Here Come the “Docpreneurs”
Young, Ambitious, and Determined to Improve Health Care

BY VICKI RITTERBAND
VITAL SIGNS STAFF WRITER

When he was a medical student rotating through a local community hospital, Josh Mandel, M.D., was struck by an inefficiency he became determined to fix. Every morning, another medical student arrived at the ED at 5 a.m. to copy the vitals of patients admitted overnight onto a piece of paper. The process would take an hour. Staff would then use those notes to conduct rounds.

“It was error-prone, time-consuming, and not a learning opportunity,” said Dr. Mandel, 33. “I ended up building a software tool that automated the workflow. I learned a lot about how systems work and a lot about how to take medicine into my own hands and build better tools.”

Dr. Mandel is part of a growing cadre of young physicians doing just that. Working at the intersection of technology and medicine, these 30-something former whiz kids with undergraduate engineering or computer science degrees from top tier colleges view technology as a way to shake up health care business as usual — its high costs and inefficiencies. And they are being nurtured by a local environment that in the past several years has become a hothouse for health care entrepreneurship.

“Boston has the highest density of physicians per capita along with tremendous academic institutions,” said Omar Amirana, M.D., 51, senior vice president at Allied Minds, a science and technology development and commercialization company. “It has a never ending source of new ideas and forward thinking physicians working in an ecosystem that lends itself to entrepreneurship, especially in the life sciences.”

That ecosystem includes top notch universities and health care organizations; hackathons where ideas are spawned; business accelerators and incubators that take bright ideas one step further; and lots of venture capital hungry for promising businesses to invest in. Even institutions like Brigham and Women’s Hospital, with its two-year-old Innovation Hub, have caught the entrepreneurial bug. And the Massachusetts Biotechnology Council has seen such an explosion of interest in physician-led innovation that in 2015 it launched a chapter of the Society of Physician Entrepreneurs, which Dr. Amirana co-chairs.

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Supporting Our Patients Through the Opioid Crisis

I hope your 2016 is off to a successful and productive start.

Over the holidays, Massachusetts legislators were busy crafting opioid abuse prevention and treatment legislation that will strike an important balance between the critical need to reduce opioid overdoses with the imperative to effectively and responsibly treat pain.

We thank our lawmakers for taking into consideration MMS commentary, as well as the concerns of clinicians who address the issues of addiction and pain management on a daily basis.

The MMS looks forward to working closely with the Massachusetts legislature and the Baker administration to enact this legislation soon.

We were also pleased by the recent move by the DPH to enable hospitals to enroll residents in the prescription monitoring program. The residents will be able to log on to the database under the authority of a fully licensed representative of the training program.

Just last week the MMS hosted a webinar about Massachusetts’ new Opioid Therapy and Physician Communication Guidelines, a set of MMS guidelines incorporated into the MA Board of Registration in Medicine’s comprehensive advisory to physicians this year. That webinar material will be online and available to members soon.

In the coming months, you will be hearing more about how we as physicians can continue our ongoing efforts to educate prescribers and patients about opioid safety, as well as how we can more comprehensively support our patients who are undergoing treatment and recovery. As always, you can read about all of these issues at www.massmed.org/opioids.

“Docpreneurs” continued from page 1

more physicians driving that vehicle,” said Greg Goodman, 29, a first-year resident at Steward Carney Hospital, who interviews physician entrepreneurs each week for his podcast, The ModernMD (themodernmd.com). “At the end of the day, we’re physicians because we want to heal people, but it’s exciting to heal the health care system too.”

The Hackathon

In the past few years, the ground floor for many promising local health care innovations has been the hackathon, typically co-sponsored by some combination of universities, medical schools, and health care organizations. MIT Hacking Medicine and Tufts’ MedStart are two of the most well known local hacking events. Clinicians, programmers, designers, and others gather for a weekend of spontaneous creation, or “disruption,” in the parlance of innovation. Teams form around a problem or idea, then spend the next 24 to 36 hours collaboratively building the solution, which often takes the form of a mobile app. Teams present their projects to a panel of judges for recognition and prizes.

It was September 2013 when YiDing Yu, M.D., 30, walked into a Brigham and Women’s Hospital-sponsored hackathon with the germ of an idea and the confidence of a young physician who had already launched two companies by age 18. Like Dr. Mandel, Dr. Yu had seen an outdated process during her training—paramedics relaying medical information via radios to hospital EDs—and knew it was ripe for disruption.

“At the hackathon, people gravitated toward me,” said Dr. Yu, whose full-time job is as chief innovation engineer at Arius Health. “I had a good pitch, I was a physician, and I had a solution for a pain point.” Two days later, her team of 11 people had created the first incarnation of what would become Twiage, (twiagemed.com) a HIPAA-compliant smartphone app that sends photos, video, EKGs, and GPS-tracked estimated arrival times from the ambulance to the hospital’s computer system so staff can better prepare for arriving patients.

The Twiage system is being piloted in every ambulance that serves the South Shore, with plans to expand to three additional hospitals in 2016, and was the 2013 winner of MMS’s Information Technology Award in the resident category.

A Foot in Both Worlds

Dr. Yu, like other young physician-entrepreneurs, still keeps a foot in the clinical world. In addition to her roles as chief medical officer of Twiage and chief innovation engineer at Arius, she practices as an internist at Vanguard Medical Associates.

That dual identity is also critical to physician-innovators like Craig Monsen, M.D., 29, the founder of symptom checker startup Symcat (www.symcat.com), which he launched during medical school. But it was while working at his current job as a resident at Brigham and Women’s that he conceived of his company’s other popular product, a cardiovascular risk calculator that determines whether a patient should be put on a statin. The mobile-friendly calculator was based on 2013 guidelines issued by the American College of Cardiology and the American Heart Association. But those guidelines were only available in a cumbersome spreadsheet that was nearly impossible to access on a cell phone.

“Without being in that clinical environment, I may have missed out on that opportunity,” said Dr. Monsen. “Being in a clinical environment continues to pay dividends in ways that are sometimes hard to define. But to be frank, it’s not always easy to juggle both Symcat and residency. I have little doubt that Symcat would be further along if I weren’t doing my residency.”

Jennifer Joe, M.D., 36, said that her job as an ER doctor for the Veterans Administration was challenging to manage while running two companies, Medstro (medstro.com), a physician social network, and MedTech Boston (medtechboston.medstro.com), a news site. Medstro has hosted several NEJM Group interactive forums for physicians and MMS members. “When you’re in the ER, with patients coding, alarms going off and telephones ringing, you can’t hop on a conference call,” said Dr. Joe. So she has stepped away from clinical medicine for now. “But for companies involved in redesigning health care delivery, it’s hard to do unless you have the experience of delivering care in multiple settings and understanding the pain points,” she said.

Observers believe physician entrepreneurship will only grow as the popularity of college computer science classes reaches all-time highs. “You look at places like Stanford and Harvard where the introduction to computer science courses have roughly 1,000 students,” said Dr. Monsen. “There’s going to be a huge denominator of people with computer backgrounds and many of them will bring that to medicine.”

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EDITOR: Erica Noonan
STAFF WRITERS: Deb Beaulieu-Volk, Vicki Ritterband
EDITORIAL STAFF: Charles Alagero, Office of General Counsel; Robyn Alie, Public Health; Lori DiChinata, Government Relations; Kerry Ann Hayon, Managed Care; Stephen Phelan, Membership; Cathy Salas, West Central Regional Office; Jessica Vautour, Physician Health Services

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BY RYAN MARLING
PPRC STAFF

While numerous factors will determine the long-term sustainability of accountable care organizations, the model is here to stay. New variations of ACO models are being tested across the country and national accreditation and certification standards are being set by the Department of Health and Human Services and more locally by the Massachusetts Health Policy Commission. A new guide authored by Physician Practice Research Center experts titled MMS Guide to Accountable Care Organizations Part 2: Exploring the Future of ACOs joins our series of resources designed to help practices navigate the road to being part of an ACO and features insights into how ACOs are faring, strategy options for prospective participants, and discusses the regulations and potential risks and benefits associated with each model.

An exploration of challenges and successes of the Pioneer and Medicare Shared Savings Programs at state and national levels aim to give physicians a head start in preparing for the future of ACO models. A few tips highlighted in the guide:

• Having a strategy for integration into an ACO is essential, as multiple major components of the practice need to change simultaneously during the transition.
• The utilization of population health management capabilities is not sustainable for a practice unless the reimbursement structure is modified so that savings from such procedures can be collected.
• It’s important to consider your prior experience taking on financial risk when considering the different types of ACOs (e.g., shared risk, shared savings, global risk), and consider utilizing a phased approach over the first three years, with the percentage split of surplus/deficit and level of risk increasing over time.

The ACO model is built upon a philosophy of constant improvement with an eye to the future, so our review of Next Generation ACOs and Medicare value-based payment goals will review what is on the horizon for this dynamic delivery model. The movement toward alternative payment methods can no longer be ignored, so let us give you the information you need to know about ACOs to best align the future direction of your practice.

Learn more and get your free download at www.massmed.org/acoguide.

LAW AND ETHICS

New National Practitioner Data Bank Reporting Rules Could Affect Your Practice

BY LIZ ROVER BAILEY, ESQ
MMS ASSOCIATE COUNSEL

In April of 2015, the Centers for Medicare and Medicaid Services (CMS) issued an updated version of its National Practitioner Data Bank Guidebook, clarifying which entities must report what actions to the National Practitioner Data Bank (NPDB). As most physicians are aware, an entity such as a state board of registration in medicine, a professional liability insurance company, or a hospital is under certain obligations to file reports with the NPDB.

The 2015 Guidebook contains significant changes regarding reporting of hospital adverse actions. As a threshold matter, CMS has always sought to prevent the situation where a hospital starts an investigation, and the physician, to avoid an adverse finding and concomitant report to the NPDB, agrees to surrender clinical privileges. Thus, CMS requires that any surrender of privileges while a physician is subject to an investigation be reported to the NPDB.

The 2015 Guidebook, however, has expanded the definition of “surrender” to include non-renewal of privileges or the taking of a leave of absence. Thus, an obstetrician/gynecologist who decides not to renew obstetrical privileges while still continuing to practice as a gynecologist has “surrendered” privileges. If any portion of that physician’s practice was part of an ongoing investigation at the moment of “surrender,” this decision not to renew certain privileges — perhaps simply to be able to work a more reasonable schedule — would be reportable to the NPDB. Similarly, a surgeon who took a three-month leave to travel the world with family would be subject to reporting if there were any ongoing investigations at the time.

The expansion of the meaning of “surrender” would be difficult enough to navigate by itself, but CMS has gone further, and expanded the definition of an “investigation.” According to the Guidebook, any inquiry into a physician’s competence or conduct is an investigation. In other words, if a nurse wonders why a surgeon appeared unsettled during a routine surgery and mentions it to a medical staff leader, an “investigation” would be deemed to have begun.

Finally, there need not be any nexus between the topic of the investigation and the privileges surrendered, or the leave taken, in order for the surrender to be reportable. Thus, in the case of the OB/GYN mentioned above, her decision to stop her obstetrical practice would be reportable if, coincidentally, there were an inquiry about any of her work as a gynecologist. If she had not stopped practicing as an obstetrician, there would have been no report of the inquiry at least until its outcome had been determined. And in the case of the surgeon who had long planned a three-month leave of absence?

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.
Curbing Firearm Violence: Vital Signs Talks with Michael Hirsh, M.D.

By Robyn Alie
MMS Public Health Manager

In 2002, Michael Hirsh, M.D., began the “Goods for Guns” weapons exchange program in Worcester, which is now held annually on the anniversary of the Newtown school shooting. The program has seen roughly 2,600 firearms turned in, three-fourths of which are handguns. Dr. Hirsh, the director of trauma services at the Trauma Center and Pediatric Intensive Care Unit of the UMass Memorial Children’s Medical Center, puts the total cost for collecting 2,600 firearms at less than the cost of caring for four patients who might have been injured by those weapons.

While at Columbia Presbyterian in 1981, a fellow resident went home to bring crackers to his pregnant wife and was shot in the chest by a 15-year-old boy, beginning Dr. Hirsh’s interest in preventing firearm violence. He met Sarah Brady, the wife of secret service agent Jim Brady, who had just started up a center to end handgun violence. “She got it way back then, that there are conditions — poverty, racism, food insecurity — that contribute to violence. But the only thing that elevated violent acts into lethal acts was the handgun,” he said.

Vital Signs: What is the role of physicians in addressing this issue?

Dr. Hirsh: This has become critical. It’s very important for doctors to ask their patients about the status of gun ownership and how guns are stored. We know that the gun in the home increases the risk of femicide by five times, suicide by five times, and homicide by eight times. These are not insignificant. You may be taking care of your own house fine. Are you sure that your kids are going to be OK? Seventy percent of kids know where the weapons are.

With the opioid epidemic, we’ve seen an uptick in break-ins. Stealing a gun is a way of getting cash. Up to 35 percent of gun violence in Central Massachusetts is done with stolen weapons.

Vital Signs: What is the response of patients when you broach the subject of gun ownership?

Dr. Hirsh: You have to be forthright and say that the American Academy of Pediatrics says the three most important safety questions I can ask a parent are about child restraint, smoke alarms in the home, and guns in the home. In the south, you add in pool safety. I try to ask all those questions, so I’m not just focused on the gun. I tell them that kids are very inquisitive. We just want to make sure they’re safe.

With your adult patients, ask if there are children going through your home — nephews, nieces, grandchildren. Patients have the right to refuse to discuss this — I don’t mind. In 30 years, one patient questioned why I was asking, and no one refused to answer.

This doesn’t have to be a 12-minute interview. Questionnaires are important — add guns to it.

Vital Signs: Beyond the practice, is there a greater role for physicians or the MMS?

Dr. Hirsh: The state of Florida passed a law in 2011 (banning physicians from asking about gun ownership). This law is First Amendment rights being trumped by Second Amendment rights. Florida has ruled that the interview is conduct not speech; therefore, it can be regulated.

It’s bad for gun violence for sure. And it’s the establishment of the precedent of the slippery slope that would enable a legislature to decide what topics are taboo — maybe it’s sexual reproduction, maybe it’s drug use. If we allow this kind of intrusion into the doctor-patient relationship, we’ve given up one of our strongest weapons. Organized medicine is our best help. The MMS this past year reaffirmed the sanctity of the doctor patient relationship, which should be inviolate.

Motor vehicle fatalities this year are going to be fewer than firearm fatalities. In the 1950s, there was the same attitude to the car as there is now to guns: it wasn’t the car killing people — it was the driver. There has been a multipronged approach to the car. We now have airbags, seatbelts, crumple zones, rumble strips, and worked to change the social norm that it’s not funny anymore to drive drunk.

There are analogous things we can do with the gun: on the research side, the gun technology side, and the liability side. This is where we have to go with the gun now. It’s the unsecured weapon that is a public health problem.

MMS 12th Annual Public Leadership Forum on Firearm Violence: April 5

By Greg Gould
MMS Public Health Staff

“Do you have a gun in your home?” This simple question can feel like a difficult subject to broach with patients.

On November 18, 2015, the MMS hosted the Initiating a Conversation with Patients on Gun Safety webinar to help physicians confidently and sensitively discuss firearm ownership and safety with their patients.

The webinar addressed a broad range of important gun safety issues: advice on starting conversations in both pediatric and adult settings, the medical and legal issues relevant to physicians, proper safe storage techniques, the history of firearms in the United States, and the significant effect the presence of a firearm has on the chance of a fatal suicide attempt. A recording of the one-hour CME program is now available on the MMS website at www.massmed.org/gunsafety.

MMS will hold its 12th Annual Public Leadership Forum, Firearm Violence: Policy, Prevention, and Public Health, on April 5. The forum will discuss the role of clinicians in implementing a public health approach to understanding and addressing the epidemic of firearm violence facing the nation. The forum will take an integrative approach by bringing together speakers that come from a diverse array of backgrounds, including law enforcement and community activism. Presentations and discussion panels will discuss topics ranging from the epidemiology of firearm violence to techniques physicians can use to begin discussions on firearm safety with their patients.

Georges C. Benjamin, M.D., executive director of the American Public Health Association, will keynote the program, addressing gun violence in America as a problem of public health and actions that medical professionals can take to help keep their communities and patients safe.

Massachusetts Attorney General Maura Healey will speak about the steps being taken by law enforcement to reduce gun violence throughout the Commonwealth. David Hemenway, Ph.D., director of the Harvard Injury Control Research Center, will present research on the epidemiology of firearm violence and the impact of both intentional and unintentional firearm injury on public health. Reverend Jeffrey Brown, president of Rebuilding Every Community Around Peace, will share his experience in planning and implementing community-based interventions to prevent firearm and other forms of violence.

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State Standards for PCMHs Continue to Evolve

BY BRENDAN ABEL
MMS ASSISTANT COUNSEL

Patient-centered medical homes (PCMHs) have emerged over the past several years as an impactful, data-driven innovation in the delivery of primary care. Rooted in team-based care, PCMHs emphasize coordination of care and communication between a care team and the patient. Mounting evidence indicates the PCMH model supports high quality and cost savings to practices that have transformed and reorganized practices to it.

In light of this evidence base, the Massachusetts legislature featured the promotion of PCMHs in its comprehensive health care cost containment bill, Chapter 224. Specifically, Chapter 224 charged the Health Policy Commission to create a PCMH certification program. The bill outlines two levels of PCMH certification — a baseline model and a best practice “Prime” certification.

The Health Policy Commission (HPC) had a tough task initially — the certification would be voluntary and it would lack defined incentives for providers who achieved it. Also, there is already an existing, well-established PCMH certification program through the National Committee for Quality Assurance (NCQA). The HPC established from the outset that it wanted to align its own certification with the NCQA's but decided to add behavioral health integration as a key factor to its own certification.

The MMS engaged with the HPC throughout this process to advocate for and provide written comment for a state certification that was closely aligned with NCQA and offered flexibility to practices seeking this certification. Any substantial additions to the NCQA were suggested to be reserved for the heightened “Prime” certification.

After a lengthy development process and a few changes in direction, the HPC recently approved its plan for PCMH certification. For now, any practice who achieves NCQA Level II or Level III or 2014 Recognition will be eligible for the base HPC PCMH certification. Practices will be able to apply for an elevated Prime certification if they achieve NCQA Level II or Level III or 2014 Recognition and they complete an HPC/NCQA Assessment of Behavioral Health Integration. This behavioral health add-on includes factors such integration of developmental, depression, anxiety, and substance use disorder screenings into clinical practice using standardized screens and the promotion of evidence-based mental health and substance use disorder decision support.

The state has allocated funding to the HPC to be used to provide technical assistance to practices who are seeking to obtain the Prime certification. Discussions for the use of this funding include providing training on various behavioral health diagnostic tools, support or training for medically assisted treatments of substance use disorders, and directories for non-prescribing behavioral health directories.

Patient-centered medical home certification can be a great way to improve coordination of care, ultimately leading to high quality and lower cost care. The MMS will continue to provide additional details about the HPC certification process and the technical assistance it plans to provide to help facilitate behavioral health integration.

Your EHR continued from page 1

author) William Gibson reportedly said, “the future is already here, it’s just not very evenly distributed.” Take electronic prescribing, for example — a huge success across the country. Similarly, lab results delivery is very widely available in most health care delivery areas across the country. EHR-to-EHR exchange has been harder to accomplish because it relies on coordination of many different vendors as well as many different providers. Even here we’re seeing tremendous progress though. The Massachusetts Health Information Highway has over 500 provider organizations connected and conducts over two million secure health information exchange transactions per month.

However, interoperability will never be “done.” As information technology gets better and medical advances continue, our expectations will grow as well.

We’ve seen with computers and smartphones that the more they do, the more we want. The same is true for interoperability as well.

MMS: What timeline do you expect in terms of seeing widespread improvements in interoperability?

MT: We’re already seeing them. It’s important for us to have some perspective though. Just like you can’t have a good telephone network until most people have a telephone, you can’t have good interoperability until most providers have an EHR. A short five years ago, less than 10 percent of physicians had an EHR. That number is now over 75 percent, and for hospitals it is now over 90 percent. So, why do we think that we should have universal interoperability already, when just a couple of years ago most physicians didn’t even have an EHR? No other industry has achieved it that fast, and yet, no other industry is as complex as health care.

The biggest barrier to interoperability until now has been lack of demand — physicians weren’t asking for interoperability because they didn’t have EHRs and because prevailing models of care and payment didn’t require interoperability. The world is different now, and physicians are demanding interoperability from each other and from their vendors, and we’re seeing the market respond. Within the next few years I think we’ll see close to nationwide ability to send clinical documents to any provider in the country, and we’ll see the maturation of nationwide health information networks that also enable query and retrieve capabilities as well.

These networks are already emerging rapidly — like Epic’s Care Everywhere, Surescripts, CommonWell, the MA Healthway, etc. — and in the next few years we’ll see the building of “bridges” across these networks in the same way that phone networks and ATM networks are stitched together to provide universal coverage.

MMS: Do you think some regulation or a government mandate is inevitable down the road?

MT: I hope not. It would be a terrible mistake, and I guarantee that most physicians will be very unhappy with any kind of government mandate for interoperability, whether at the state or federal level. Health care and IT are too complex to expect that the government can get it right or keep up with it. The best prescription for getting more interoperability is to expand value-based purchasing through Medicare and Medicaid that pays for better care and improved outcomes. That will create more demand for interoperability but will allow providers and their vendors to come up with the best ways to accomplish it.
Conflict in the Workplace: A New Urgency

Dr. Diana Dill is a professional coach and psychologist with a background in both consulting psychology and cognitive behavioral therapy. She has more than 20 years of experience helping practicing physicians address developmental goals and overcome challenging occupational problems. She is a core member of the faculty of Managing Workplace Conflict: Improving Leadership and Personal Effectiveness, a highly interactive, content rich, risk management CME program, designed to help all physicians explore and contend with the complex and at times contentious relationships that pervade our high-pressure, contemporary work environment. This month in Vital Signs, Dr. Dill gives readers a taste of some of the topics covered in this course.

— Steve Adelman, M.D.

By Diana Dill, Ed.D.

Slammed doors, raised voices, intractable arguments.

Frustrations getting help. Abrasive interactions. Problems that escalate and don’t get fixed.

Non-compliance among staff physicians. Less frequent interactions among colleagues. Staff attrition.

These are signs of conflict that physician leaders and individual physicians experience in the workplace. Physicians may find they don’t know what to do and their strategies escalate the conflict instead of resolving it. A highly regarded PHS/MMS course, Managing Workplace Conflict, addresses this gap and shows how to reframe conflict and manage it effectively.

Conflicts in the medical workplace are inevitable. In any work group we can expect to find people’s agendas are sometimes at odds, and conflict results. Conflict can feel threatening, so we want to avoid or control it. Or we can treat conflict as a sign that there is something not working right, which we can improve to everyone’s benefit. Conflict can be treated as an opportunity to address differing agendas and, ideally, resolve them so the system can regain its balance.

It is becoming more urgent than ever to address conflict well in the medical workplace. Our medical systems are increasingly complex, with greater potential for differing agendas. But we need effective teamwork if we want to deliver quality care. In the past, we minimized conflict by working independently. But now, instead of the solo practitioner, we need team players who work well within an interconnected system.

A well-functioning interconnected system of practice requires us to work together under stress to address technical, process, and interpersonal problems, and resolve them while keeping relationships sound. We also need to recognize differing agendas and negotiate acceptable solutions which maintain the goodwill of the organization.

Stress on our medical systems is making conflict more likely. As workloads increase and autonomy diminishes, physician stress has increased, with more than 40 percent of physicians nationally reaching the breaking point we call burnout. Burnout is physical, emotional, and moral exhaustion, and it impairs judgment and social skill.

Burned-out physicians are less motivated to address and resolve conflict effectively. Disruptive behaviors can erupt, further damaging teamwork, and put patient safety at risk. Other physicians may withdraw from active engagement, detracting from a well-functioning system. Many feel isolated and confused by what is happening. Building effective conflict-management skills can help them regain some control.

To address these difficulties and build conflict management capacity, Physician Health Services and the Massachusetts Medical Society jointly sponsored the program Managing Workplace Conflict: Improving Leadership and Personal Effectiveness, which was supported by a grant from the Physicians Foundation. Participants from across the state and across specialties met for two days in November to discuss — in a confidential and supportive setting — conflicts they found challenging, and to learn new frameworks for thinking about them.

Through lectures, simulations, role-playing, and discussion, participants heard about and practiced attitudes and skills they need to manage conflict well. They left feeling less isolated and more “normal” about conflicts, equipped to think clearly and act skillfully in addressing conflicts in their workplaces.

Managing Workplace Conflict offers CME credit and will be offered again March 24–25, 2016, and in October 2016. For more information, visit our website at www.physicianhealth.org.

MMS Committee Appointments 2016–2017

Deadline for Consideration: March 3, 2016

If you would like to become more involved in the MMS, consider participating on a committee or the Member Interest Network (MIN) Executive Council. Committee appointments are for specific terms, usually three-year renewable commitments. We have put in place resources for distance participation including conference calls, online meetings, and video conferencing at regional offices. Those with limited time who wish to participate can take advantage of these means.

The listing below includes all MMS committees and the MIN Executive Council. For committee descriptions and an application form to be considered for a committee, contact Sandra Manchester at the MMS Executive Office (800) 322-2303, ext. 7012, or email smanchester@mms.org. If you would like to join the MIN Executive Council, contact Cathy Salas at the West Central Regional Office (800) 322-2303, ext. 7715, or email csalas@mms.org.

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(Limited openings in accordance with bylaws)
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- Finance
- Member Services
- Recognition Awards
- Strategic Planning

Standing Committees

Appointed by the President-elect
(Limited openings in accordance with bylaws)
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- Communications
- Ethics, Grievances, and Professional Standards
- Interspecialty
- Judicial
- Medical Education
- Membership
- Professional Liability
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Special Committees Appointed by the President-elect
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- Diversity in Medicine
- Environmental and Occupational Health
- Geriatric Medicine
- Global Health
- History
- Information Technology
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- Maternal and Perinatal Welfare
- Men’s Health
- Nutrition and Physical Activity
- Oral Health
- Preparedness
- Senior Physicians
- Senior Volunteer Physicians
- Sponsored Programs
- Sustainability of Private Practice
- Student Health and Sports Medicine
- Violence Intervention and Prevention
- Women in Medicine
- Young Physicians

District Appointed Committees

(Contact your district medical society for more information)
- Legislation
- Nominations

Member Interest Network (MIN)

Executive Council
- Arts, History, Humanism, and Culture

WWW.MASSMED.ORG
Health care delivery is undergoing a major transformation. NEJM Catalyst, a new online resource from NEJM Group, connects health care executives, clinical leaders, and clinicians to share innovative ideas and practical applications for enhancing the value of health care delivery.

NEJM Catalyst, in conjunction with its founding advisor, Dr. Thomas Lee, M.D., has carefully selected a team of lead advisors and thought leaders from across a variety of disciplines. These experts share their perspectives and offer solutions to meet your organization’s most urgent challenges.

NEJM Catalyst brings you insightful articles, real-life examples, and other resources from a network of top thought leaders, experts, and advisors:

- **Practical innovations in health care delivery** — Innovations in your organization with actionable ideas on important topics affecting the rapidly changing health care industry, including care redesign and patient engagement.

- **Impeccable quality and impact** — Setting new standards via selective, relevant insights, and information from highly regarded experts.

### Themes

- **Care Redesign**
  - Active contributions from renowned authorities, thought leaders, and advisors — Prominent experts and influential opinion leaders from provider organizations across the globe come together to offer personal perspectives and experiences on the transformation of health care.
  - Independent and impartial curation — Unbiased, objective content presents new thinking and cutting-edge strategies without the influence of outside interests.

- **New Marketplace**
  - An exchange of ideas among executives and clinicians — Executives, leaders, and clinicians from across the health care community share ideas and perspectives on ways to advance health care delivery in these challenging but opportunity-filled times.

- **Patient Engagement**
  - NEJM Catalyst Insights Council — A resource featuring executives and clinicians from organizations around the country who are surveyed on a regular basis. Their collective input is analyzed and highlighted in Insight reports.
  - NEJM Catalyst Connect — a weekly newsletter with the most current actionable ideas and practical solutions.

Explore NEJM Catalyst at catalyst.nejm.org.

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**ACROSS THE COMMONWEALTH**

### District News and Events

#### NORTHEAST REGION

**Charles River** — Executive Committee Meeting. Tues., Feb. 16, 6:30 p.m. Location: MMS Headquarters, Waltham.

**Middlesex Central** — Executive/Delegates Meeting. Thurs., Feb. 18, 7:45 a.m. Location: Emerson Hospital, Concord.

**Norfolk** — Executive Committee Meeting. Wed., Feb. 10, 6:00 p.m. Location: MMS Headquarters, Waltham.

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.

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**WEST CENTRAL REGION**

**Berkshire** — Legislative Breakfast. Fri., Feb. 12, 7:30 a.m. Location: Berkshire Medical Center, PDR B, Pittsfield.

**Franklin** — Legislative Breakfast. Fri., Feb. 26, 7:30 a.m. Location: Baystate Franklin Medical Center, Conference Room A, Franklin.

**Hampshire** — Executive Committee Meeting. Mon., Feb. 8, 6:00 p.m. Location: Spoletto’s, Northampton.


**Worcester North** — Social Event. Mon., Feb. 22, 6:00 p.m. Location: Doubletree, Leominster.

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.
This guide will discuss how social media is used by both physicians and patients, describe the frequent concerns physicians may have regarding social media use, and recommend actions physicians can take to maintain a positive professional online presence.