physician while near-universal health care begins to kick in across the country?

KVEDAR: The movement toward health insurance exchanges is going to be a powerful opportunity to draw health consumers into their own care. At the Center for Connected Health we believe that patients are the biggest untapped source of health care reform. In our experience, they do so much, when given the opportunity, to step up and care for themselves. I think one of the reasons we haven’t seen more of that is that the ingredients weren’t there, and health information exchanges will be powerful for that.

MORRISON: In some senses, the experience of next year is going to be about the rest of the country going through some modified version of the joy and rapture you’ve all been through over the last five years. The big story in Massachusetts isn’t coverage, but cost. A part of what physicians here are experiencing is the same trend across the country, which is that increasingly medicine is not about individual doctors seeing patients at their practice — disconnected from the rest of the health care system — but rather they are part of the continuum of care in a sophisticated, large, well-financed enterprise where what they’re doing is increasingly tied economically to the fate of the larger system. And 2014 is a signal event because every state is going through that on a massive scale.

VS: Movements toward accountable care and cost containment make patient engagement more important than ever. How will physicians continue to perfect that skill in the coming year?

KVEDAR: The movement toward accountable care will continue to morph and change. I think 2014 is a signal event because every state is going through that on a massive scale. And 2014 is a signal event because every state is going through that on a massive scale.

As Massachusetts-based providers, we’ll have to be on the lookout for patients who are measuring and quantifying their own health and welcome their information into the practice, not necessarily because it will change decision-making, but more because it’s a sign that they’re participating in their care and we really should embrace patient self-care. It’s one of the things that’s going to get us out of this crazy morass we’re in, where we pay so much for health care.

Physicians have seen an explosion in HIT growth over the past several years. In 2009, just 10 to 20% of Massachusetts practices were using EHRs. In August 2013, the MMS Committee on Information Technology surveyed several thousand MMS members and found that 79% were using EHRs, indicating Massachusetts is one of the top states in EHR adoption nationwide.

Extrapolated to the estimated 18,000 clinical physicians in Massachusetts, that leaves fewer than 3,500 local clinicians not using EHRs. But that is not a permanent state of being; by January 2017 all providers will be required to use an EHR connected to a health information exchange (HIE).

Although EHRs have seemed a singular focus for physicians and practice managers for many years, there are now many new opportunities to use EHR data.

BY TALIA GOLDSMITH
PPRC SPECIALIST

Five Key Changes for Physician Practices

BY LEON BARZIN
MMS HIT DIRECTOR

HIT Disruptions and Your Practice
Next 3 Years will Bring More, Costly Changes

January 2014

October 2014

January 2017

EHR Stage 2 Upgrades

ICD-10 Conversion Deadline

HIE Participation Deadline
Futurists continued from page 1

care and yet our docs are all overworked.

VS: Are the changes underway going to be good for all doctors?

MORRISON: It depends [on] what kind of doctor you are. If you are a procedurally oriented specialist doing marginally indicated things and have a nice living right now, I think this world is not going to be as good for you. We’re going to drive out variation; we’re going to drive out inappropriateness; we’re going to concentrate utilization among the higher performing — and higher performance is not just clinical excellence, but also affordability. So if you’re in the wrong part of that distribution of clinical performance in the wrong specialty, I think the world may not be better.

But if you put the patient first — then say we actually are successful in creating incentives for patients and providers to use resources more effectively and efficiently — then there’s a win-win here. Conceivably you can have better care and lower costs and achieve the Triple Aim. If that’s the goal and you want those things to happen, it’s not a bad thing we go through this redesign.

VS: How will payment reform continue to affect the way Massachusetts physicians practice?

KVEDAR: In Massachusetts, we’re pretty far down that road. At Partners we’re heavily under risk with all of our payers and we have about 500,000 covered lives and we’re very serious about it. In the eastern part of state it’s pretty universal that providers are at risk. And that’s going to lead them to worry less about traffic in the office and more about the quality of care. It’s not that we didn’t worry about quality of care before, but you just did everything in the office because it was maximally convenient for the doctor and it’s where the locus of care was. Now the locus of care is spread out to where the patient is.

VS: What do you see as the future of team-based care? Will we continue to perfect the model?

MORRISON: What doctors need to understand is that this change requires a complete redesign. When it comes to the patient-centered medical home (PCMH), there’s a misconception, not among leaders, but among rank-and-file doctors that they’ll finally get more resources to look after every patient the same way. I keep saying that no, that would be dumb. That would be expensive and redundant in terms of resources. What we really want to do in a PCMH is have people look after themselves on their iPads most of the time. And with that, you use analytic and predictive modeling resources to concentrate your power on the multiply comorbid patients that can be redirected to much lower-cost and higher-quality outcomes.

KVEDAR: Yes, that’s near the top of the list of trends to watch. People are getting better at working in teams. It takes retraining of everybody, but I haven’t seen an instance where it hasn’t been heavily embraced. And it really does open up the door for some very novel and high-quality care models. When you have every provider empowered to practice to the top of his or her license, you really have a much better and more efficient care model.

VS: A trend toward massive consolidation is still going strong in Massachusetts and elsewhere. What are your predictions for the future of independent medical practice?

MORRISON: It’s extremely unlikely that many doctors will succeed without some kind of alliance to a larger group. There may be opportunities and certainly are opportunities in concierge medicine, but quite frankly there’s not enough rich people to go around.

I have been since my introduction to health care 30 years ago a large fan of large sophisticated multispecialty group practices as a building block of proper safe health care delivery system. I’m a Scottish Canadian Californian, and it’s the weakness of the Canadian system in my opinion that they don’t have sophisticated multispecialty group practices as a building block and they have solo fee-for-service physicians who are relatively disjointed and disconnected from one another.

VS: Does our health care marketplace have room to incorporate the emergence of more retail-based and urgent care centers without undermining our push toward better-coordinated care?

KVEDAR: Yes. I definitely think they’re an asset because those patients are people that weren’t getting served by our current system, otherwise they wouldn’t have gone to a retail clinic. Obviously, there’s a convenience aspect. But they provide a narrow scope of services, which are very algorithmic and it all makes sense.

I hope, however, that the goal is for data to flow over the information exchange and be accessible by the patient’s doctor so that care is not fragmented. Ideally, information should flow through in a way that can be captured at the time of the next visit with the patient’s regular doctor. VS

Editor’s note: These interviews have been edited and condensed for clarity.

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Five Key Changes
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bonus structures and reimbursement arrangements. Risk contracts are gathering momentum in this market as well. Blue Cross Blue Shield of Massachusetts (BCBSMA), Harvard Pilgrim Health Care, and Tufts Health Plan have increased their risk contract offerings from approximately 19 in 2008 to 34 in 2012.

How will this impact your practice?
Given the changing environment and the increasing complexity of contracting arrangements, you may encounter scenarios where you have existing informal relationships that must be formalized through a contract. If you encounter this, take your time and be sure to complete your due diligence and consider seeking legal review before entering into a contractual relationship.

RESOURCES
• PHYSICIAN EMPLOYMENT OPTIONS WEBINAR
• PHYSICIAN EMPLOYMENT GUIDE WHITE PAPER: WWW.MASSMED.ORG/EMPLOYED

2 PHYSICIAN REIMBURSEMENT.
We will see more ACO models and global budgets. The emergence of new payment models such as value-based care will continue to influence reimbursement strategies in 2014. Both commercial and public payers are working on creating plan benefit designs that incentivize patients to seek physicians who provide quality care at a lower cost and in turn reward physicians who provide quality care at lower cost.

For physicians, achieving high patient satisfaction and quality scores is paramount as reimbursement continues to incorporate rewards for meeting predefined metric targets. In today’s health care environment, using data to help drive the decision-making process is becoming increasingly important and ultimately linked to physician reimbursement.

How will this impact your practice?
Data is your friend. Learn how to use your electronic medical records (EMRs) to help address care and quality gaps in your practice. Understand what you are required to do in order to position yourself for success under both your public and commercial payer contracts. Focus on implementing processes that help to support the use of data in your practice. Understand what your benchmarks are and focus on improving one area at a time.

RESOURCES
• USING DATA WISELY WEBINAR: WWW.MASSMED.ORG/USINGDATAWISELYPRESENTATIONS

3 FEDERAL AND STATE REGULATIONS.
Federal and state legislative changes will continue to occur as components of the Affordable Care Act continue to roll out. As components of Chapter 224 continue to be implemented in 2014, Massachusetts physician practices will be subject to new requirements. Two specific examples are price transparency and consumer engagement.

How will this impact your practice?
These changes will impact your practice mainly from an administrative standpoint. Understanding what the changes are (e.g., new requirements for physician licensure, ICD-10), flexibility in terms of adapting your practice to accommodate these changes, and communicating with patients will be vital.

RESOURCES
• PPm PRACTICE PULSE NEWSLETTER: WWW.MASSMED.ORG/NEWSLETTERS

4 WELLNESS, PREVENTION, AND PATIENT ENGAGEMENT.
The increased adoption of accountable care organizations (ACOs), integrated care delivery models coupled with the requirements of Meaningful Use Stage 2 and the Massachusetts Chapter 224 requirements around medical home implementation have kindled discussions on wellness, prevention, and patient engagement in 2013. These conversations will continue throughout 2014 as the health care industry works to implement initiatives to promote wellness, facilitate disease prevention, and engage patients as active participants in the care delivery process.

How will this impact your practice?
The movement towards wellness and prevention activities will require physicians to create new strategies to involve patients in health care decision-making. A focused effort on wellness and prevention may be accomplished through patient education (for instance, on healthy eating), disease prevention activities, and the sharing of information and data with your patients.

RESOURCES
• EIGHT PRINCIPLES OF PATIENT ENGAGEMENT: WWW.MASSMED.ORG/8PRINCIPLES

5 ICD-10.
The emphasis on ICD-10 will intensify starting in January 2014, as we prepare for the October 1, 2014, deadline for compliance. While that may seem a long way off, the transition to ICD-10 is highly complex and can lead to the need for significant changes in people, processes, and technology in your practice.

How will this impact your practice?
ICD-10 implementation requires significant preparation. Practices are urged to perform documentation gap analysis now — under ICD-9 — to identify weaknesses and develop a plan to address any issues that might arise while implementing ICD-10.

RESOURCES
• THE TRANSITION TO ICD-10 VIDEO SERIES
• THE TRANSITION TO ICD-10: KEY CONSIDERATIONS FOR PHYSICIAN PRACTICES WHITE PAPER
• WWW.MASSMED.ORG/ICD10

TRENDWATCH ➤

LEIF BRIERLEY
MMS HEALTH POLICY ANALYST

Getting the most value-per-dollar spent has become a key focus for the U.S. health care system. Policymakers will continue to tie cost containment efforts to improved quality of care for the foreseeable future. The latest innovations in health care delivery are pointed toward this unified goal: providing high-value, patient-centered health care.

“High-value health care” and “value-based care” are the latest buzzwords in health policy, reflecting the myriad of delivery system changes taking place and health care delivery innovations proliferating around the country. Accountable care organizations (ACOs) exist in all 50 states, global budgets and financial risk arrangements make up an increasing portion of payer contracts, and patient-centered medical homes have become a focus for primary care physicians. In 2014, these innovations will continue to evolve.

With national and state-based health reform rapidly changing the dynamics of the health care system, physicians have started to experience firsthand the shift away from a reimbursement system based on volume (e.g., global budgets, where physicians are being asked to efficiently manage the care of their patient population within a spending target, while meeting quality benchmarks). As health reform progresses, physicians will increasingly need to be active participants in order to ensure that new models of care are delivering true value-based care for patients.

In 2014, the focus on value-based care will result in physician practices continuing to adopt strategies to become more patient-centered, take on risk-based contracts (or more risk-based contracts), consider clinically integrating, and adopt new care delivery methods. Physicians should consider how the components of value-based care work in their practice and what initiatives they are already working on that might support and fit into the increasingly popular concept of value-based care. Delivering low-cost, high-quality care is a win-win for patients and physicians alike.
NEW IN 2014 ➢

BY ROBYN ALIE
MMS PUBLIC HEALTH MANAGER

As near-universal access to health insurance expands nationwide, the public health community looks forward to the coverage for preventive services required by the new law. Services such as cancer screenings, vaccinations, chronic disease management, and mental health and substance use services will save lives and reduce longer-term health care costs.

As we have learned in Massachusetts, however, insurance coverage does not always mean access to care. The MMS’s most recent study on patient access to care, published earlier this year, showed significant declines in the rates of primary care physicians accepting new patients. For certain patients, disparities in access to quality, timely health care remain.

This March, the MMS will hold a leadership forum to examine health care disparities in Massachusetts, and discuss what more can be done to ensure equitable access. The forum will also cover the integration of mental health services, through events aimed at engaging medical students, college students, and secondary school students from diverse backgrounds.

Achieving Parity for Mental Health

The Society will also focus on disparities in care for people with mental health issues in the coming year. While mental health and substance abuse issues affect almost half of Americans, mental health is not treated the same as physical health conditions in a system which faculty at MMS’s 2013 public health leadership forum called “unequivocally broken,” “confusing,” and “isolating.”

The Affordable Care Act recognizes mental health as an essential condition that insurers will be required to cover beginning in 2014. However, the different systems for referrals, authorizations, and reimbursement for mental health care make navigating the system complex, cumbersome, and restrictive for both patients and providers.

Two state commissions are examining the ability of the public and private mental health systems to meet patients’ clinical needs, as well as barriers to integration of primary care and behavioral health services. One has recommended a team-based clinical model to coordinate services, adequate reimbursement, transparency, workforce training, and modifications to prior authorization processes. The second commission, which includes representation from the MMS, is expected to issue a report soon. The MMS will continue to explore what we — and the health care community as a whole — can do to achieve the integration and parity of mental health care and physical medicine.

Deadline for Foundation Grant Programs is Jan. 15

The MMS and Alliance Charitable Foundation is accepting letters of inquiry for its Community Action and Care for the Medically Uninsured grant programs until Wednesday, January 15, 2014. These grants support physician-led volunteer initiatives that provide free care to uninsured patients and increased access to care for the medically underserved, as well as health initiatives targeting public health issues. In 2013 the Foundation awarded 11 grants, ranging from $5,000 to $35,000. Organizations submitting successful letters of inquiry will be invited to submit full grant proposals by March 1. For more information and to access the Letter of Inquiry form, visit www.mmsfoundation.org.

BUSM Attends President Obama’s ACA Forum

Members of the MMS’s Boston University School of Medicine Chapter attended a forum on the Affordable Care Act featuring a visit by President Obama on October 1.

Ongoing Public Health Campaigns

Massachusetts has long been a national leader in public health. We had the highest flu vaccination rates in the country last season, and one of the lowest rates of adult obesity. Yet more than 40 percent of residents did not receive a flu vaccination, and 23 percent of adults are obese; obesity is one of the biggest drivers of chronic disease and health care costs.

The MMS will continue to work to improve vaccination rates and obesity prevention and treatment, as well as advocate to prevent tobacco use, particularly among young people, and keep abreast of developments as medical marijuana dispensaries open in Massachusetts. We remain committed to violence prevention efforts and our work with state officials to ensure that the health care community is prepared for disasters — natural and manmade. Physicians are the key to Massachusetts’ success in public health and prevention, and the MMS’s activities toward identifying and bridging gaps in care and prevention foster that success. /35
STATE UPDATE

Scope of Practice is 2014 Legislative Priority

BY RONNA WALLACE
MMS LEGISLATIVE CONSULTANT

One of the top state advocacy priorities for the MMS in 2014 is scope of practice legislation. Legislation to allow optometrists and podiatrists to perform more complicated medical and surgical procedures and to grant advance practice nurses independent practice will continue to be major concerns for the Society in the coming year.

Among the most concerning of nursing scope of practice bills is legislation that would grant independent practice to nurse anesthetists and nurse practitioners, including prescriptive authority and the ability to order and interpret tests. Physician supervision would be completely eliminated and there would be no limitations in a practice setting.

Other scope of practice bills relate to midwives and nurse midwives, which would allow professional midwives to order and interpret clinical tests and obtain and administer certain drugs and medications. One proposal calls for nurse midwives to be primary care providers, able to practice medicine in any setting and with any patient population.

Psychiatric nurse mental health specialists are also seeking expanded scope of practice, including legal permission to order and interpret tests and prescribe medications.

Scope of practice has been a challenge in the regulatory arena as well. The Board of Registration in Nursing is poised to implement new regulations to allow advanced practice nurses to sign documents previously requiring a physician’s signature, and to allow nurse midwives independent practice. The MMS has been a vocal opponent of these proposed regulations.

The MMS has repeatedly urged the legislature not to expose the public, particularly our most vulnerable patients, to the independent practice of individuals with minimal training and no oversight whatsoever. Independent practice is not the model that has helped nurse practitioners in establishing their profession. Integrated, physician-led teams are the standard of care as well as the model for the future.

Any consideration of independent practice for nurse practitioners must address the lack of public protections required of nursing. Nurse practitioners are not subject to the public protections the legislature has created for the practice of medicine by physicians. Nurse practitioners do not have profiles listing their education, specialties and history of discipline, criminal convictions, or malpractice payments. They are not currently required to use the Prescription Monitoring Program or carry professional liability coverage.

In addition, unlike physicians, nurse practitioners are not subject to mandatory continuing education requirements in specific areas, such as electronic medical records and a host of other legislative mandates.

Nationally, organized nursing has been working very hard to expand scope of practice for the field, but what has been effective in other states is not necessarily appropriate for Massachusetts. The MMS will continue to urge legislators to consider the benefits to the public in maintaining the Massachusetts system of integrating nurse practitioners into a comprehensive health care team and not replace it with a legal framework for the independent practice of medicine by nurses. US

FEDERAL UPDATE

SGR Repeal in Sight

Last month, the AMA’s House of Delegates voted overwhelmingly to support a resolution calling on Congress to repeal Medicare’s Sustainable Growth Rate, the failed physician payment formula.

“We’re pulling out the stops to get Congress to act and take a fiscally responsible course that will stop the annual cycle of draconian Medicare cuts and short-term patches,” said AMA President Ardis Dee Hoven, M.D.

MMS officials have also supported the resolution and submitted comments to the bipartisan Congressional group working on the plan.

MMS President Ronald Dunlap, M.D., praised efforts to permanently repeal the flawed formula, but expressed concerns that current proposals do not contain new payment formulas that will allow physicians to make technological and other investments necessary to achieve the quality markers required by a new approach.

Among other recommendations, Dr. Dunlap urged Congress to include at least a 0.5 percent update for physicians starting in 2014, expand assistance programs for small practices, refinement of value-based program requirements, and allowances for multiple alternative payment models.

– Alex Calcagno

HIT Disruptions

continued from page 1

several additional technology-driven practice changes on the horizon.

Here are some crucial upcoming HIT events and deadlines expected to affect Massachusetts physicians and medical practices, as well as some of the associated costs.

January 2014

EHR Stage 2 Upgrades. As Meaningful Use moves to additional stages, EHRs are required to add significant new features and they will charge for additional functionality and interfaces to various services, patient portals, lab feeds, government entities, billing clearing houses, and quality reporting. Cost: System-support contracts required to obtain these upgrades typically cost 18 to 20% of the purchase price of the system on an annual basis.

October 2014

ICD-10 Conversion Deadline. Already delayed once by a year, this change to documentation and critical billing information is unlikely to be postponed again. It will essentially require all practices to adopt some sort of electronic system in order to bill within the complex rules of ICD-10 coding. Cost: United Healthcare estimates a total cost of $83,000 to $252,000 to accommodate the conversion for a 1- to 3-physician practice, depending on whether the practice has an EHR or not.

January 2017

Deadline for HIE Participation. Massachusetts will mandate that all physicians use an interoperable, connected EHR. Cost: Although the Massachusetts state HIE, called The Hlway, is subsidized, there will be costs to build and install interfaces in addition to monthly usage fees. An interface can cost upwards of $10,000 — and in some cases additional usage charges for larger practices.

Ongoing

The change from paper records to electronic documentation brings a host of additional ongoing technology requirements. Cost: Very dependent on individual practice needs and requirements.

• Analytical and reporting systems/services to support new quality and payment models
• Data conversion associated with EHR change — practices joining larger organizations and ACOs, may incur significant data movement and conversion efforts and fees as they merge their patient records into the new system
• IT Training, IT Services, and project management for both
• Encryption, backup, intrusion protection, and disaster recovery/system failover systems for on-site EHRs
• Cost of providing for more stringent HIPAA protections, audits, and documentation

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PHYSICIAN HEALTH MATTERS

TRENDWATCH »

BY STEVE ADELMAN, M.D.
PHS DIRECTOR

Recapturing Our Calling as Healers

Since starting medical school more than three decades ago I have never experienced as much change and pressure in the health care environment. As 2013 winds down there is every indication that the atmospherics, which have us all reeling, will continue into 2014 and beyond.

The current zeitgeist is captured by Dr. Bradley Allen, a pediatric heart surgeon who once served as director of the Children’s Heart Institute of Houston, in a recent opinion piece in The Wall Street Journal. He asserts that the current health care climate in this country is transforming the medical profession into a nightmarish “factory” of underpaid doctors working long hours in “assembly line fashion.” His personal sentiments capture the troubled mood of many physicians around the country and across the Commonwealth. There have been several telling experiences that have come my way in recent months:

• A medical school classmate who works in a large multispecialty group told me that some senior physicians beloved by their large panels of devoted patients are making precipitous decisions to retire early.
• A senior medical specialist in a profitable community hospital was troubled with the loss of collegiality in the profession. “We just don’t talk anymore,” he said, referring to his contacts with other physicians. “What happened?” he asked, with a sad and wistful look on his face.
• An intensivist who customarily recharged his emotional batteries by performing in a community orchestra lamented that the long hours and cumulative stress and strain of his work have made it increasingly difficult for him to commit to his orchestra’s concert schedule.
• My neighbor, a successful primary care internist, alerted me that his son, an academically gifted and empathic young man, had turned down multiple medical school acceptances and opted for a graduate program in public policy. My neighbor was relieved.

I am sorry to say that the anecdotes go on and on. It may be time for us to heed Charles Rosen’s 1967 VISTA recruiting slogan: “If you’re not part of the solution, you’re part of the problem.” What follows are a few of the countermeasures that come to mind.

**Engage and get active.** Learn as much as you can about the inner workings of medicine by participating in work groups that have an impact on the practice lives of physicians. Learn to think globally while acting locally. You can do so at the level of your practice, your hospital, the district medical society chapter, the MMS, your specialty, a health plan committee, or other formats.

**Create time to breathe and think.** Clearly, this is more easily said than done. Try your best to live within your means — requiring less money may help you to scale down your work effort. Time is the most precious commodity in the daily lives of most practicing physicians.

**Take excellent care of yourself.** Do your best to nourish the sustaining human connections in your life. As you nurture relationships with loved ones, redouble your efforts to take time at work to focus on the human side of your interactions with colleagues and team members.

As I travel around Massachusetts meeting physicians in a variety of practice settings, I am convinced that those who balance excellent self-care and a nourishing personal life with the demands of medical practice are best equipped to soldier through the current onslaught.

In Kansas and Missouri, the boards of medicine are known as the boards of “healing arts.” We must do everything possible to recapture the artistry and wonder of our calling as healers. It is up to us to use our wisdom, experience, and centrality of our roles to energize ourselves and invigorate our profession during this time of change and transition.

Steve Adelman, M.D., is the director of Physician Health Services, Inc., and a clinical associate professor of Medicine at UMass Medical School. His passions include running and traditional Jewish Sabbath observance with family and friends.

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**The MMS Mourns Physician Health Pioneer Michael Palmer, M.D.**

Michael S. Palmer, M.D., one of the nation’s leading authorities on physician health and a founding associate director of Physician Health Services (PHS), died suddenly on October 30. He was 71 years old.

In addition to his trailblazing work on physician health, Dr. Palmer was an accomplished author of 17 suspense novels, including several New York Times bestsellers. His work has been translated into 35 languages.

At the time of his death, Dr. Palmer was an associate director emeritus of Physician Health Services, and was still very actively involved in the organization. He spoke openly about his own recovery from drug and alcohol abuse. In a 1996 New York Times article he said, “You’re taught from the day you start medical school that you’re a god, that you can have power over life and death. So when your life starts to crumble and the highest power you see is looking back in the mirror — and you know that power is flawed — it is very hard to get past that. … The doctor’s intelligence is often a barrier to recovery. But once he gets into recovery, it’s a huge asset because he sees the logic.”

Dr. Palmer was remembered fondly by his colleagues and friends at MMS.

“Michael was, and still is, the spiritual godfather of Physician Health Services. He possessed a unique combination of selflessness, keen intelligence, and compassion. His bottom line was to do what was in the best interest of physicians and patients, and he always stepped up to be helpful in the most trying of circumstances,” said PHS Director Steve Adelman, M.D.

Dr. Palmer served as a clinical instructor in medicine at Tufts University and was on the faculties of Harvard Medical School and the University of Cincinnati School of Medicine.

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A gathering of attendees from the MMS Alliance 2013 Northeast Leadership Conference in Lenox, Massachusetts, on October 10.
**District News and Events**

**NORTHEAST REGION**


Middlesex Central — Holiday Party. Sun., Dec. 8, 4:00 p.m. Location: Concord Country Club, Concord. Executive Committee. Thurs., Dec. 19, 7:45 a.m. Location: Emerson Hospital, Concord. Executive Committee. Thurs., Jan. 16, 7:45 a.m. Location: Emerson Hospital, Concord.

Middlesex West — Executive Committee Meeting. Wed., Jan. 22, 6:00 p.m. Location: Office of Jennifer Thulin, M.D., 67 Union St., #505, Natick.

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

**SOUTHEAST REGION**

Norfolk South — Holiday Event. Wed., Dec. 11, 6:00 p.m. Location: Quincy Marriott, Quincy. Annual Toys for Tots Program and Scholarship Awards.

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

**WEST CENTRAL REGION**

Hampden — Winter Meeting. Tues., Jan. 28, 6:30 p.m. Location: Springfield Marriott, Springfield. For more information, contact Hampden District Office at (413) 736-0661 or hdms@massmed.org.

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.

**Statewide News and Events**

Member Interest Network — AHH&C MIN Executive Committee Meeting. Wed., Feb. 12, 6:00 p.m. Location: Mechanics Hall, Worcester.

For more information, or if you have statewide 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.

Katherine Ballis, M.D., 60; Somerville, MA; University of Pennsylvania School of Medicine, 1980; died April 9, 2013.

Mordecai E. Berkowitz, M.D., 83; Gloucester, MA; Tufts University School of Medicine, 1956; died July 7, 2013.

Robert F. Cooney, M.D., 79; Wareham, MA; Tufts University School of Medicine, 1945; died August 6, 2012.

Jane Desforges, M.D., 91; Melrose, MA; Tufts University School of Medicine, 1945; died September 7, 2013.

Albert Haddad, M.D., 96; Paxton, MA; Albany Medical College, 1943; died October 1, 2013.

Russell S. Hoxie, M.D., 83; Oak Bluffs, MA; Cornell University Medical College, 1952; died July 30, 2011.

Max D. Lack, M.D., 97; Boston, MA; Kansas City University of Physicians and Surgeons, 1941; died November 12, 2012.

Marshall A. Lamb, M.D., 99; Lunen-burg, MA; Tufts University School of Medicine, 1939; died March 30, 2013.

David B. Lovejoy Jr., M.D., 64; Marblehead, MA; University of Rochester School of Medicine, 1975; died May 27, 2013.

Elizabeth Martinez, M.D., 47; Boston, MA; Johns Hopkins University School of Medicine, 1992; died September 19, 2013.

John F. McClellan, M.D., 64; Marshfield, MA; University of Pennsylvania School of Medicine, 1975; died September 10, 2013.

Paul V. Nally, M.D., 82; Shrewsbury, MA; Creighton University School of Medicine, 1965; died September 24, 2013.

J. David Poutasse, M.D., 78; Pittsfield, MA; Harvard Medical School, 1959; died October 22, 2102.

Harry T. Powers, M.D., 95; Satellite Beach, FL; Cornell University Medical College, 1943; died August 18, 2013.

Dennis J. Sanidas Jr., M.D., 75; East Falmouth, MA; Boston University School of Medicine, 1961; died April 22, 2013.

Melvin I. Shoul, M.D., 91; Newton, MA; Tufts University School of Medicine, 1947; died September 30, 2013.

Gordon L. Snider, M.D., 91; Longmeadow, MA; University of Toronto, 1944; died June 8, 2013.

**ANNUAL MEETING**

Data-Driven Clinical Decision Making and Improving Quality of Care

**Thursday, May 15**
- House of Delegates Opening Session
- Reference Committee Hearings
- Ethics Forum
- President’s Reception and Nancy N. Caron Annual Art Exhibit and MMS and Alliance Charitable Foundation Auction
- International Medical Graduates Annual Reception

**Friday, May 16**
- Annual Education Program
- Shattuck Luncheon and Lecture
- Presidential Inauguration and Awards Reception and Dinner

**Saturday, May 17**
- House of Delegates Second Session
- Alliance Annual Meeting, Brunch, and Program
- Annual Meeting of the Society Luncheon

Online registration opens in late February.

SAVE THE DATE!
2014 Annual Meeting
May 15–17, 2014
Seaport Hotel and World Trade Center, Boston
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   Michael Palmer, M.D.

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MMS SPONSORED AND JOINTLY SPONSORED CME ACTIVITIES

LIVE CME ACTIVITIES
Go to www.massmed.org/calendar. Unless otherwise noted, event location is MMS headquarters, Waltham.

SAVE THE DATE
2014 Annual Education Program — Data-Driven Clinical Decision Making and Improving Quality of Care
Fri., May 16, 2014, 8 a.m. to noon
Seaport Hotel and World Trade Center, Boston

2014 Shattuck Luncheon and Lecture
Fri., May 16, 2014, 12:30 to 2:00 p.m.
Seaport Hotel and World Trade Center, Boston

12th Annual Symposium on Men’s Health
Wed., June 11, 2014, 8 a.m. to 5:00 p.m.

ONLINE CME ACTIVITIES
Go to www.massmed.org/cme.
Risk Management CME

End-of-Life Care
• End of Life Care (3 modules)
   – Ethics and End-of-Life Care
   – Advance Care Planning
• Communication and Conflict Resolution in End-of-Life Care
• The Importance of Discussing End-of-Life Care with Patients
• Legal Advisor: Advance Directives

Pain Management
• 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

Other Risk Management CME
• Principles of Palliative Care and Persistent Pain Management
• Guide to Accountable Care Organizations: What Physicians Need to Know
• HIPAA 2.0: What’s New in the New Rules?
• Cancer Screening Guidelines (2 modules)
   – Colorectal Cancer Screening Guidelines
   – Screening for Breast Cancer: Update on Guidelines and the Ongoing Controversy
• Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
• Engaging Patients in the New Era of Health Care
• Collaboration and Conflict: Communicating Effectively with Colleagues
• Effective Chart Review for Quality Improvement

Other CME
• Contracting with an ACO
• A Roadmap to Bring an End to HIV and STDs in Massachusetts: (4 modules)
• Finance 101 for Physicians and Practice Administrators
• 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

TO REGISTER FOR ANY OF THESE ACTIVITIES, CALL (800) 843-6356.
CME CREDIT: These activities have been approved for AMA PRA Category 1 Credit™.

For additional information, contact the Department of Continuing Education and Certification at (800) 322-2303, ext. 7306, or go to www.massmed.org/cmeCenter.