

VITAL SIGNS



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VOLUME 21, ISSUE 3, MARCH 2016

Not One-Size-Fits-All: A Look at Alternative Practice Models

BY DEBRA BEAULIEU-VOLK
VITAL SIGNS STAFF WRITER

Recent changes in the health care landscape have pushed many physicians to look at their careers differently than previous generations. In particular, more doctors at all career stages are seeking employment or other types of affiliations that will allow them to practice medicine within current realities.

While many physicians in Massachusetts can and do adapt and thrive in the face of change thrust upon them, a number of others have chosen deliberately not to bend their plans to accommodate the system, but to challenge the system in an effort to make room for the way they desire to practice.

Vital Signs spoke with three Massachusetts doctors who have eschewed some “traditional” elements of medical practice, brought back types of care that have faded, or some combination of both. They shared their insights into how these alternative practices fulfill and challenge

them, and how they believe daring to be different affects their patients and potentially the health care system at large.

Delving into Direct Primary Care

A classic example of physician entrepreneurship is seen with the rise of concierge medicine and

patients, the health care system, and for physicians like himself.

“Everything I do now has one of three purposes: growing my business, advocating for the model, and taking care of patients, which is the most important,” Gold said. “Everything I do has a purpose, rather than pushing pa-

into the office unnecessarily, he does so by offering patients access to him via email, text message, or video-conferencing.

And considering that independent telemedicine companies charge patients an average of \$90 for an electronic consult with a physician they don’t know, having the service included in their membership is a great value for patients, he said. “Anything we can do to get away from this archaic model that everything requires a visit so that insurers can get billed and doctors can get paid, we try and do.”

Thus, with a higher level of attention and easier access, the DPC model has the potential to save patients out-of-pocket costs, even when paying for a high-deductible plan on top of their memberships to cover specialty and emergency care (which their doctor is also better able to help coordinate), according to Gold and other proponents.

Recent data from Seattle-based Qliance suggests that the DPC model can be scaled to cut costs

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Jeffrey Gold, M.D.



Timothy Lowney Jr., D.O.



Jeffrey Wacks, M.D.

related models that allow physicians to contract with patients directly. In February 2015, Jeffrey Gold, M.D., became the first physician in Massachusetts to open a small, independent direct primary care (DPC) practice.

A year into his endeavor, launched with the help of a loan from a patient, Gold is as passionate as ever in his belief that the DPC model is win-win-win for

per and seeing 20 to 25 people and being exhausted at the end of the day — and for what? At least now my exhaustion is from growing a business and taking care of people.”

Because Gold’s patients pay a monthly membership fee of \$30 to \$125, depending on age, he’s able to invest the time in seeing just five to eight per day. And if he can avoid bringing patients

CMS Issues Instructions on Meaningful Use Hardship Exemptions

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

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

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

for the hardship exemption will allow physicians to avoid a Meaningful Use penalty in 2017.

The American Medical Association is encouraging all physicians subject to the 2015 Medicare Meaningful Use program to apply for the hardship exemption. All applications from eligible professionals must be received by CMS by 11:59 p.m. EST on March 25, 2016. Eligible hospitals

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Opioids: “Start Low and Go Very Slow”

MMS Webinar Free to All Prescribers

BY ERICA NOONAN
VITAL SIGNS EDITOR

Opioid therapy should be treated with the same comprehensive, team-based approach used to successfully manage conditions such as diabetes and hypertension, according to Daniel P. Alford, M.D., director of Boston University School of Medicine’s Clinical Addiction Research and Education Unit.

He offered a set of practice guidelines to all prescribers

during a recent MMS live webinar on the new Massachusetts Opioid Therapy and Physician Communication Guidelines.

“Start low and go very slow,” said Dr. Alford, describing new guidelines that call for minimum dosages, extensive documentation and assessments, and non-opioid approaches to manage chronic pain in patients.

The hour-long educational webinar, is currently available free of

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PRESIDENT'S MESSAGE



New Approaches

In this month's issue of *Vital Signs*, we hear from three physicians who have chosen alternative approaches to creating and sustaining a medical practice.

But their attitudes towards patient care are anything but unconventional. Jeffrey Wacks, M.D., who recently launched his own direct primary care practice, said what almost every physician — regardless of specialty or practice type — feels keenly.

"The job we have is tough by its very nature. We are taking care of people and their health and we take that responsibility very seriously. The things that we do really affect people's lives, and with that there's a lot of stress," said Dr. Wacks.

Also this month, we learn more about the state's plans to overhaul the prescription monitoring program, changes that should be evident by this summer. The new system will be easier to navigate, have improved search capabilities, and will allow for integration into electronic health records. Prescription data will be more up-to-date, with data uploaded by pharmacies every 24 hours rather than every seven days.

I hope all prescribers in our membership have had a chance to watch the free MMS webinar covering the new Massachusetts Opioid Therapy and Physician Communication Guidelines. The hour-long educational webinar is currently available for free on the MMS website as part of our ongoing Smart and Safe opioid abuse awareness and prevention campaign. We hope it helps you — and all of your colleagues — feel more prepared to help patients consider the risks of opioid therapy and possible alternatives.

— Dennis M. Dimitri, M.D.

Alternative Practice Models

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for the system as well, Gold noted. In a two-year experiment comparing the cost of traditional primary care to comprehensive DPC, employers participating in the study saved about \$2,000 per employee per year through decreased hospitalizations, specialty care, and surgeries.

The House Call Conundrum

Another not-so-new way to keep downstream health care costs down is home-based care for patients at high risk of hospitalization, according to Timothy Lowney Jr., D.O., who devotes about half of each work day to seeing patients at the hospital, the nursing home, or home.

As some proof of the theory, Lowney cites a 2014 pilot project between his practice and Norwood Hospital in which 112 high-risk patients in a transitional care program received a series of home visits for six to eight weeks after being discharged from the

hospital. Within six months of beginning the program, the patients' 30-day readmission rates dropped to 8.04 percent — roughly half of the baseline rate.

"It's a relatively small sample size of patients but it shows that what we're doing does work," Lowney said. "Even if you drop the readmission rate by 1 or 2 percent for a large volume of patients, you're talking about tens of millions of dollars (number corrected from print edition) just in Massachusetts saved in Medicare spending. So we're trying to get insurers to actually pay us to do it."

In the meantime, Lowney pays for the overhead to see patients at home with revenue generated in the office. "Half my time is spent in the home-care setting whereas probably 60 percent of my revenue is generated with the other 50 percent of my time," he explained.

Moreover, it's not an easy grind, Lowney acknowledged. For doctors coming out of medical school with approximately a mortgage's worth of debt, it can be far more enticing to see a lot

of patients in an outpatient practice every day. "No insurance company actually pays you to do [house calls] and keep the lights on," he said.

Despite the drawbacks of poor financial incentive and daily logistics challenges, Lowney said he enjoys having so much variety in his practice and the fulfillment of forming close long-term relationships with patients and their family caregivers.

By bearing witness to patients' living situations and getting to know families on a deeper level, Lowney can effect change in the immediate and long term. For example, he can play a role in getting patients referred to elder services in their communities to get help with house cleaning or medication management, as well as communicate with patients and families about end-of-life care. "It allows us to avoid issues like being in and out of the hospital during the last few months and helping people die comfortably at home. There's a lot you

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Letter to the Editor: Reconsider Opposition to Aid in Dying

Doctors and medical societies should debate and reconsider their positions on aid in dying. The California Medical Association recently withdrew its opposition and has enacted a law like that of Oregon. These laws compel no one; they only permit.

Doctors opposed to such laws usually cite "do no harm" and uncertainty about length of life with even the gravest terminal illnesses.

Hospice experience indicates that doctors usually overestimate the length of life, but the critical question is whether patients

themselves should have some say about how their lives should end. We believe that when things are clearly bad, but doctors' knowledge about the exact prognosis is necessarily limited, patients should have more authority, rather than less, to decide what should be done. Affording patients control and agency at the end of life would be a kindness and accord with doctors' role as

helpers. Denying them this seems to us to be doing harm.

We wonder whether the Massachusetts Medical Society's continuing objection to aid in dying is the majority view of its members or rather an obsolescent reflex of its leadership?

— Carl N. Brownsberger, M.D., Belmont, MA

— Kathleen Mogul, M.D., Newton, MA

— Lawrence Hartmann, M.D., Cambridge, MA

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; vital signs@mms.org; or fax to (781) 642-0976.

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Massachusetts Retail Clinics, Urgent Care Centers See Significant Growth

BY JAMES DZIOBEK III
PPRC RESEARCH AND DATA ANALYST

In 2015, 38 percent of Massachusetts emergency department visits were for nonemergency conditions and 73 percent of recent emergency department visits were for care after normal operating hours at the doctor's office or clinic.

Research by the Robert Wood Johnson Foundation (RWJF) suggests that retail clinics may provide after-hours care options for patients when their physician's office is closed and their treatment is not life-threatening. Interestingly, the RWJF reports that retail clinics and urgent care center locations tend to be in higher-income, urban, and suburban settings. A national survey of emergency physicians conducted by the American College of Emergency Physicians last year found that 43 percent of physicians felt that urgent care centers did not reduce ED visits for patients with less severe illnesses, and 49 percent of physicians felt

that retail clinics did not reduce ED visits for patients with less severe illnesses. According to recent analyses by the Massachusetts Health Policy Commission



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(HPC), emergency department usage in 2014 was 30 percent lower when there was a retail clinic or urgent care center located within five miles of a patient's residence.

Retail or Limited Store-Based Clinics

According to a recent report by the HPC, there are currently 58 retail clinics in Massachusetts — all operated by CVS MinuteClinic. The number of retail clinics has expanded significantly from 11 in 2008 to 58 in 2015

(an increase of 427 percent). In Massachusetts, retail clinics are also called limited-service store-based clinics with direct patient care provided by nurse practitioners. These standalone clinics are often located inside of pharmacies or other retail stores and have a limited scope of services which include treatment of minor illness such as sore throat, treatment of minor wounds and abrasions, wellness services like sports physicals, and simple blood tests for diabetes and cholesterol levels.

Urgent Care Centers

Another addition to the health care community in Massachusetts is the increasing prevalence of urgent care centers. The number of urgent care centers in Massachusetts has expanded from 10 in 2008 to 84 in 2015 (an increase of 740 percent). These urgent care centers are staffed with physicians and may also include other licensed health care professionals. Urgent care centers may provide similar services to those offered in retail clinics with additional services like x-rays, intrave-

nous therapy, and the ability to treat non-life threatening complaints (conditions as ones that could have been treated by a regular doctor if one had been available). Currently, there are 84 urgent care centers owned by hospitals and health care systems, physician groups, and corporate chains in Massachusetts, according to the HPC and annual National Provider Identifier registry data.

In response to the expansion of the retail clinic and urgent care marketplace, the MMS Physician Practice Resource Center continues to monitor the expansion of retail clinics within the state and has developed a resource guide for physicians and their practices.

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Alternative Practice Models

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can do besides treating x, y, or z in the office" he said.

Daring to Be Different

Resources for physicians such as Gold and Lowney are less than abundant. Lowney often relies on his practice partner and father, Dr. Timothy Lowney Sr. "When we have questions, we sit down and brainstorm the best way to use my time most efficiently. It's definitely been a trial-and-error process."

As for Gold, he has the benefit of learning from the founders of earlier DPC practices such as AtlasMD. The American Academy of Family Physicians has also created a DPC toolkit and hosts an online interest group in which

members can post and answer questions.

Starting from Zero

For a new generation of doctors interested in the model, Gold has served as a mentor himself. Jeffrey Wacks, M.D., who graduated from family medicine residency last June, for example, spent a month shadowing Gold in his practice in preparation to open his own DPC office in July 2016.

Wacks' plunge directly into DPC out of residency is particularly daring, but it's been part of his plan since medical school. "For me, the challenge is going to be starting from zero. Marketing is going to be very important to attract new

patients, which won't be from a pool I already have," he said. "The advantages of doing it this way are that I'm at a point in my life I'm able to take more of a risk and put in that energy."

As part of that groundwork, Wacks has researched the model extensively, attended conferences, built a website and social media presence, and committed himself to ongoing learning. Despite all of these efforts and the challenges inevitably ahead, Wacks said he isn't worried about burning out.

"The job we have is tough by its very nature. We are taking care of people and their health and we take that responsibility very seriously. The things that we do really

affect people's lives, and with that there's a lot of stress," Wacks said. "But that's what I love. That's what I want to do. I love taking care of people and developing those long-term longitudinal relationships with people and helping them through difficult times in their lives," he said.

Eliminating Stress

The pressure of seeing 20 to 30 patients per day and completing hours of paperwork, however, Wacks is eager to do without. "That's the unnecessary stress doctors take home. That's the stress we need to get rid of, the bureaucratic things that come from dealing with a third party are the things that are really hurting our profession," he said.

Meaningful Use Hardship

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and critical access hospitals must apply no later than April 1, 2016.

Applying for the hardship will not prevent a physician from earning an incentive. It simply protects a physician from receiving a

Meaningful Use penalty. Therefore, physicians who believe that they met the Meaningful Use requirements for the 2015 reporting period are encouraged to apply for the hardship protection to avoid financial penalty in 2017.

How to Apply

CMS Issues Instructions for New MU Hardship Exemption

APPLICATION DEADLINES

ELIGIBLE PROFESSIONALS: MARCH 15, 2016

ELIGIBLE HOSPITALS AND CRITICAL ACCESS HOSPITALS: APRIL 1, 2016

CMS has published the process that eligible professionals and eligible hospitals can use to apply for the new "flexible" hardship exemption for the 2015 Meaningful Use reporting year.

Read more and access application forms on the CMS website at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/paymentadj_hardship.html.

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

April 5, 2016



Georges C. Benjamin, M.D.

This year's forum will feature keynote speaker, Georges C. Benjamin, M.D., executive director

for the American Public Health Association; Massachusetts Attorney General Maura Healey; and a diverse group of public health, judicial, and medical professionals. They will all share their experiences and insights and discuss a public health action plan on these topics:

- Guns and Health
- Reducing Gun Violence in the Commonwealth
- Changing the Conversation about Firearms
- Community-Based Prevention
- Reviving Research to Prevent Gun Violence
- Recognizing Symptoms That Indicate High Risk of Gun Violence
- Discussing Guns with Patients and Parents
- Ethical and Legal Constraints Reporting Requirements

National Quality Experts to Help Practices Improve Immunization Rates

Most adults have probably not received all the vaccines they need. According to data from the Behavioral Risk Factor Surveillance System, in 2013 in Massachusetts only 37 percent of adults 18 and older received Tdap vaccine, 30 percent of adults 60 or older received shingles vaccine, and 49 percent of adults 18 and older received the flu vaccine. Without the recommended vaccines, adults and their loved ones are vulnerable to serious disease.

Take a Stand

The Immunization Action Coalition has launched *Take a Stand*, a new program aimed at boosting adult immunization rates through the use of standing orders in physician practices. The free program includes an interactive four-hour workshop, led by a multidisciplinary team of experts in adult immunization followed by one year of basic support. The workshop will include discussion of legal principles and education about why and how to establish and implement standing orders. The program aims to help practices improve patient care and reduce costs by enhancing efficiency in delivering adult vaccines.

The program will take place in Massachusetts (one of only 15 states where the program will be offered) on June 7, 2016, in coordination with the Massachusetts Department of Public Health Immunization Program. Practices delivering one or more adult vaccines are eligible to apply for this opportunity.

Visit www.standingorders.org or contact info@standingorders.org for more information.

Standing Orders

Studies show the critical role of physicians and other health care providers in educating their patients about recommended vaccines and ensuring that they are fully immunized.

The CDC and the U.S. Community Preventive Services Task Force recommend the use of standing orders programs in physician practices to improve immunization rates.

In Massachusetts, it is legal and permissible for physicians to provide standing orders for nurses and pharmacists to administer vaccines according to protocol.



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The 21st Annual Massachusetts Adult Immunization Conference

The 21st Annual Massachusetts Adult Immunization Conference

Wednesday, April 27, 2016

8:00 a.m. to 3:30 p.m.

Best Western Royal Plaza Hotel, Marlborough

Presented by the Massachusetts Adult Immunization Coalition and the Massachusetts Department of Public Health

Featuring:

Robert H. Hopkins Jr., M.D., FAAP, FACP chief of internal medicine at Arkansas Children's Hospital; member of the ACIP Adult Immunization Work Group.

Workshops on:

- Massachusetts Immunization Information System (MIIS)
- Epidemiology of Vaccine Preventable Diseases
- Adult Vaccine Storage and Handling
- HPV Quality Improvement Project
- Outreach to Diverse Communities
- American Cancer Society FluFIT program

For information, visit <http://maic.jsi.com>.

Questions? Contact Rebecca Vanucci at rebecca.vanucci@state.ma.us or (617) 983-6534.

Massachusetts PMP Overhaul Underway

Changes Expected to Be Operational Mid-2016

BY BRENDAN ABEL, ESQ.
MMS ASSISTANT COUNSEL

The prescription monitoring program — long regarded as clunky and unworkable, yet important — is scheduled to receive a long-overdue overhaul over the first half of 2016. The PMP, as it is called, is a web-based database that allows prescribers and pharmacists to look up past 12 months of prescription histories of their patients, with the intention of supporting safe prescribing and dispensing. The PMP allows physicians to know if similar or contraindicated medications are being prescribed by other Massachusetts prescribers.

Eleven Clicks

All physicians in Massachusetts are automatically enrolled in the PMP with their most recent renewal of their state controlled substance registration. Current laws require prescribers to check the PMP prior to issuing a prescription of a Schedule II or III narcotic or a benzodiazepine to a patient for the first time.

The Massachusetts PMP has been plagued by several shortcomings, including significant usability issues. Physicians often remark that it takes “11 clicks” to get from the opening screen to the information being sought. Data updates are often delayed, and the program fails to show prescriptions filled in the past weeks. The MMS has long advocated for improvements to the system to improve timeliness and reliability of the data, and to increase usability to allow for better integration into physicians’ clinical practice.

Some improvements have come in the past several weeks, and a significant overhaul of the system is expected over the next several months.

Resident Access

Prescription data in the PMP is now more up-to-date thanks to a legal change requiring the data to be uploaded by pharmacies every 24 hours rather than every seven days. And a few weeks ago, the Medical Society assisted the



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DPH in allowing all medical residents in the Commonwealth to gain access to the PMP.

The biggest changes to the PMP should be evident by this summer. The DPH has finalized an agreement with a new vendor, Appriss, to completely overhaul the system. The new \$6.5 million system will be easier to navigate, have improved search capabilities, and will allow for integration

into electronic health records. Since the new vendor currently runs the PMPs of 23 other states, the new system will also allow for queries into several nearby states. (However, at present, New Hampshire will not be part of the interstate search.) The new system will continue to allow for resident access and will allow for the easier addition of an unlimited number of nonprescriber delegates.

New System Improvements

The MMS has been invited to participate in key stakeholder meetings to monitor implementation and share physician concerns. The new system will have new user instructions and will require new profiles to be set, so we plan to work closely with the DPH to make the transition process as simple as possible.

The MMS looks forward to the new system and the improvements that it will present to physicians. The value of the PMP is clear, and the Society appreciates the investment to create a system that reflects our priority to protect the health and safety of patients.

Opioids

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charge to all prescribers on the MMS website as part of the Society’s ongoing Smart and Safe opioid abuse awareness and prevention campaign.

In other developments related to the opioids epidemic:

MassBio Conference

At a policy breakfast hosted by the Massachusetts Biotechnology Council, executives from three local biotech companies — Alkermes, kaleo, and Collegium Pharmaceuticals pledged their organizations resources to help to resolve the crisis. MMS President Dennis M. Dimitri, M.D., reaffirmed the Society’s commitment to reducing excess supply of opioid medications in the community.

He added that because patients treated for chronic pain frequently have multiple co-morbidities, an integrated approach which

includes behavioral health is necessary to address the underlying issues that cause patients to become addicted.

“When you integrate, you get better outcomes,” Dr. Dimitri said.

Federal Legislation

In Washington, the Massachusetts congressional delegation has led much of the federal dialogue and debate surrounding opioids and appropriate pain management. Most members have sponsored, cosponsored, or supported a federal initiative to address this public health crisis. One effort that is critical to pending state legislation would seek the DEA’s approval for state bills allowing so-called “partial fill” prescriptions.

In the U.S. Senate, Sen. Elizabeth Warren led the bipartisan

effort with Sen. Edward Markey and three other senators, sending a letter to the DEA in late December requesting guidance on the development of a new rule to make clear to states that the partial filling of prescriptions for Schedule II drugs is permitted under federal law.

In the U.S. House of Representatives, Rep. Katherine Clark sponsored a bipartisan letter signed by 47 members of the House — including every member of the Massachusetts congressional delegation — seeking clarification of the DEA rules.

If approved, states would be allowed to pass laws to allow patients to partially fill their prescriptions.

The MMS is in strong support of facilitating partial fill options

for opioid prescriptions. It is important to underscore that the Society’s opioid prescribing guidelines, which were adopted for use last year by the Mass. Board of Registration in Medicine, recommend that “the starting dose should be the minimum necessary to achieve the desired level of pain control and to avoid excessive side effects.”

The MMS believes that this policy could contribute to a significant reduction in unused pills in medicine cabinets available for misuse and diversion while allowing patients who are in pain to receive necessary medication appropriately.

Passage of federal legislation to address the many aspects of the opioid crisis is one of the main congressional health care priorities for the spring. The MMS will continue to work closely with the members of the Massachusetts congressional delegation on a variety of initiatives to address this public health crisis.



PHYSICIAN HEALTH MATTERS

It's Getting Hot in Here: The Latest on Physician Burnout

BY STEVE ADELMAN, M.D.
PHS DIRECTOR

A recent study published in the Mayo Clinic Proceedings lends further evidence to what some are starting to refer to as the mounting occupational health crisis in health care. Between 2011 and 2014, an objective measure of burnout now registers 54 percent of practicing physicians as “burning out” (up from 46 percent), according to a December 2015 study by Shanafelt et al.

Physicians in high burnout specialties like family medicine, internal medicine, and emergency medicine are experiencing burnout at a rate of approximately 60 percent! As physician burnout increases, the work-life satisfaction of physicians has decreased from 49 to 41 percent.

This is a large study with a non-physician, general population control group. Physicians work an average of 55 hours per week compared to 40 hours for non-physicians. And we are 75 percent more likely to experience suicidal ideation in the course of a year.

Accompanying this eye-opening burnout study is a provocative editorial by William Lanier, M.D., editor-in-chief of the Mayo Clinic Proceedings, and Dan Ariely, Ph.D., a professor of psychology

and behavioral economics at Duke. They hypothesize that the following three factors play a significant role in the burnout and dissatisfaction of practicing physicians:

1 Asymmetrical Rewards:

In our industrialized “zero defect” environment, physicians are expected to deliver excellent and cost-effective care in a fashion that delights every single patient. In many systems, there is a relentless focus on the practicing physician’s imperfections. A busy internist may see 30–40 patients in the course of a day in the office. If a single patient complains that the doctor seemed rushed and unsympathetic, that complaint may become the focus of a time-consuming sit-down that may take on a life of its own. The positive care experiences of the overwhelming majority of the physician’s patients fade in comparison to the hassles and scrutiny brought on by a single patient complaint.

2 Loss of Autonomy:

Practicing physicians, especially those who are employed and those who work in primary care, now answer to a coterie of masters. A bevy of metrics, initiatives, guidelines, prior

authorization busy-work, and required protocols now jockey with click after click on the electronic medical record to take up the majority of one’s time in the office. Although the doctor-patient clinical encounter remains at the heart of medical practice, non-value-added intrusions get in the way at every turn. Here in Massachusetts, some patients come to the office armed with an agenda that they expect their physician to follow. One internist I met last month was rather taken aback when he tried explaining to his patient why it was unwise for him to switch her to a new medication she had seen advertised on TV. The patient replied, “How dare you not listen to me? What are you — an idiot?” Along with a loss of autonomy, many of us also experience a troubling loss of respect and status.

3 Cognitive Scarcity:

This refers to the challenge of making complex decisions at a breakneck pace. ORs are tightly scheduled. Physicians in office practices are over-booked, with same-day requests squeezed in to enhance satisfaction scores. Changes in coverage and societal ills like drug addiction have many emergency departments filled beyond capacity. To many

physicians, the practice of medicine feels like a game of “Whack-a-Mole.” But patients are not moles; they are fellow human beings, with serious illnesses, complex problems, life and death concerns. Practicing physicians do not have the luxury to recharge their batteries — the onslaught of pain, suffering, and rapid-fire decision making is incessant. The enormity of all of this requires us to reflect and recover, yet we lack time buffers to regain our footing and equanimity.

Ariely and Lanier do not offer a concrete fix for a system that is dehumanizing the central figures upon whom it relies. The profession has changed around us, yet our macho culture and industrialized work environment have failed to accommodate to the reality of this occupational health crisis and the burnout it is producing. It’s time for us to step up, as individuals, groups, organizations, and systems to identify and address the root causes of a phenomenon that threatens the health and well-being of the best and brightest.

For more information, please contact Physician Health Services, Inc. at (781) 434-7903, or visit our website at www.physicianhealth.org.

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

Essex South — Delegates Meeting. Tues., Mar. 1, 6:00 p.m. Location: Beverly Depot, Beverly. Membership Meeting. Wed., Mar. 23, 6:00 p.m. Location: Spinelli’s, Lynnfield. Guest Speaker: Joseph C. Kvedar, M.D., vice president of Connected Health, Partners HealthCare.

Middlesex — Legislative Breakfast. Fri., Mar. 18, 7:30 a.m. Location: Lynch Board Room, Mount Auburn Hospital, Cambridge

Middlesex Central — Executive/Delegates Meeting. Thurs., Mar. 17, 7:45 a.m. Location: Emerson Hospital, Concord.

Suffolk — Annual Meeting. Wed., Mar. 30, 6:00 p.m. Location: Downtown Harvard Club, Boston. Guest Speaker: Kenneth Kaitin, Ph.D. Topic: Decoding the Drug Development Process and the Vagaries of Drug Pricing.

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

Norfolk South and Plymouth — Joint District Meeting. Wed., April 6, 6:00 p.m. Location: Neighborhood Club, Quincy. Speaker: Dennis Dimitri, M.D., MMS president.

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

Hampshire/Franklin — Annual Meeting. Tues., Mar. 22, 6:00 p.m. Location: Wiggins Tavern, Northampton Inn, Northampton.

Guest Speaker: Dennis Dimitri, M.D., MMS president. Topic: Doing No Harm: The Opioid Epidemic and Physicians in 2016.

Worcester — Women in Medicine Leadership Forum. Wed., Mar. 9, 5:30 p.m. Location: Beechwood Hotel, Worcester. Guest Speaker: Stacy Potts, M.D. Panelists: Mary Constanza, M.D., Lynda Young, M.D.; Rebecca Lundquist, M.D.; and Gillian Griffith.

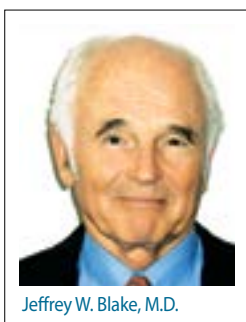
For more information, or if you have West Central news to contribute, please contact Cathy Salas, West Central Regional Office at (800) 522-3112 or csalas@mms.org.

Dr. Jeffrey W. Blake Named MMS Senior Volunteer Physician of the Year for 2016

The Committee on Senior Volunteer Physicians is pleased to announce that Jeffrey W. Blake, M.D., has been selected to receive the 2016 Senior Volunteer Physician of the Year Award.

Dr. Blake, of Sheffield, MA, has been a MMS member since 2004.

In 2003 Dr. Blake joined with a small group of physicians and community leaders who developed what became Volunteers in



Jeffrey W. Blake, M.D.

Medicine (VIM) Berkshires. In 2004 he was a founding member of the Board of Trustees, and has been very instrumental in the growth of VIM. Over the past 12 years Dr. Blake has volunteered more than 3,500 hours to provide direct patient care, as well as leadership and administrative expertise.

Dr. Blake was instrumental in developing VIM's first Shared Medical Appointment pilot program,

funded by the MMS and Alliance Charitable Foundation.

Dr. Blake is dedicated to the health of the community and committed to his volunteer work. His weekly work in the clinic has a meaningful impact on the individual and the community.

Dr. Blake is a graduate of the Columbia University College of Physicians and Surgeons and is board certified in Internal Medicine and Cardiology. Dr. Blake has also served as the director for Nuclear Cardiology at Westchester County Medical Center.

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.

Dick A.J. Brown, M.D., 82; Needham, MA; Northwestern University Medical School, 1958; died May 19, 2015.

Frank G. DeLuca, M.D., 84; Portsmouth, RI; University of Bologna, 1955; died September 11, 2011.

Robert L. Early, M.D., 94; Marco Island, FL; Harvard Medical School, 1951; died March 5, 2014.

Corinne S. Ertel, M.D., 67; Waban, MA; University of Michigan Medical School, 1979; died August 31, 2015.

Jeffrey R. Fine, M.D., 75; Charlestown, MA; Hahnemann Medical College, 1966; died October 21, 2015.

Manuel G. Fergau, M.D., 43; Galax, VA; Boston University School of Medicine, 1997; died October 30, 2014.

Edward J. Gliniski, M.D., 74; Milton, MA; Boston University School of Medicine, 1968; died August 25, 2015.

John W. Keller, M.D., 96; Grantham, NH; Harvard Medical School, 1949; died September 11, 2015.

Donald K. Kiersey, M.D., 96; Summerfield, FL; Trinity College, University of Dublin, 1956; died September 19, 2015.

James K.S. Kirkaldy, M.D., 86; Middlebury, VT; University of Edinburgh, 1951; died May 19, 2015.

Irma M. Lessell, M.D., 79; Lexington, MA; Boston University School of Medicine, 1977; died August 27, 2014.



Henry Tulgan, M.D., was honored recently by the Accreditation Council for Continuing Medical Education as recipient of the 2015 Rutledge W. Howard, M.D., Award for Individual Service to the Intrastate Accreditation System.

From left to right: MMS Education Compliance Office Manager Anan Nathif; Dr. Tulgan and his daughter, Ronna Tulgan Ostheimer; and MMS Committee on Accreditation Review Chair Byron Roseman, M.D.

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.

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
- Sustainability of Private Practice
- Student Health and Sports Medicine
- Violence Intervention and Prevention
- Women in Medicine
- Young Physicians

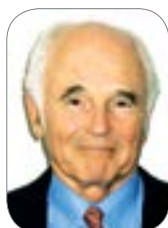
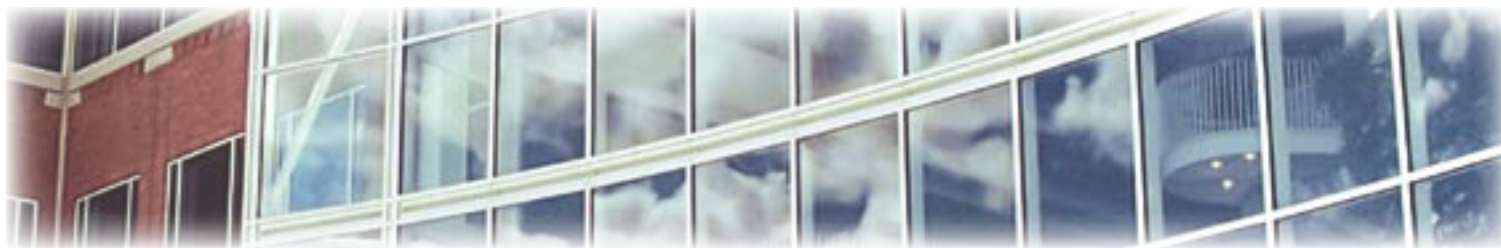
District Appointed Committees

(Contact your district medical society for more information)

- Legislation
- Nominations

Member Interest Network (MIN) Executive Council

- Arts, History, Humanism, and Culture



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 - > New Opioid Guidelines Webinar Available
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 - > Letter: Reconsider Aid in Dying Position
- 3 > **Mass. Retail Clinics See Significant Growth**
- 4 > **2016 MMS Public Health Leadership Forum Is April 5**
 - > Improving Adult Immunization Rates
- 5 > **Mass. PMP Overhaul is Underway**
- 6 > **The Latest on Physician Burnout**
 - > Across the Commonwealth
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 - > MMS Committee Appointments 2016–2017
 - > In Memoriam



MASSACHUSETTS
MEDICAL SOCIETY

VITALSIGNS

VOLUME 21, ISSUE 3, MARCH 2016

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MMS AND JOINTLY PROVIDED CME ACTIVITIES

LIVE CME ACTIVITIES

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

Cutting-Edge Advances in Women's Cardiovascular Care

Sat., March 19, 2016

Managing Workplace Conflict

Thurs., March 24–Fri., March 25, 2016

Being Prepared for the Unexpected: Building Resilient Communities

Wed., May 18, 2016

MMS and RIMS Directors of Medical Education Conference

Thurs., May 19, 2016

14th Annual Symposium on Men's Health

Thurs., June 16, 2016

ONLINE CME ACTIVITIES

Go to www.massmed.org/cme

Risk Management CME

Electronic Health Records Education (3 modules)

- Module 1 — EHR Best Practices, Checklists and Pitfalls
- Module 2 — Making Meaningful Use Meaningful: Stage 1
- Module 3 — Making Meaningful Use Meaningful: Stage 2

End-of-Life Care

- End-of-Life Care (2 modules)
- End-of-Life Care (3 modules)
- The Importance of Discussing End-of-Life Care with Patients
- Advance Directives (Legal Advisor)
- Principles of Palliative Care and Persistent Pain Management (3 modules)

Pain Management and Opioid Prescribing

- **NEW!** Opioid Prescribing Guidelines in Practice
- Managing Pain Without Overusing Opioids
- The Opioid Epidemic (6 modules) — MMS 11th Annual Public Health Leadership Forum
- Principles of Palliative Care and Persistent Pain Management (2 modules)
- Opioid Prescribing Series (6 modules)
- Identifying Potential Drug Dependence and Preventing Abuse (*Legal Advisor*)
- Managing Risk when Prescribing Narcotic Painkillers for Patients (*Legal Advisor*)

Medical Marijuana (4 modules)

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

Additional Risk Management CME Courses

- **NEW!** Initiating a Conversation with Patients on Gun Safety
- Intimate Partner Violence
- Understanding Clinical Documentation Requirements for ICD-10
- ICD-10: Beyond Implementation
- Prostate Cancer and Primary Care
- Cancer Screening Guidelines (3 modules)
- HIPAA 2.0: What's New in the New Rules?
- Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
- Effective Chart Review for Quality Improvement



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.