

VITAL SIGNS



MASSACHUSETTS
MEDICAL SOCIETY

Every physician matters,
each patient counts.

VOLUME 20, ISSUE 3, MARCH 2015



The Changing Landscape of End-of-Life Planning

New Rules and Training for MDs Bring Some Gains, More Progress Needed

BY VICKI RITTERBAND
VITAL SIGNS STAFF WRITER

As a geriatrician and chair of the MMS Committee on Geriatric Medicine, Eric Reines, M.D., is immersed in advance care planning. But after several fruitless attempts to get his own parents to talk to him about their end-of-life wishes, he finally gave up. In 2012, as his father was dying of cancer, he asked the primary care physician to attempt the conversation. It went well and while his father's death wasn't perfect, there were elements that were meaningful to everyone involved.

"Even the best laid plans of mice and men often go awry," said Dr. Reines. "But you still have to talk about it with your patients, stay connected with them on these issues, be flexible, and roll with the punches."

Dr. Reines, who practices at Element Care in Lynn, is part of a growing contingent of physicians, policymakers, and patients trying

to change some stark facts about how life ends for most Americans. About 50 percent die in a hospital, although 70 percent say they would prefer to die at home. The reasons for the disconnect are complex: when they do occur, conversations about end-of-life care often happen in acute care settings amidst a crisis. Many physicians feel ill-equipped and too pressed for time to have these tough talks earlier; and patient wishes sometimes get lost in a highly fragmented health care system.

Three years ago, the state started mandating that Massachusetts physicians complete two credits of continuing medical education in end-of-life care. Officials and end-of-life advocates also began strongly advocating for the use of medical orders of life-sustaining treatment, or MOLST forms.

Recent books authored by physicians Atul Gawande, M.D., and Angelo Volandes, M.D., calling for a revolution in how the medical profession approaches death as

well as an Institute of Medicine's 2014 report on end-of-life care have also pushed the issue forward. And as of December 2014, the state began requiring hospitals, clinics, and long term care facilities to offer end-of-life counseling to terminally ill patients.

Huge Variability Among Physicians

Is all of this activity paying off in more physician-patient end-of-life conversations? "There is huge variability among physicians — the literature says only about half the patients who should be having these conversations are having them," said Jatin Dave, M.D., medical director of geriatrics at Tufts Health Plan and a Brigham and Women's geriatrician.

"It is improving a bit, but it's nowhere near the tipping point," he said. "You have to have the time and skill set to have the conversation, a way to make sure it's reimbursed and a system to transfer the information from one care setting to another."



© 2015 Thinkstock

Time Pressures

In an ideal world, end-of-life conversations between physician and patient should be unhurried and iterative, taking place over a period of time, said physicians interviewed by *Vital Signs*. But the reality is that in a world of 20-minute office visits, they're a challenge to fit in. "Time is the enemy," said Susan Moynihan, M.D., a Marblehead internist. "I like to get things done, check things off my to-do list, but you can't rush this." Dr. Moynihan will broach the topic with her patients and give them literature to take home and discuss with their loved ones. At the next visit, she'll ask them if

continued on page 2

White House Drug Policy Director to Keynote MMS Opioid Forum

"An Epidemic That Starts in the Medicine Cabinet"

BY ROBYN ALIE
MMS PUBLIC HEALTH MANAGER



Michael Botticelli

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

Drug Policy, who will keynote the Massachusetts Medical Society's April 8 Public Health Leadership Forum on opioids.

Mr. Botticelli has been in Washington since November 2012, previously serving as deputy director of National Drug Control Policy. Prior to his federal appointment, Mr. Botticelli spent many years at Massachusetts Department of Public Health, most recently as the director of the Bureau of Substance Abuse Services.

VS What does the opioid issue look like at the national level?

Botticelli We've made significant progress in reducing alcohol, tobacco, and other drug use in the

United States. I think it's tremendously hopeful as we think about the prescription drug and heroin issue, the opioid issue. We [have seen] some significant reductions in prescription drug use, particularly among young adults.

While we are the federal government, we fully acknowledge that if we're going to have success, it's really about federal, state, and local entities working in partnership to make sure that we have a comprehensive response

around drug issues, particularly around the opioid epidemic.

There's a huge variation in the number of pain prescriptions that are being issued on a state-by-state basis and actually Massachusetts was on the low end of that when [CDC] looked at the number of prescriptions per 100 adults. And, no surprise, we do see significant state level variations as we look at the number of opioid related overdoses, both prescription drugs and heroin.

continued on page 4



End-of-Life Planning Progress

In the three years since Massachusetts began mandating end-of-life care education for physicians, we have seen some encouraging gains in this area.

Many more of us are better equipped and confident in our ability to guide patients and their families through this delicate and painful conversation.

However, more progress is needed, as we learn in this month's *Vital Signs* cover story. Patient wishes are still getting lost in our highly fragmented health care system.

We must be mindful that multiple conversations are often needed as the end approaches, especially with family members who may be unaware of the patient's wishes and have trouble grasping the realistic clinical situation. Many health systems are creating documentation tools to ensure patient wishes travel wherever they do, which is an important step that will help in better end-of-life care.

Also this month, we have the first of a two-part interview with Michael Botticelli, director of the White House Office of National Drug Policy and keynote speaker for the MMS Public Health Leadership Forum on April 8. He is familiar face from his tenure as the former director of the Bureau of Substance Abuse Services at the Massachusetts DPH.

Opioid addiction is "an epidemic that starts in the medicine cabinet," he reminds us. His perspective is fascinating, and I encourage you to read it and let me know your thoughts as we continue crafting MMS policy and practices to cope with this crisis.

— Richard S. Pieters, M.D.

End-of-Life Planning

continued from page 1

they're ready to choose a health care proxy. "After three or four of these conversations, I'll have a sense of what they want," she said.

Like Dr. Reines, Dr. Moynihan cautioned that things don't always go according to plan. "They change their mind, they've chosen a health care proxy who's incapable of making decisions or they haven't communicated their wishes to the proxy. It can be a bit of a morass."

Physician Training

The MMS's Committee on Geriatrics compiled a collection of online resources, at www.massmed.org/advancecareplanning, which includes a brochure the committee developed to help physicians talk with patients about end-of-life planning. Many medical groups have internal systems of their own as well. Harvard Vanguard Medical Associates recently developed a robust advance care strategy that includes physician training and efforts to better document patient wishes in the EHR so they're communicated across the care system.

And while advance care planning has traditionally been considered the purview of primary care physicians, specialists are beginning to shoulder the responsibility as well. Although Dana-Farber has had a palliative care program for two decades, in the past several years it has redoubled its efforts to ensure that patients are experiencing the care at life's end that they desire. The hospital has undertaken a randomized study looking at how closely the wishes of a group of its sickest patients are honored at the end. One group is cared for by clinicians — mostly oncologists and some nurse practitioners and physician assistants — who have

undergone training in end-of-life conversations, using a guide developed by Dana Farber geriatrician Rachelle Bernacki, M.D., palliative care expert Susan Block, M.D., and Dr. Gawande.

"A key part of the program is triggering the conversations, so we put the guide on the billing sheet so the doctors can't ignore it," explained Dr. Bernacki. "The default then becomes that they'll have the conversation." One problem Dr. Bernacki has identified is that sometimes cancer patients are reluctant to talk to their oncologists about their end-of-life preferences, fearing that they'll unilaterally withhold treatment.

Reimbursements Still an Impediment

It appears progress is finally being made on the issue of compensation for end-of-life conversations. Medicare has introduced two new codes for advance care planning — code 99497 for a 30-minute planning session with the patient, family members and/or a "surrogate," and 99498 for each additional 30-minute session. And while there's not yet any money attached to the codes, Tufts Medical Director Dr. Dave expects that to change in the next year and a half.

"Reimbursement is not the holy grail," said Dr. Dave, "but it will help by making advance care planning more sustainable. Currently physicians are doing it out of good will and with the intent of providing good care. Reimbursement will make it easier."

In addition to reimbursement, another challenge to end-of-life planning is transmission of patient wishes from one physician or care setting to another, especially if a

patient can no longer communicate. EMRs from different health care systems rarely talk to each other and regular email is insecure. Additionally, it can be challenging for a PCP to connect by phone with a hospital-based physician or a specialist about such matters. The growth of models like ACOs and patient-centered medical homes should eliminate some disconnect, observers said.

"The hospital can be a challenge," said Beth Israel Deaconess Health Care-Needham internist Jane Fogg, M.D. "You have the hospitalist and specialty team doing a lot of evaluation and diagnostics on patients at the end of their lives that can seem out of proportion to you, the primary care physician, but then again you're not there. We have to get better at collaborating with the inpatient world around end-of-life care. They have to reach out to us and vice-versa." Dr. Fogg said that at times, patients have asked her to tell their specialist they want to stop treatment, because they've felt uncomfortable asserting themselves.

While good advance care planning is the right thing to do for patients, there's a certain amount of self-interest involved for the physician, said Dr. Moynihan. She recounts the case of an elderly patient who had resisted talking to her about her wishes, had a stroke, ended up intubated and ventilated, and then died in a nursing home almost a year-and-a-half later. "The doctor and the office also suffer when this isn't done correctly," she said. "If it was your own grandmother, it would bring you to tears."

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

VITAL SIGNS is the member publication of the Massachusetts Medical Society.

EDITOR: Erica Noonan

STAFF WRITERS: Deb Beaulieu-Volk, Vicki Ritterband

EDITORIAL STAFF: Charles Alagero, Office of General Counsel; Robyn Alie, Public Health; Lori DiChiara, Government Relations; Kerry Ann Hayon, Managed Care; Stephen Phelan, Membership; Cathy Salas, West Central Regional Office; Jessica Vautour, Physician Health Services

PRODUCTION AND DESIGN: Department of Premedia and Publishing Services; Department of Printing Services

PRESIDENT: Richard S. Pieters, M.D.

EXECUTIVE VICE PRESIDENT: Corinne Broderick

DIRECTOR OF COMMUNICATIONS: Frank Fortin

Vital Signs is published monthly, with combined issues for June/July/August and December/January, by the Massachusetts Medical Society, 860 Winter Street, Waltham, MA 02451-1411. Circulation: controlled to MMS members. Address changes to MMS Dept. of Membership Services. Editorial correspondence to MMS Dept. of Communications. Telephone: (781) 434-7110; toll-free outside Massachusetts: (800) 322-2303; fax: (781) 642-0976; email: vitalsigns@mms.org.

Vital Signs lists external websites for information only. The MMS is not responsible for their content and does not recommend, endorse, or sponsor any product, service, advice, or point of view that may be offered. The MMS expressly disclaims any representations as to the accuracy or suitability for any purpose of the websites' content.

©2015 Massachusetts Medical Society. All Rights Reserved.

ICD-10 Focus on Preparation: Education and Training

BY KERRY ANN HAYON
PPRC MANAGER

This is the second in a series of Vital Signs articles to assist members in preparing their practices for ICD-10 implementation.

Currently, the date of October 1, 2015, is still the official implementation date for ICD-10. While rumors continue to circulate about another potential postponement, the Centers for Medicare and Medicaid Services have not indicated that they intend to alter this deadline. One of the most important components of successfully preparing your practice for implementation is educating and training your staff in advance.

Quick Hit ICD-10 Checklist:

- Speak with Vendors
- Educate Your Staff
- Conduct a Documentation Gap Analysis
- Review Internal Processes
- Create Your ICD-10 Conversion Plan
- Develop a Test Plan
- Create a Plan for Post Go-Live Monitoring

The PPRC often receives questions about the best time to train staff for ICD-10. We recommend in-depth training of coders and other practice staff should begin three to six months in advance of

implementation. This timeline is important for two reasons:

- Advance training will allow staff to help you with other key components of your implementation plan. For example, trained staff may be able to help you with documentation review, creating new ICD-10-based encounter forms, assist in creating a practice specific cross walk from ICD-9 to ICD-10 for your most frequently billed procedures, and help in redesigning any operational processes based on their learned knowledge.
- It will allow for staff to have an impact on practice preparations, but still allow for the information to be fresh at the point of implementation.

Given the widespread reaches of ICD-10, all staff will require some form of training. Developing a practice-specific educational plan based on a thorough need assessment for your practice will help in establishing both a timeline as well as key focus areas for the staff needs of your practice.

For additional information, please visit www.massmed.org/icd10.



PHYSICIAN PRACTICE
Resource Center

Adding value. Creating change.

CALL 781.434.7702
EMAIL pprc@mms.org
CLICK www.massmed.org/pprc

Changes Expected to the Standard Quality Measure Set

BY LINDSAY GARITO, MPH
MMS HEALTH POLICY ANALYST

Quality measurement is an important, yet still evolving part of state health care reform.

The state's 2012 payment reform law, Chapter 224, reestablished the Statewide Quality Advisory Committee (SQAC) and charged the Center for Health Information and Analysis (CHIA) with monitoring and reporting on the quality of care delivered in the state.

This led to the creation of the Standard Quality Measure Set (SQMS) to assess providers, hospitals, and post-acute care facilities, as well as the overall quality of the Massachusetts health care system and provide a standardized measurement system.

The SQMS is a combination of nationally accepted measurement data, such as the Consumer Assessment of Healthcare Performance and Systems surveys, hospital process measures from CMS, and the Healthcare Effectiveness Data and Information Set (HEDIS). The SQMS is used to quantify health care processes, structures, outcomes, and patient experiences in order to determine



how well the Massachusetts health care system is performing.

The set currently contains 140 measures that align with state priorities for health care improvement and that are primarily process measures designed to measure how consistently a workflow is followed. Process measures are useful when a given process can be linked to a desirable outcome. Screening for breast cancer, cervical cancer, colorectal cancer, or lead poisoning are examples of HEDIS process measures that are included

in the set. Among physicians, process measures remain controversial. Many physicians have raised concerns about process measures' usefulness in improving health care outcomes.

Despite the debate over the utility of these measures, a recent CHIA report using SQMS data indicates that overall, Massachusetts hospital performance is strong. However, the report also notes areas for improvement. Eighty percent of hospitals in the Commonwealth received Medicare penalties for excessive

unplanned readmissions in 2014, which makes the Bay State the fourth most penalized state in the United States.

Massachusetts medical group performance on clinical quality measures varied both across and within measures, but remained at or close to the national 90th percentile benchmark. Patient satisfaction with the care received from primary care groups was the highest on communication with physicians and nurses.

In the future, CHIA has said it plans to add outcome measures to the set, and it has identified areas where it plans to develop new measures. Key priorities for measure development include behavioral health, pediatrics, end-of-life care, resource efficiency, and patient-centered care. In 2015, there will be six SQAC meetings (which are open to the public) in order to discuss current and future uses of the SQMS as well as any annual updates to the measure set.

MMS will continue to monitor the development of new quality measures statewide and will provide updates in the coming year.

MMS Opioid Forum

continued from page 1

VS How would you explain these regional differences?

Botticelli There are probably multiple factors.... It could be a function of not having standard clinical guidelines as it relates to pain prescribing. I think it might relate to the variability — although that's changing — around the sophistication and utilization of Prescription Drug Monitoring Programs [PDMPs]. It might be a function of state legislation and state support for this kind of comprehensive prescription drug abuse strategy that Massachusetts has implemented.... There are a significant number of states that don't have a robust treatment program or haven't significantly expanded Medicaid and insurance status like Massachusetts has.

VS How is the prescription opioid problem similar to or different from other substance abuse?

Botticelli Unlike other drugs — heroin, cocaine, marijuana — that are illegal and are driven by an illegal drug trade, prescription drugs are not. These are legally prescribed substances. We've known for a long time that people — particularly kids and young adults — are less likely to see prescription drugs as dangerous because they are prescribed by physicians. As you move into why people start misusing pain medication, we know diversion from legitimate prescriptions is a huge factor. About 70 percent of people who start misusing pain medications get those free from family and friends who have gotten that prescription from just one doctor.... This is an epidemic that starts in the medicine cabinet.

VS What do you feel are the interventions that work? What more is needed to address those unique issues?

Botticelli In 2010, our office issued a strategy to reduce the epidemic of prescription drug misuse in the United States. It has four main pillars. The first one is education: it primarily speaks to educating the prescriber community on safe and effective opioid prescribing. When you look at the significant health

consequences that we've had around prescription pain medication, there's a direct correlation to just the volume of pain medication that's being prescribed. Our office has always been trying to promote a balanced plan around prescribing. We don't want people to suffer needlessly in pain. But we also want prudent and responsible prescribing, to understand where we do not necessarily have to prescribe. The automatic response to pain shouldn't be prescribing opioids. We want to make sure that there's a comprehensive assessment going on about whether or not alternatives to opioids can be used. Chronic opioid prescribing may not be having the intended health benefits that people thought. Massachusetts was actually one of the first states — and one of the few states — that implemented mandatory continuing medical education for prescribers.

The second component is monitoring. A main pillar of our plan is having good usable PDMPs across the country. In 2006, I think we had 26 states that had [PDMPs]. Some of those didn't keep up with the number of schedules, may not have been providing real-time data, so a big push at the federal level is to make sure all states have a

[PDMP]; to make sure those programs have good, reliable, as close to real-time data as possible; that they're easy to use. We've been working... to make sure that these programs are linked to electronic health records. We understand that physicians are working within busy practices. The other issue that we heard from the medical community — that we are attending to — is interstate operability.

VS How far away do you think we are from those reliable, almost real-time PDMPs across the country?

Botticelli I think we're getting there. I think of this as looking at the next generation of prescription drug monitoring programs — PDMPs 2.0. It was a big push just to get prescription drug monitoring programs online. The next piece is how do we use that information not only for identification of high utilizers, but also as a clinical intervention to get people into treatment? We're seeing states looking at how might physicians partner with treatment programs, or [how to] get physicians good information about creating opportunities to identify those folks and creating a referral to treatment.

This is where we've begun to see some really good outcomes

coming from the development and implementation and utilization of [PDMPs]. Tennessee... [passed] a state law where prescribers have to check the PDMP when they're first prescribing. So, over the past two years they've seen a 47 percent reduction in the number of high utilizers in prescription drug monitoring programs.

There was probably no more outlier state than Florida. Because of lax legislation and regulation, Florida was the state with the highest number of opioid pain prescriptions. One county, Broward County, accounted for something like 50 percent of all the prescriptions in the United States. It was huge. Through legislative action and the development and utilization of a [PDMP], they actually saw a significant reduction in opioid-related overdoses associated with prescription pain medication. So, we're beginning to see, in states that have good, reliable [PDMPs], and where physicians and other prescribers access that information, that we really can make significant changes.

Coming in April's Vital Signs, Mr. Botticelli will speak about treatment and the evolving role of physicians and others in the opioid addiction epidemic.



Free Networking Dinner for Medical Students, Residents, Early Career Physicians

REALITY MEDICINE

Wednesday, March 25, 2015, 6:00 p.m.

Hiebert Lounge, Boston University School of Medicine

Meet and talk with experienced physicians on issues important to you for a successful career in medicine, and hear presentations, on such issues as:

- What today's physicians need to know about treating diverse populations
- How to choose a specialty
- Tips for success for minority medical students and physicians in Massachusetts
- Diversity in medicine — how does it affect you?

Hosted by the Massachusetts Medical Society Committee on Diversity in Medicine

For more information, to register, and to suggest topics for discussion visit www.massmed.org/RealityMedicine.

New Legislative Session Brings Bills on Health Care Teams, Road Safety

BY RONNA WALLACE
MMS LEGISLATIVE CONSULTANT

The 2015–2016 state legislative session is off and running, with new faces and leadership on Beacon Hill.

Of importance to health care stakeholders are the appointments of Marylou Sudders as secretary of the Executive Office of Health and Human Services, and Monica Bharel, M.D., as commissioner of the Department of Public Health.

Prior to her appointment, Secretary Sudders was a member of the Health Policy Commission, president of the Massachusetts Society for the Prevention of Cruelty to Children, and a past commissioner of the Department of Mental Health. Dr. Bharel is a 20-year veteran of the public health world and most recently worked as the chief medical officer for the Boston Health Care for the Homeless Program.

In the state house, Sen. Stanley Rosenberg (D-Amherst) was elected Senate president, replacing the retired Therese Murray (D-Plymouth). Rep. Robert A. DeLeo (D-Winthrop) was re-elected speaker of the House. With more than 20 new House members and four new state

senators, there will be significant changes in leadership and many new committee appointments.

The MMS is off and running, too, with several new pieces of legislation requested by our members during last year’s annual and interim meetings.

Headlining the MMS legislative package is “An Act to Promote Team Based Health Care.” Filed by Senator Thomas P. Kennedy (D-Brockton), this bill would ensure that evolving models of team-based health care will be led by physicians, while clarifying the important role that advanced care nurses and physician assistants play as part of the health care team.

Two other initiatives introduced by the MMS this year would expand the use of helmets by bicyclists and would protect diabetic students by expanding their access to glucagon. Another new bill would expedite the medical decision-making process for incompetent patients lacking a health care proxy.

For a full list of MMS legislative activities, see www.massmed.org/2015-2016Legislation.

New Bills Filed by the MMS in the 2015–2016 Legislative Session

An Act to Promote Team-Based Health Care

This bill would ensure that evolving models of team-based health care will be led by physicians — the health care professionals best suited to guide other members of patient care teams — and would clarify the important role that advanced care nurses and physician assistants play as part of the teams. In addition, the bill would further enhance transparency in team-based care, ensuring that patients understand who is providing care and who is leading their team.

An Act Improving Medical Decision Making

This bill would require collaboration in the health care industry around the issue of guardianship for incompetent patients lacking a health care proxy. The purpose of the bill is to expedite the medical decision-making process for such patients in order to ensure access to necessary care in a timely manner.

An Act Relative to Bicycle Safety

As rates of cyclists continue to rise in Boston and elsewhere in the state, and as helmet usage for bicyclists involved in accidents requiring EMS remains below 50 percent, this bill seeks to expand to persons of all ages the bike helmet requirement that currently applies to persons 16 years or younger. The bill also directs the Department of Public Health to pursue means by which to encourage bicycle operators to wear highly visible waist-up clothing while bicycling.

An Act Improving Students’ Access to Life-Saving Treatments

This legislation would address the need for others to help students with diabetes by administering injections of glucagon.

An Act to Reduce Administrative Burdens for Health Care Providers

This legislation would reduce the administrative burden of physicians by prohibiting health care entities from forcing health care providers to create new legal entities and/or establish new tax identification numbers as a condition of contracting to provide health care services. Such requirements are costly and burdensome for physicians.

Medicare and ACA Remain on Federal Agenda: Prognosis Unclear

BY ALEX CALCAGNO
MMS DIRECTOR OF COMMUNITY AND
FEDERAL RELATIONS



Contact Alex at
(781) 434-7214 or
acalcagno@mms.org

While prognostications abound regarding what will happen in the 114th Congress, for health care advocates the reality is clear:

while the leadership has changed, the challenges remain the same. Here at the MMS, our agenda is familiar:

Medicare SGR Crisis — The latest Medicare Sustainable Growth Rate patch expires at the end of March 2015. The 114th Congress will either need to pass the full reform bill or pass yet another patch. It is early in the session, but it appears the new leadership is not

interested in reinventing the whole SGR repeal package. Full repeal by end of this month is a longshot, but Congress isn’t likely to let physicians suffer the SGR costs, so the result may be on a patch with some improvements built in. We will update all member communication channels with developments as they happen.

Medicaid Reimbursement

Problems — The Affordable Care Act included a provision that paid Medicaid primary care providers Medicare rates for two years, a long overdue reimbursement adjustment. However, the provision and money expired at the end of December 2014. The reimbursement expansion enabled primary care practices to take in more Medicaid patients — a very good thing — until the reimbursement was restored to the former minimal

levels. The problem is that Medicaid reimbursement is so low that physicians who run their own practices financially have a difficult time running the practice if a significant percentage of their care is grossly underpaid. The ACA also provided language giving bonuses to primary care providers who work in underserved areas, and that money has now also dried up. Restoring these provisions and funds is a high priority for national and state physician and patient organizations. The problem? Where will the money come from and how do we get support for extending an ACA provision in a Republican-led anti-ACA environment? Fortunately, several states have decided to continue the funding independently, understanding how critical it is to ensure access to care for those who truly are the most in need.

Affordable Care Act — The Supreme Court is expected to hear the case, *King vs. Burwell*, which maintains that the subsidies in the ACA should only go to those who obtain health insurance through state-run exchanges. There are currently 14 state run exchanges and should the Supreme Court rule that was the intent of the ACA, an estimated 8.5 million people in the 37 other states will lose health insurance. An estimated 10 million will lose health insurance in total, but about 1.5 million are expected to be able to obtain it otherwise. Support for the ACA may now come from an unlikely source: more than two dozen Republican governors who could in the near future find themselves in the position of fighting for these federal subsidies critical for their constituents to obtain health insurance and to balance their state budgets.

PHYSICIAN HEALTH MATTERS

Healing Thyself: Self-Referrals to PHS for Coaches, Psychiatrists, and Therapists Has Doubled

Physicians Wish to Optimize Performance, Health, and Happiness

BY STEVE ADELMAN, M.D.
PHS DIRECTOR

Over the past two decades, more than 2,500 Massachusetts doctors have used our state physician health program, Physician Health Services, Inc.

For the most part, PHS referrals have been initiated by others concerned about the physician's health and well-being: medical leaders, colleagues, training directors, and family members often contact PHS about a doctor in distress as the first step in the referral process. Sadly, many busy doctors tend to look the other way when it comes to their own personal challenges in the domains of substance use, mental health, workplace behavior, job performance, and cognition.

But that pattern is changing, and some physicians are beginning to optimize their health and ability to practice by identifying problems early and taking care of them before they escalate out of control. We are encouraged by the fact that over the past two years, the percentage of self-referrals to PHS has more than doubled, reaching one-third of

all referrals. This is a very welcome development — how many times have we told our patients that an ounce of prevention is worth a pound of cure?

Unfortunately, many physicians still believe that seeking services from PHS will somehow imperil their medical licensure. Our consultative services are free and highly confidential; PHS is a peer review program that is entirely separate from the Board of Registration in Medicine.

A self-referral starts with a phone call; you need not identify yourself if you prefer not to do so. In the initial phone call, we'll discuss whether or not it makes sense for you to come in for an information consultation. The information consultation is a 90-minute meeting with me, the director. During that meeting I'll hear more about you and your current challenges, and we'll decide together which — if any — steps make the most sense. What follows is a handful of typical self-referral scenarios that will give you a flavor of how PHS can be helpful to you:

- An internist going through a divorce finds that he is more

impatient in the office. He comes to PHS for an information consultation. It appears that he would benefit from meeting with a psychotherapist experienced in working with doctors, and he is given the name of three such clinicians who practice in convenient locations.

- A general surgeon has been asked to take on a leadership role in her local hospital. Throughout her life she has avoided taking on such challenges, but at this stage of her career she really wants to feel more comfortable about stepping up and getting more involved in leadership. She contacts PHS, wondering if coaching or therapy might be of some benefit. At the end of her consultation, she is given the names of three professional coaches who have extensive experience working with physicians, all of whom are also licensed mental health professionals.
- An emergency medicine specialist has been experiencing flashbacks and nightmares

since he attempted to resuscitate a mangled trauma victim who died in the ED. He contacts PHS, asking for a referral to a psychiatrist. In an initial meeting he reveals to the director that he has been chronically anxious since his childhood, which he described as abusive and traumatic. He has never opened up about this before to anyone. The director recommends a more thorough assessment aimed at determining the nature and severity of his longstanding difficulties. He readily agrees to proceed with the assessment, which culminates in a set of recommendations that lead to his feeling and functioning better in a sustainable and enduring way.

These three fictional anecdotes are very representative of the growing stream of self-referrals to PHS. We remain at the ready to help you with any and all health-related concerns. It's as simple as picking up the phone and calling (781) 434-7404.

Managing Workplace Conflict

IMPROVING LEADERSHIP AND PERSONAL EFFECTIVENESS



THURSDAY AND FRIDAY, MARCH 19–20, 2015

Elective Follow-Up Session
WEDNESDAY, JUNE 3, 2015

Register at www.massmed.org/cme/events.



Photo by Frank MacMillan Jr., M.D.

ESSEX NORTH DISTRICT JAZZ BRUNCH Merry Byrne, David Byrne, M.D., Yamil Kouri, M.D., Suzanne Kouri, Nancy Faye Glass, and Don Ross, M.D., all members of the Essex North District Medical Society, enjoy the music of the Boston Jazz Quartet at the Renaissance Country Club in Haverhill on January 25.

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

Essex South — Delegates Meeting. Wed., March 18, 6:00 p.m.
Location: Beverly Depot, Beverly.

Middlesex — Executive Committee. Wed., March 11, 8:30 a.m.
Location: MMS Headquarters, Waltham.

Middlesex Central — Annual Meeting. Tues., March 31, 11:45 a.m.
Location: Emerson Hospital, Concord. Guest Speaker: Alex Calcagno, MMS Federal Relations Director.

Middlesex North — Annual Meeting. Thurs., March 26, 6:00 p.m.
Location: UMass Inn and Conference Center, Lowell. Guest Speaker: Dennis Dimitri, M.D., MMS President-Elect.

Middlesex West — Annual Meeting. Wed., March 25, 6:00 p.m.
Location: Samba's Steak and Sushi Restaurant, Framingham.

Suffolk — Annual Meeting. Thurs., March 26, 6:00 p.m. Location: Downtown Harvard Club, Boston.

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

SOUTHEAST REGION

Barnstable — District Meeting. Tues., March 31, 6:00 p.m. Location: New Seabury Country Club, Mashpee. Speaker: MMS President Richard Pieters, M.D.

Norfolk South — District Meeting. Tues., March 24, 6:00 p.m. Location: Neighborhood Club, Quincy. Speaker: Stephen Corn, M.D.

Southeast Regional Caucus. Wed., April 15, 6:00 p.m. Location: LeBaron Hills Country Club, Lakeville. Delegates from Barnstable, Bristol North, Bristol South, Norfolk South, and Plymouth District Medical Societies will meet to review and discuss the resolutions prior to Annual Meeting 2015.

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

WEST CENTRAL REGION

Berkshire — High School Doctor for a Day Program. Thurs., March 19. Orientation 7:30 a.m. Debriefing 4:00 p.m. Location: Berkshire Medical Center, Pittsfield.

Hampden — Legislative Breakfast. Fri., March 27, 7:30 to 9:00 a.m. Location: Hilton Garden Inn, Springfield. **High School Doctor for a Day.** Thurs., April 2. Orientation 7:30 to 8:30 a.m. Debriefing 5:00 to 6:30 p.m. Location: Mercy Medical Center, Deliso Conference Center, Springfield.

Hampshire/Franklin — Annual Meeting. Thurs., March 26, 6:00 p.m. Location: Blue Heron. Speaker: Ruth Potee, M.D. Topic: Opioid Use and Addiction. CME Available.

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

Statewide News and Events

Arts, History, Humanism, and Culture Member Interest Network — Winter Eagles Program. Sun., March 1, 10:00 a.m. to 1:00 p.m. Location: Joppa Flats, Newburyport.

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.

Joey S. Rottman, D.O., 55; Boxford, MA; College of Osteopathic Medicine and Surgery, Iowa, 1988; died November 15, 2014.

Maurice Vanderpol, M.D., 92; Needham, MA; Boston University School of Medicine, 1949; died October 19, 2014.

Martin J. Wohl, M.D., 82; Brookline, MA; Columbia University College of Physicians and Surgeons, 1957; died August 20, 2014.

MMS Committee Appointments
2015–2016

Deadline for Consideration: March 6, 2015

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 (i.e., 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, contact Sandra Manchester at the MMS Executive Office at (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 at (800) 322-2303, ext. 7715, or email csalas@mms.org.

Board of Trustees Committees
Appointed by the Board

(Limited openings in accordance with bylaws)

- Administration and Management
- Finance
- Member Services
- Recognition Awards
- Strategic Planning

Standing Committees Appointed
by the President-elect

(Limited openings in accordance with bylaws)

- Bylaws
- Communications
- Ethics, Grievances, and Professional Standards
- Interspecialty

- Judicial
- Medical Education
- Membership
- Professional Liability
- Public Health
- Publications
- Quality of Medical Practice

Special Committees Appointed
by the President-elect

- Accreditation Review
- Diversity in Medicine
- Environmental and Occupational Health
- Geriatric Medicine
- Global Health
- History
- Information Technology
- Lesbian, Gay, Bisexual, and Transgender Matters
- Maternal and Perinatal Welfare
- Men's Health
- Nutrition and Physical Activity
- Oral Health
- Preparedness
- Senior Physicians
- Senior Volunteer Physicians
- Sponsored Programs
- Student Health and Sports Medicine
- Violence Intervention and Prevention
- Women in Medicine
- Young Physicians

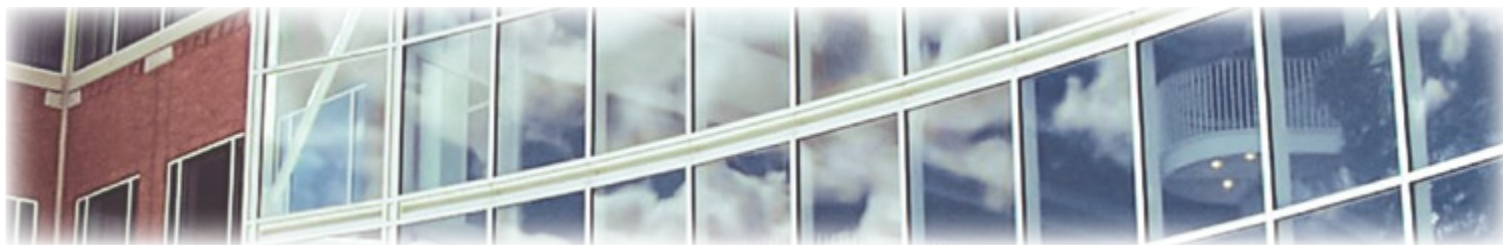
District Appointed Committees

(Contact your district medical society for more information)

- Legislation
- Nominations

Member Interest Network (MIN)
Executive Council

- Arts, History, Humanism, and Culture



IN THIS ISSUE

- 1 > Helping Patients with Final Plans
> Q & A with White House Drug Policy Director
- 2 > President's Message: End-of-Life Planning
- 3 > ICD-10 Staff Education and Training
> Standard Quality Measure Set Changes
- 4 > Reality Medicine Networking Dinner, March 25
- 5 > New Legislative Session Brings Health Care Team Bill
> Congress Considers Changes to ACA, Medicaid
- 6 > Physician Self-Referral to PHS Doubles
> Workplace Conflict Workshop, March 19–20
- 7 > MMS Committee Appointment Deadline, March 6
> Across the Commonwealth



MASSACHUSETTS
MEDICAL SOCIETY

VITALSIGNS

VOLUME 20, ISSUE 3, MARCH 2015

860 Winter Street, Waltham, MA 02451-1411

NONPROFIT U.S.
POSTAGE PAID
BOSTON, MA
PERMIT 59673

MMS AND JOINTLY PROVIDED CME ACTIVITIES

LIVE CME ACTIVITIES

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

Managing Workplace Conflict

Thurs. and Fri., March 19 and 20, 2015

Public Health Leadership Forum — The Opioid Epidemic: Policy and Public Health

Wed., April 8, 2015

MMS and Rhode Island Medical Society Directors of Medical Education Conference

Thurs., May 14, 2015

Preparing for Infectious Disease in a Disaster and Beyond

Wed., May 27, 2015

13th Annual Symposium on Men's Health

Thurs., June 18, 2015

ONLINE CME ACTIVITIES

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

Electronic Health Records Education (3 modules)

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

End-of-Life Care

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

Pain Management

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

Medical Marijuana (4 modules)

- Module 1 — Medical Marijuana: An Evidence-Based Assessment of Efficacy and Harms
- Module 2 — Medical Marijuana in the Commonwealth: What a Physician Needs to Know
- Module 3 — Medical Marijuana in Oncology
- Module 4 — Dazed and Confused: Medical Marijuana and the Developing Adolescent Brain

Other Risk Management CME

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

- Cancer Screening Guidelines (3 modules)

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

Other CME

- Genetically Modified Foods: Benefits and Risks
- Physician Employment Options in the Health Care Environment
- Contracting with an ACO
- Finance 101 for Physicians and Practice Administrators
- A Roadmap to Bring an End to HIV and STDs in Massachusetts (3 modules)
- Using Data Wisely
- Just a Spoonful of Medicine Helps the Sugar Go Down: Improve Management of Type 2 Diabetes
- Weighing the Evidence on Obesity
- Aggregating the Evidence on Antiplatelet Drugs: A Review of Recent Clinical Trials
- Acid Suppression Therapy: Neutralizing the Hype
- Preventing Overuse of Antipsychotic Drugs in Nursing Home Care



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

FOR ADDITIONAL INFORMATION AND REGISTRATION DETAILS GO TO
WWW.MASSMED.ORG/CMECENTER, OR CALL (800) 843-6356.