

VITAL SIGNS



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EHR Implementation: Advice from the Trenches

BY VICKI RITTERBAND

For Theodore Mason, M.D., buying an electronic health record (EHR) system is a little like purchasing a fancy new sports car. The salesperson shows you a shiny red Porsche, with great acceleration and state-of-the-art features. You're awed and you buy it, explains Dr. Mason.

But there's a twist.

"When it's time for delivery, they back up a truck and dump a huge pile of Porsche parts on your steps. Now it's your turn to put it together," says Dr. Mason, an otolaryngologist with Ear, Nose and Throat Surgeons of Western New England. "With our EHR, we had to do a lot of customization, work-arounds, and adjust it for our practice flow. It ended up being much more work under the hood than we expected."

As the second year of a federal incentive program that rewards physicians who adopt EHRs begins, more Massachusetts practices are going digital. *Vital Signs* asked four veterans of successful implementation to offer advice for practices following in their digital footsteps. Here are some of their suggestions.

Hire an In-House Informational Technology (IT) Expert

When there's a pile of car parts at your doorstep, it's time to call in



Theodore Mason, M.D., of Ear, Nose and Throat Surgeons of Western New England (left) and his colleague, Daniel Plosky, M.D. (right). Their practice designed exam rooms so physicians could see their computer monitors while facing the patient.

an expert, according to Dr. Mason, who is one of his office's two EHR physician champions, but still felt he lacked the expertise to assemble the new sports car. Staff at his western Massachusetts practice floundered for a couple of months and finally bit the bullet and hired an outside expert. "It's less costly to go without an IT person, but implementation will take twice as long and will be twice as difficult, and everyone will be twice as annoyed," he says.

Not every practice, however, can afford an IT staffer or sees it as a priority. Tech-savvy practice administrator Sandra Rondeau also wears the hat of IT expert at Lung Specialists of the Merrimack Valley. After the vendor's formal two-day

training, Rondeau relegated her other responsibilities to the back burner for a couple of weeks as she helped colleagues master the new system.

Plan for a Paperless Office

A workflow that makes sense in a paper-based system may not be practical in an electronic world. Mapping out current workflows and retooling them for an electronic environment is a critical pre-implementation task, according to several practices.

Converting paper to pixels is a monumental task, so plan carefully. Pediatrics West and its affiliate New England Center for Mental Health paid nurses extra for several months to

preload the system with clinical information, including patients' medical histories, problem lists, their most recent heights and weights, and vaccine schedules, according to Jessica Hennessey, the practices' director of operations and management.

Rondeau's one regret about Lung Specialists' implementation is that the practice didn't have a better plan for scanning paper records. "You need to decide what really needs to be scanned, how it should be e-filed, if the scanned document requires a physician sign-off, and if you have enough scanners in place," says Rondeau.

Train and Then Train Some More

Two days of in-office training — usually with the vendor — seems to be the norm, although a couple of practices wished they had the luxury of an additional day of training. Not surprisingly, physicians who came of age during the days of the typewriter took much longer to learn the systems than those who grew up with a mouse in their hands, and those differences need to be factored into any training schedule. For physicians who don't type, practices like Pediatrics West purchased voice recognition software.

Don't train too early — no more than a week or two before going

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A Five-Star Office Visit? Online Doctor Reviews Grow

BY ERICA NOONAN

Editor's Note: This is part of an ongoing series of Vital Signs articles about physicians, social media, and technology.

These days, everyone goes online to check out reviews of a new restaurant, film, or electronic gadget. But in recent years, a growing

number of websites have begun rating physicians, and some of them — critics contend — use the same sort of evaluation criteria used to praise a new dishwasher or a waiter's particularly attentive table service.

Some services, like Yelp, Citysearch, Yahoo, Zagat's, and Angie's

List, are oriented to consumer goods and services. Others, like RateMDs, Healthgrades, and Avvo, are specifically medically oriented.

Many physicians are quite uncomfortable at the prospect of their names popping up online attached to a rating from an

unhappy patient. A few doctors have been so unhappy by online criticism that they attempted — so far, unsuccessfully — to sue patients who made unflattering remarks about them online.

One well-publicized case from 2010 involved a Chicago cosmetic

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PRESIDENT'S MESSAGE



Keeping New Licensure Mandates at Bay on Beacon Hill

One of the most troublesome issues to emerge in recent weeks is the state Board of Registration in Medicine (BRM) decision to require physicians to complete CME courses in pain management and end-of-life care during the process of renewal or obtaining a new license.

Effective February 1, physicians who prescribe controlled substances (Schedules I through VI) must complete at least three credits of education and training in pain management and opioid education. Also effective February 1, physicians renewing or seeking a new license must take two CME credits in end-of-life care. The credits can qualify as either category 1 or category 2 and may be counted as risk management credits.

The MMS has a number of resources and courses to help physicians fulfill both of these requirements. A listing of courses can be found on our website at www.massmed.org.

The MMS opposes both of these requirements as a condition of licensure and continues to advocate on behalf of physicians on the issue. The Society's Board of Trustees is scheduled to meet with officials from the BRM in March to discuss these and other new licensing regulations. However, it is unlikely that either the board or the state Legislature will reverse their rulings in the near future.

Going forward, our intention is to look for opportunities to tailor existing mandates to apply only to physicians directly involved in opioid prescribing or end-of-life care on a significant basis. We will be sure to keep you updated with any new developments.

Lynda M. Young

— Lynda M. Young, M.D.

EHR Implementation

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live — or people will forget what they have learned, advises Lexington Eye Associates director of information systems, Christopher McDonald. Like other practices, Lexington Eye Associates staggered its EHR training: successive groups of providers and technicians trained on and then test-drove the new system for several weeks at a time, according to McDonald. Then when it was time to go live, one office at a time took the plunge, from smallest to largest. "By the time we got to our fourth office in Lexington, all of the problems we were going to have had already happened," says McDonald.

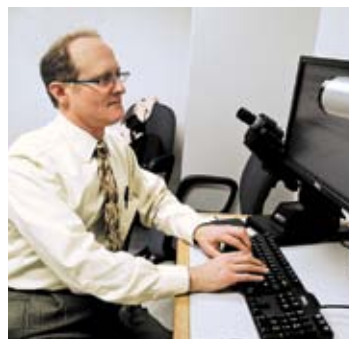
After formal training, most practices continued to provide extra help for a short time. Lung Specialists' trainer stood outside the exam rooms on the go-live day, ready to answer questions as physicians emerged from patient encounters.

Once the trainers leave, the physician champions often take over. Jerry Schreiberstein, M.D., F.A.C.S., one of ENT Surgeons of Western New England's two IT physician leaders, spends part of practice meetings teaching new functions of the EHR, most recently how to communicate with patients through the patient portal. His practice also sometimes seeks computer advice from an ENT practice in Albany, New York, that uses the same EHR system.

Lessen the Patient Load in the First Months and Don't Sweat the Productivity Dip

Every practice *Vital Signs* spoke to drastically cut its physicians' patient load in the first days of the new electronic regime — typically

by about half — then gradually added patients back onto the schedule as the physicians became more comfortable with the system. Administrators said schedules were back to normal quicker than they anticipated, typically within one to three months. "It was important to take the burden off the doctors and let them focus on using the EHR," says ENT Surgeons of Western New England administrator Doug Apirian.



James Umlas, M.D., of Lexington Eye Associates

Plan for the Impact of Technology on the Physician-Patient Relationship

When ENT Surgeons of Western New England moved into a new space after EHR implementation, the practice designed the exam rooms so physicians could see their computer monitors while facing the patient. "You want to have that face-to-face interaction with the patient, to be able to glance at the monitor, but still make eye contact," says Dr. Mason.

Pediatrics West views its exam room laptops as important interactive tools: flip-top screens allow clinicians to review growth charts and other health data with their young patients.

Remember that Paperless Doesn't Mean Perfect

Pediatrics West's Hennessey says she was initially surprised by how often the loss of an Internet

connection or server woes rendered her office's EHR system inaccessible. About a month after the EHR was installed, the practice set up a backup system on a separate server. Now each evening the office runs a "downtime report" for the next day's patients, which extracts the most critical health data from the EHR so it is available if it becomes temporarily inaccessible the next day.

For Lexington Eye Associates, whose patients move to different areas of the clinic in a single visit, it was hard for staff to quickly ascertain who a patient was and the purpose of the visit without some kind of a paper reminder. "You've got a person in front of you, but you don't know who they are until you've spent five minutes on the computer," explains director of information systems McDonald. About a year into using the EHR, the practice began giving patients a single piece of paper containing key demographic and clinical information so staff members can get a quick snapshot of the patient standing in front of them.

Big Benefits, but Not Financial Ones

Has it been worth it? The benefits are huge agrees every practice: easier access to legible, better organized patient information; more accurate coding; improved ability to manage diseases; and improved communication, to name a few. And while every practice has saved money on expenses such as medical records staff, transcription, and transportation, the cost of implementation, maintenance, and support has so far offset any savings.

"Practices need to view an EHR system in the same way they view medical equipment — as a necessary tool to provide quality health care," says Rondeau. **VS**

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PPRC Offers Professional Help with ICD-10 Coding Challenges

Industry discussion about postponing implementation of ICD-10 has left many Massachusetts physicians wondering, is all the preparation necessary? Preparing your practice for the anticipated October 2013 ICD-10 deadline is more important than ever before.

During and after implementation there will be a heightened awareness around the proper use of codes, mainly to ensure that transactions and processes are working properly. However, this may result in increased exposure to fraud and abuse allegations if documentation does not adequately support the levels of coding. In order to mitigate risk, it is important to take appropriate steps well in advance of implementation.

The Physician Practice Resource Center (PPRC) is available to help you make informed decisions by offering a new service during a time of increased risk and reimbursement uncertainty. The PPRC offers documentation gap analysis services provided by



PHYSICIAN PRACTICE RESOURCE CENTER

Jane Tuttle, CPC, a coding and documentation analysis expert.

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. Ms. Tuttle is a certified coding and compliance educator and consul-

tant with more than 22 years of experience in health care administration, including practice management, billing, coding, reimbursement, chart auditing, corporate compliance, and HIPAA regulations.

Through the PPRC, Ms. Tuttle will audit practice charts, make recommendations for improvement, and teach physicians about appropriate and effective documentation. To obtain these services at member-preferred pricing, contact the Physician Practice Resource Center at (781) 434-7702.

In addition to these new services, the PPRC also has a host of other ICD-10-related resources, which can be found at www.massmed.org/icd10. **VS**

— Kerry Ann Hayon

MMS Online Tools, Templates, and Timelines for ICD-10

Conversion to ICD-10 on October 1, 2013, will impact technical and administrative practice operations across all levels of patient care.

To help with the transition, the Massachusetts Medical Society is providing physician practices with easy-to-use tools that focus on delivering practical information on implementing ICD-10 in the practice setting. Some of the online tools feature AMA educational resources, including a project plan template, a timeline for meeting the compliance deadline, and tips for testing transactions using the 5010 platform.

For transition tips and more information on ICD-10 tools, visit www.massmed.org/icd10. **VS**

— Talia Goldsmith

Five-Star Office Visit

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surgeon who subpoenaed Yelp and Citysearch for the IP addresses to identify the computers that seven reviewers used to make their comments. The websites themselves were protected by a federal law that prohibits them from being sued over third-party postings.

Some medical practices have attempted to avoid online doctor-patient confrontations by asking patients to sign a waiver pledging not to post online comments about their physicians as a condition of treatment. Silencing patients is not the answer, says Bryan Vartabedian, M.D., a pediatric gastroenterologist at Texas Children's Hospital and creator of the popular medical blog 33charts.com.

"Let the patients speak," he wrote on his site. "The suggestion that you can control public dialog reflects an embarrassing misunderstanding of how the world shares information. Physicians should encourage dialogue,"

Vartabedian said. "How about we work to assure that our level of service and care is so extraordinary that the conversation is largely positive?"

Kevin Pho, M.D., creator of KevinMD.com, one of the Web's most popular and influential medical Internet platforms, said physician time is probably better spent creating a strong positive online and social media presence, not agonizing over anonymous reviews. "Doctors ask me all the time about how they can remove a negative review on a website, and I tell them, well, you probably can't," said Pho, a New Hampshire-based internist. "The good news is that you can control what shows up first in a Google search of you by establishing your own Twitter, Facebook, Google+, and LinkedIn profiles."

Self-generated profiles not only rank higher in online searches, but are also under a physician's control, Pho said. "So you may not be able to get a negative review pulled down, but you can bury it

under other links you do control," he said.

John Swapceinski, cofounder of RateMDs.com, said most of the 1.36 million physician ratings posted on his site since it launched in 2004 are not critical ones. Approximately 70 percent of the comments — rating 302,000 physicians in the U.S. and Canada — are positive, he said. Swapceinski said he began the RateMDs service after founding the successful college professors rating site, RateMyProfessors.com.

"What is a more important occupation than (being a physician?) It is a matter of life and death," he said in a recent interview with *Vital Signs*.

His company receives several requests from physicians every day to remove patient comments. Unless a comment accuses a physician of illegal activity, he almost always refuses. "It's human nature not to want to be rated negatively by other people, but it doesn't mean it should be illegal," Swapceinski said. "It is a freedom of speech issue."

He said he has noticed an upsurge in recent months of doctors hiring paid services to fabricate positive patient reviews to counter the authentic negative ones.

A 2011 study seems to support the idea that most online comments about doctors are not critical, though most physician advocates agree they are incomplete and flawed. Researchers at the University of Maryland and the University of Minnesota found that most doctors who appeared in online ratings had good reputations in offline patient satisfaction surveys.

By and large, online rating sites "are not a venue where disgruntled patients are complaining," wrote report co-author Jeffrey McCullough, Ph.D. However, the report stated that the ratings do lack good measures for clinical quality, and tend to focus on the patient experience. "[The ratings] are missing what a lot of consumers ought to really care about," he said. **VS**

2012 MMS Public Health Leadership Forum: Should We Mandate Public Health?

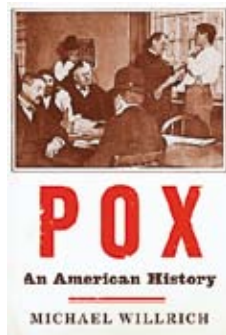
The MMS will present its annual Public Health Leadership Forum on April 11, 2012. This free CME program will center on public health mandates, weighing public health benefits against the rights of individuals and businesses.

"This forum is extremely topical," said Louis Fazen, M.D., chair of the MMS Committee on Public Health. "We see it every day in the ongoing political campaigns debating the size and role of government in individuals' lives." Government efforts to limit the sale of tobacco products, to require health insurance, or to ban trans fats in restaurants are viewed by some as necessary; others see them as unacceptably intrusive.

Author and Brandeis University history professor Michael Willrich, Ph.D., will provide a historical framework for the discussion. Willrich's book *Pox: An American History*, published last year, describes the government's response to the smallpox epidemic in Boston at the turn of the 20th

century and the public reaction that resulted.

The scale of the mandate — universal vaccination — generated an enormous amount of conflict, particularly among working-class Americans who viewed this level of compulsion as a violation of their rights, said Willrich.



"Massachusetts historically was both a leading state in public health policy — very progressive — and a place with a concentrated anti-vaccination movement," said Willrich. This made Boston the epicenter of

Massachusetts Medical Society Public Health Leadership Forum: Mandating Public Health

April 11, 2012 • 1:00 to 5:00 p.m.

Historical Background: The Health Mandate Question in the United States
Michael Willrich, Ph.D., Brandeis University

The Political and Legal Costs of Mandates

Wendy Parmet, J.D., Northeastern University School of Law

The Ethics of Public Health Mandates

George J. Annas, J.D., M.P.H., Boston University Schools of Public Health, Medicine and Law

Mandated Public Health: Perspectives from a Practicing Physician

James J. O'Connell, M.D., Boston Health Care for the Homeless Program

Jointly sponsored by the Harvard School of Public Health Center for Public Health Leadership in cooperation with the Boston University School of Public Health, the University of Massachusetts School of Public Health and Health Sciences, and the Tufts University School of Medicine Public Health and Professional Degree Programs

the conflict, with court cases, arrests, raids by health officials on tenement districts, and a vibrant local anti-vaccination movement, he said. "Key players on both sides," noted Willrich, "were doctors."

The events of the time set legal precedents regarding limits to

individual liberty and government authority and provide lessons for public health practice today. **VS**

For more information, visit www.massmed.org/forumagenda or call (800) 843-6356.

MMS and DPH Explore Ways to Improve Mass. Adult Immunization Rates

More Than 90 Percent of Adults Not Fully Vaccinated

More than 46,000 adults die every year in the U.S. of vaccine-preventable diseases or their complications, according to the Centers for Disease Control and Prevention. While Massachusetts has some of the highest childhood vaccination rates in the nation, more than 90 percent of Bay State adults are not fully vaccinated. It's estimated that 95 percent of vaccine-preventable diseases in the state occur in adults.

Numerous studies have documented the biggest barrier to getting adult patients vaccinated is their medical providers' failure to recommend and offer vaccine. Vaccine presents hurdles for health care practices, such as up-front costs for vaccine, storage limitations, integrating vaccination into practice workflow, and payment and reimbursement issues.

One of the most important factors contributing to the success of childhood vaccination is the Immunization Initiative, which has been hosted by the Massachusetts Chapter of the American Academy of Pediatrics since 1994.

Massachusetts Adult Immunization Rates	
Ever had Zoster 60+ years of age	16%
Ever had Tdap 18+	17%
Hep B series 18+	42%
Ever had PPV23 18 to 64 with diabetes	57%
Ever had HPV females 18 to 26	57%
Flu high risk 18 to 64	59%
Hep B high risk 18+	64%
Ever had PPV23 > 65	71%
Flu > 65	73%

Source: Unpublished data from the 2010 Massachusetts Behavioral Risk Factor Surveillance Survey

MCAAP members, the Massachusetts Department of Public Health, family physicians, school nurses, and other stakeholders meet regularly to address issues around pediatric vaccination and advocate for policies that facilitate pediatric vaccination.

With this success in mind, the MMS and the Massachusetts Department of Public Health are now exploring ways to improve vaccination rates for Massachusetts adults. For more information on the initiative, or to provide feedback regarding successes and challenges related to adult immunization, contact Robyn Alie at ralie@mms.org.

— Donna Lazorik,
Massachusetts Department
of Public Health

Physician Guide to Adult Immunization

The American College of Physicians developed a Guide to Adult Immunization to help physicians implement systematic processes for incorporating vaccination in their day-to-day practice. This guide outlines quality improvement principles, resources for practical application, vaccine recommendations and indications, and information about vaccination in special populations. The guide has information useful to clinicians, administrators, and office staff and is available at no cost on the ACP website, <http://immunization.acponline.org>.

STATE UPDATE

New Care System Expected for “Dual Eligible” Patients

For the past two years, the Patrick Administration has been developing a system of integrated care organizations (ICOs) to deliver comprehensive care to Massachusetts residents 21 to 64 years of age enrolled in both Medicaid and Medicare. Combined state Medicaid and Medicare spending on these approximately 115,000 “dual eligible” individual is projected to reach \$3.85 billion in 2012.

At this point, hearings are complete, and pending Centers for Medicare and Medicaid Services (CMS) approval, we anticipate the first enrollments to begin in January 2013. Key concepts of the proposed integrated care organization model include patient-centered care with comprehensive care coordination, including services such as home health, behavioral health, and acute care.

The MMS joined the Massachusetts Hospital Association, the Home Care Alliance of Massachusetts, and the Massachusetts Association of Behavioral Health Systems last year in support of the administration’s approach, while also giving our perspective on key issues that must be addressed.

The Society’s initial concern was that since Medicare and MassHealth rates for services differ significantly, Medicare funds should not simply be placed into MassHealth accounts for payment at MassHealth rates.

The Society signed a letter to that effect last year and was pleased by subsequent provisions specifying that ICOs will operate under a patient-centered medical home model that guarantees continuity of care by requiring good faith efforts to contract with patients’ existing physicians

Central to the effectiveness of the pilot project is the adoption of adequate payments for providers who choose to participate. ICOs must provide meaningful rates to providers both in and out of network to make this pilot work for patients, providers, and the Commonwealth.

either as network providers or through out-of-network coverage. Enrollment in the program will be automatic for patients; however, they will have an opportunity to opt out of the system and continue with existing providers under a fee-for-service system.

Central to the effectiveness of the pilot project is the adoption of

adequate payments for providers who choose to participate. ICOs must provide meaningful rates to providers both in and out of network to make this pilot work for patients, providers, and the Commonwealth. The MMS strongly suggested that bidders be required to reimburse providers at least at the 2011 Medicare rates rather than at lower MassHealth levels.

The proposal is awaiting CMS approval, and we are a long way from the creation of a new and comprehensive system. The MMS will continue to work with interested parties and the Patrick Administration as the proposal progresses. Physicians are advised to watch for the development of ICOs and to carefully weigh the pros and cons of participating under contract with these entities as they emerge. **VS**

— William J. Ryder

FEDERAL UPDATE

Supreme Court Hearings on Patient Protection and Affordable Care Act to Begin

In late March, the U.S. Supreme Court is scheduled to hear arguments challenging the Patient Protection and Affordable Care Act. A ruling on the landmark 2010 health law is expected in June.

Because of the importance of this case, the court said it would allocate five-and-a-half days for oral arguments, as opposed to the usual one hour.

The Court is expected to hear arguments on four key issues: the constitutionality of an individual insurance mandate; whether other parts of the law can be maintained if the individual mandate is struck down; the constitutionality of requiring states to expand their Medicaid benefits or lose their federal Medicaid matching funds; and whether or not the nation’s highest court should rule on any of the issues at this time, given that the mandate

does not go into effect until 2014.

Options before the court include upholding the law, striking down the entire law, striking down the most controversial provisions, or deciding that any decisions at this time are premature given the 2014 implementation date for key provisions. The Obama administration maintains

Options before the court include upholding the law, striking down the entire law, striking down the most controversial provisions, or deciding that any decisions at this time are premature given the 2014 implementation date for key provisions.



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that Congress has the authority “to regulate commerce, levy taxes and enact any necessary and proper laws,” and that without the individual mandate, requirements banning preexisting conditions and other insurance reforms would be virtually impossible to implement.

As significant as the Supreme Court’s ruling will be this spring, the outcome of the 2012 presidential and congressional elections will also be critical. Most

leading Republican candidates have campaigned on promises that, if elected, they intend to dismantle or even completely repeal the Obama administration’s health care law. If President Obama is elected to a second term in November, his administration will likely seek to strengthen the law and to seek the appropriations necessary for its full implementation.

It seems that the American public is still split on the issue. A Kaiser Family Foundation poll conducted in January found that 37 percent of Americans have a favorable view of the law and 44 percent unfavorable. Another poll showed 50 percent of respondents favor keeping or expanding the law, and 40 percent either favor repealing the law or replacing it with an alternative approach. **VS**

— Alex. Calcagno

PHYSICIAN HEALTH MATTERS

Five Steps to Better Work-Life Integration for Physicians

How can a dedicated physician integrate a medical career with a full, rich personal life? We have five suggestions, ranging from balancing priorities to tending to your own health as carefully as your patients' well-being.

Priorities change. Review yours often.

Priorities change at various life, career, and family stages. It's essential that physicians regularly reflect on their priorities. A proven technique is to write your life priorities in a column in order of importance. For example: home, family, health, career, leisure, friends, financial security, relationship, spirituality, service, personal development, and any other category of importance. In a second column, list these same areas in order of time you actually spend on them. Comparing the two columns helps show

whether your time is spent where it matters most to you.

Know what you can control.

With only 24 hours in a day and 168 hours in a week, managing your time is essential. Yet, parts of life are simply beyond our control. In *The 7 Habits of Highly Effective People*, author Stephen Covey writes about "circles of influence," things that concern us that we can control, and "circles of concerns," things that concern us that we cannot control.

Spending too much time thinking about issues over which you have as no influence is a waste of precious time. It is important to ask yourself, "Do I have direct influence regarding this issue?" If not, focus on issues where you can make a difference.

Your health matters too.

Physicians know that those who take care of their bodies are

more productive, happier, and feel more balanced. Yet for some clinicians, eating well, sleeping enough, and exercising regularly get crowded out by other demands. Some physicians take better care of their cars than their bodies! Get started by selecting just one aspect of self care to improve and "tune up."

Take a meditative moment.

Both spiritual and emotional well-being affect energy, efficiency, and ultimately, productivity. Spirituality can come in many forms, including sitting on a beach, snowshoeing in the woods, looking at the stars at night, or sitting on a porch in the summer. Each can be spiritually nurturing experiences and increase emotional well-being. Even 15 minutes of walking outside can do wonders for a feeling of balance. Walking with a spouse, partner, child, or

friend also allows the bonus of connection with a special person. Mini-meditations during the workday — even five minutes — can help you keep your day on track.

Expect the unexpected.

There will always be surprises, good and bad, at home and at work. Accept that things you couldn't have anticipated or prepared for will happen. The key to managing the event is not losing sight of your own well-being. Talk to friends and family. Seek out support — and professional help, if appropriate.

— Donna Singer M.S.,
P.C.C., principal of

Donna Singer Consulting, LLC

For more information on work-life integration, please contact Physician Health Services, Inc., at (781) 434-7404 or visit www.physicianhealth.org.

Learn to Diffuse, Prevent Workplace Conflict

More Than 300 Physicians Have Attended Workshop Since 2005

You aren't alone when it comes to conflict with staff, peers, and patients.

Learn how to diffuse and even prevent workplace conflicts in hospital and private practice settings with one of the MMS's longest-running risk management CME programs, Managing Workplace Conflict: Improving Personal Effectiveness. More than 300 physicians have attended this highly successful two-day workshop since 2005.

Now in its seventh year, Managing Workplace Conflict combines medical and organizational conflict training with interactive case scenarios and role-plays with fellow physicians. The program is for physicians and residents interested in sharpening their conflict resolution, interpersonal communication, and leadership skills. **VS**

Here are some comments from past participants:

"This is truly an excellent workshop. I felt a strong sense of community with the other MDs as we shared our travails. All of the instructors/facilitators contributed to allowing the group to work as it did."

"Please keep doing this important work. The health care system and our patients benefit greatly. I know that I will attend again in two years... I got so many new insights this time, I'll bet it will be that way again."

"This course reminded me of ways to communicate effectively, and the pitfalls docs and medical staff can fall into."



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Managing Workplace Conflict: Improving Personal Effectiveness

March 29, 2012
7:30 a.m. to 4:00 p.m.
and March 30, 7:30 a.m. to 3:00 p.m.

This activity has been approved for AMA PRA Category 1 Credit™. For more information, visit www.massmed.org/cme/events or call (800) 843-6356.



Marian Craighill, M.D., chair of the MMS Committee on LGBT Matters, (center) joins with others on January 19 in support of a new law on transgender anti-discrimination protections. From left to right are Gavi Wolfe, legal counsel, American Civil Liberties Union, ACLU-MA, Kara Suffredini, executive director, MassEquality, Gunner Scott, executive director, Massachusetts Transgender Political Coalition, and State Representative Carl Sciortino.



Keep up with MMS news and events @MassMedical.

IN MEMORIAM

The following deaths of MMS members were reported to the Society in February 2012. We also note member deaths on the MMS website at www.massmed.org/memoriam.

Adrian Blake, M.D., 81; Auburndale, MA; Royal College of Surgeons, Ireland, 1952; died December 5, 2011.

Charles D. Cook, M.D., 91; Lyme, CT; Harvard Medical School, 1944; died September 4, 2011.

Kristen M. Ettensohn, M.D., 27; University of Massachusetts Medical School, Worcester, 2010; died July 11, 2010.

Steven J. Kaner, M.D., 63; Las Vegas, NV; Tufts University School of Medicine, 1974; died October 15, 2011.

William B. Kannel, M.D., 87; Framingham, MA; Medical College of Georgia, Augusta, 1949; died August 20, 2011.

Eugene La Lancette, M.D., Ph.D., 76; Fitchburg, MA; University of Pennsylvania School of Medicine, 1970; died October 19, 2011.

Harold J. Lehmus, M.D., 92; Coventry, CT; New York University School of Medicine, 1943; died February 17, 2011.

Avard M. Mitchell, M.D., 92; Wellesley, MA; Harvard Medical School, 1950; died February 23, 2011.

Howard Sachs, M.D., Ph.D., 85; Easthampton, MA; Case Western Reserve University School of Medicine, 1976; died December 6, 2011.

B. Lincoln Wales Jr., M.D., 92; Northfield, MN; Cornell University Medical College, 1944; died September 20, 2011.

ACROSS THE COMMONWEALTH

District News and Events

Barnstable — Executive Committee. Wed., Mar. 7, 6:00 p.m. Location: Coonamesett Inn, Falmouth. **Joint Annual Meeting with Cape Cod Health Care.** Wed., Mar. 28, 5:30 p.m. Speaker: Lynda Young, M.D., MMS president. For more information, contact the Southeast Regional Office.

Berkshire — Annual District Meeting. Wed., Mar. 7, 6:00 p.m. Location: Spice Dragon Restaurant, Pittsfield. Guest speaker: Lynda Young, M.D., MMS president. Topic: Charting the Course. **High School Doctor for a Day Program.** Mon., Apr. 2, 7:30 a.m. to 4:30 p.m. Location: Berkshire Medical Center, Pittsfield. For more information, contact the West Central Regional Office.

Bristol North — Legislative Breakfast. Fri., Mar. 30, 7:30 to 9:00 a.m. Location: Margaret Stone Conference Room, Morton Hospital, Taunton. For more information, contact the Southeast Regional Office.

Charles River — Legislative Breakfast. Fri., Mar. 16, 7:30 a.m. Location: Allen Riddle Living Room, Newton Wellesley Hospital, Newton. **Executive Committee Meeting.** Tues., Mar. 20, 6:00 p.m. Location: MMS headquarters, Waltham. For more information, contact the Northeast Regional Office.

Essex South — Membership Meeting. Wed., Mar. 7, 6:00 p.m. Location: Peabody Marriott, Peabody. Guest speaker: Alex Ding, M.D., M.S. Topic: The Changing Health System and You: A View Inside the AMA Board of Trustees. **Legislative Breakfast.** Fri., Mar. 9, 7:30 a.m. Location: Beverly Hospital, Beverly. **Delegates Meeting.** Wed., Mar. 28, 6:00 p.m. Location: Beverly Golf and Tennis Club, Beverly. For more information, contact the Northeast Regional Office. For more information, contact the Northeast Regional Office.

Essex North — Delegates Meeting. Tues., Mar. 27, 6:00 p.m. Location: Evenfall Restaurant, Haverhill. For more information contact Northeast Regional Office.

Hampden — Financial Planning Seminar for Young Physicians, Residents, and Students. Wed., Mar. 21, Dinner: 6:00 to 6:30 p.m. Forum: 7:00 p.m. Members: No charge. **Legislative Breakfast.** Fri., Mar. 30, 7:30 a.m. Location: Storowtown Tavern, W. Springfield. **High School Doctor for a Day Program.** Thurs., Apr. 12, 7:30 a.m.–6:30 p.m.

Location: Baystate Learning Center, Holyoke. For more information, contact Hampden District at (413) 736-0661 or hdms@massmed.org.

Hampshire/Franklin — Social Event: UMass vs. Rhode Island Men's Basketball. Sat., Mar. 3, 4:00 p.m. Location: UMass, Amherst. For more information, contact the West Central Regional Office.

Middlesex — Executive Committee Meeting. Wed., Mar. 14, 2:00 p.m. Location: Sonesta Hotel, Cambridge. For more information, contact the Northeast Regional Office.

Middlesex Central — Annual Meeting. Tues., Mar. 6, 11:45 a.m. Location: Emerson Hospital, Concord. Guest speaker: Ronald W. Dunlap, M.D., vice president, MMS. **Executive Committee Meeting.** Thurs., Mar. 15, 7:45 a.m. Location: Emerson Hospital, Concord. For more information, contact the Northeast Regional Office.

Norfolk South — Annual Meeting. Wed., Mar. 14, 6:00 p.m. Location: Neighborhood Club of Quincy. Speaker: Lynda Young, M.D., MMS president. For more information, contact the Southeast Regional Office.

Worcester — Safe Opioid Prescribing CME Program. Wed., Mar. 14, 5:30 p.m. Location: Beechwood Hotel, Worcester. To register, visit www.wdms.org or call (507) 752-1579.

Worcester North — Annual District Meeting. Wed., Apr. 4, 6:00 p.m. Location: Chocksett Inn, Sterling. Guest speaker: Lynda Young, M.D., MMS president. Topic: Charting the Course. For more information, contact the West Central Regional Office.

Statewide News and Events

If you have news for Across the Commonwealth, contact Michele Jussaume, Northeast Regional Office, at (800) 944-5562 or mjussaume@mms.org; Sheila Kozlowski, Southeast Regional Office, at (800) 322-3301 or skozlowski@mms.org; or Cathy Salas, West Central Regional Office, at (800) 522-3112 or csalas@mms.org.

Surviving the EHR Transition



James Umlas, M.D., an ophthalmologist with Lexington Eye Associates, at work on his practice's electronic health record (EHR) system. His practice, like many others, staggered its EHR training so successive groups of providers and technicians trained on and then test-drove the new system for several weeks at a time. See "EHR Implementation: Advice from the Trenches" on page 1.

INSIDE

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MASSACHUSETTS
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VITALSIGNS

VOLUME 17, ISSUE 3, MARCH 2012

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MMS SPONSORED AND JOINTLY SPONSORED CME ACTIVITIES

LIVE CME ACTIVITIES

Go to www.massmed.org/cme/events. Unless otherwise noted, event location is MMS headquarters, Waltham.

Managing Workplace Conflict — Improving Personal Effectiveness

Thurs., March 29, 8:00 a.m. to 4:00 p.m., and
Fri., March 30, 8:00 a.m. to 3:00 p.m.

The Importance of Data Analytics in Physician Practice

Fri., March 30, 8:00 a.m. to 12:00 p.m.

CME Accreditation Orientation

Wed., April 4, 8:30 to 11:45 a.m.

Public Health Leadership Program: Mandating Public Health

Jointly sponsored by the MMS and the Harvard School of Public Health, Wed., April 11, 1:00 to 5:00 p.m.

Ethics Forum — Drug Shortages: Examining the Causes, Potential Solutions, and Effect on Patient Care

Thurs., May 17, 3:30 to 5:30 p.m., Seaport Hotel, Boston, as part of the MMS Annual Meeting

2012 Education Program — The Secret Sauce: Population Health as a Recipe for Transforming Health Care

Fri., May 18, 8:00 a.m. to 12:15 p.m., Seaport Hotel, Boston, as part of the MMS Annual Meeting

2012 Shattuck Lecture — Molecular Insights into the Gateway Sequence of Drug Abuse

Fri., May 18, 12:30 to 2:00 p.m., Seaport Hotel, Boston, as part of the MMS Annual Meeting

Providing Medical Care in an Emergency Shelter Setting

Sponsored by the MMS in collaboration with the Massachusetts Department of Public Health, Tues., June 5, 6:00 to 9:00 p.m.

Addiction Medicine for All Providers

Jointly sponsored by the MMS and the Massachusetts Society of Addiction Medicine, Thurs., June 21, 4:00 p.m. to 8:30 p.m. and Fri., June 22, 8:00 a.m. to 3:30 p.m.

SAVE THE DATE

10th Annual Symposium on Men's Health Mon., June 11

ONLINE CME ACTIVITIES

Go to www.massmed.org/cme.

Risk Management CME Series End of Life Care

- The Importance of Discussing End-of-Life Care with Patients*
- The Unintended Consequences of DNR Orders
- Legal Advisor: Advance Directives

Pain Management

- Managing Risk when Prescribing Narcotic Painkillers for Patients*

Public Health

- MA Responds Orientation Course
- Legal Advisor: Reporting Patients to the RMV

Other Risk Management CME

- A Path to ACOs
- Avoiding Failure-to-Diagnose Suits
- Getting It on Record and Getting It Right
- Seven Steps to Better Health Literacy*
- Social Networking 101 for Physicians
- Terminating the Doctor-Patient Relationship
- Informing Patients and Avoiding Litigation
- Medical Mistakes: Learn to Avoid the Common Ones*

The Legal Advisor Risk Management CME Series

- Boundary Issues in the Physician-Patient Relationship

*Also available in print. Call (800) 322-2303, ext. 7306.

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CME CREDIT: These activities have been approved for
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ext. 7306, or go to www.massmed.org/cmecenter.