

VITAL SIGNS

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2012 Annual Meeting —
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EHR Makes Three: Sharing the Exam Room

Eye Contact Still a Top Priority; How Email Can Help, Not Hamper, Efficiency

BY VICKI RITTERBAND

Using an electronic health record (EHR) in the exam room can be awkward, time consuming, and intrusive to the patient-physician relationship, but there are ways to make it an asset. Just ask internist Larry Garber, M.D., the Emily Post of EHR etiquette.

Dr. Garber doesn't write an advice column, but he does star in a video that his tech-savvy Worcester-based practice, Reliant Medical Group (formerly Fallon Clinic), produced about the dos and don'ts of using an EHR with patients. Dr. Garber plays counterpoint to the clueless doctor who does it all wrong: checking his email while the patient confides intimate medical details, cursing the computer, refusing to let the patient look on, and forgetting to log out, among other missteps.

As computers become increasingly common in the exam room, early adapters like Dr. Garber are teaching physicians how to include EHRs in the mix, ensuring that patients view the terminals as

friend, not foe. And with this new communication mode comes new rules of conduct.

"How to interact with a patient and an EHR in the exam room is such an important issue," says Dr. Garber, who is also medical director for informatics at Reliant, charged with incorporating health information technology to improve patient care throughout the organization. "That's where you're building the trust of the patient; it's where decisions are made. If you've got a computer that's interfering with that interaction, it can really interfere with how medicine is practiced."

Dr. Garber said that when his practice went looking for training material for using an EHR with patients, there was little out there. The best thing they found were tips based on a mnemonic device created by information technology pioneer Kaiser Permanente: LEVEL. These days, every Reliant staff member who works in a patient exam room is required to view the training video outlining the protocol.

L Let the Patient Look On

The first step in using an EHR effectively with patients is putting the computer in the right place, according to Dr. Garber. The computer, the patient, and the physician should form a triangle so the patient can easily look on as the physician works. Dr. Garber prefers desktop computers with monitors mounted on flexible arms that can be easily moved into a patient's line of vision.

The EHR has shifted patients' relationships with their records and their physicians, according to Dr. Garber. "It's a change from the paper world, where doctors had a chart sitting on their laps. It was very private. Patients never knew what we were writing," he said. "Since we've made the change to EHRs,

it's opened up our patients' understanding of what's in their medical records, and it encourages joint decision making because we're looking at the same information when making a medical decision."



Illustration by Chris Twichell

E Eye Contact

Dr. Garber makes a point of ignoring the computer when he enters the exam room, first greeting the patient and then beginning the conversation. Once he's

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AMA Innovator Committee to Report Findings

Mass. Global Payment Expert Among Panelists

BY ERICA NOONAN

Nearly one year ago, a dozen physician experts in innovation were invited by the American Medical Association to form a national Committee of Innovators, charged with examining the challenges physicians will face as a result of emerging health care payment and delivery reforms. Springfield internist and geriatrics specialist Philip F. Gaziano,

M.D., was one of those chosen, selected for his extensive experience with global capitation payment and delivery systems.

The past 12 months have been intense, Dr. Gaziano said in a recent interview with *Vital Signs*. The committee meets by conference call or in Washington, D.C., monthly and members correspond and exchange ideas almost daily.

The committee findings are slated to be presented to leaders from the AMA, the American College of Physicians, and the American College of Surgeons this spring.

"The emphasis is on delivering quality health care and reducing waste," said Dr. Gaziano. "And the goal is to look at both health care delivery reform and health care payment reform — you

can't do one without the other — and come up with education models and how-to documents reflecting strengths and weaknesses from the real world."

His Innovator Committee colleagues from across the country bring a wide range of expertise on topics such as medical homes, bundled payments, partial capitation, and integrated care systems.

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PRESIDENT'S MESSAGE



Reflecting on a Year of Advocacy

Looking back over the past year as the Society's president, I am struck by how much time I spent at a table. As an advocate for Massachusetts physicians, I attended many meetings of government commissions

"Sitting at the table is perhaps the most important thing physicians can do right now."

— Lynda Young, M.D.

and working groups. I saw firsthand how politicized health care and health care reform has become. We consistently did our best to speak out, consider the concerns of other stakeholders, and forge collaborative relationships with them.

But in the broader sense, sitting at the table is perhaps the most important thing physicians can do right now. These government groups are making major decisions on cost containment and health care policy that will affect us for decades. Many of the proposals we heard were attempts to regulate physicians, or put pressure on us where it didn't make any sense. I was glad we were able to step in and offer some perspective to lawmakers.

These officials had good intentions, but no idea how their ideas would affect physicians and our ability to care for our patients. They don't want to tell us how to practice medicine, but they do need us to work with them to find answers to the health care cost crisis.

Even after my term ends, I intend to keep raising my voice on health care issues, and I hope you do as well.

It has been an honor serving as your president.

Thank you,

Lynda M. Young

— Lynda M. Young, M.D.

EHR

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established rapport, he'll sign on, but he is always careful to keep up eye contact when he isn't typing. Dr. Garber is not a fan of notebook computers, because he thinks they can be a barrier to direct interaction with the patient. Family physician Hugh Taylor, M.D., disagrees. His practice, Family Medicine Associates in Hamilton, equips its exam rooms with laptops and stools on wheels for staff so doctors can easily swivel around to allow the patient to look on.

"You can position the computer on your lap, and maintain eye contact fairly well while interviewing," says Dr. Taylor. "It allows us to keep up a reasonable degree of interaction."

Value the Computer

In the first days of using a new EHR, maintaining one's interaction with the patient can be challenging, physicians say, but

patients are usually very understanding. "You try to elicit some sympathy from the patient by asking them to bear with you, that it will ultimately be really helpful for patient care," says Dr. Taylor. "They tend to give you some slack, at least for the first couple of visits, and hopefully after that you'll have figured it out."

The last thing you want to do is to denigrate the system in front of a patient, advises Dr. Garber. "You don't want the patient thinking either you're not smart enough to use the system or you bought a lousy system," says Garber. "The next thing they'll wonder is how their health will be compromised because of this horrible computer system." Instead, physicians should point out how useful the EHR is to patient care, highlighting things like e-prescribing and the accessibility of historical health data.

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Larry Garber, M.D., using an EHR at the offices of his Worcester-based practice, Reliant Medical Group. Dr. Garber is also medical director for informatics at Reliant.

Communicating with Patients via Email

As more practices adopt EHRs, which typically include patient portals with secure email capabilities, email with patients will become increasingly common.

About 40 percent of physicians say they communicate with patients via email, the number who email regularly is probably closer to 15 percent, said Daniel Sands, M.D. Dr. Sands, who co-authored a set of email guidelines for providers in 1998 that are still widely used today, believes that will change as the health care system moves toward quasi-capitated payments.

"When we free ourselves from the fee-for-service model, we'll begin to realize that there is no reason why the patient always has to come to see the physician," says Dr. Sands. "Why can't we deliver care wherever the patient needs it — by telephone, email, or telemedicine?"

Dr. Sands has some words to the wise: don't be shy about telling patients that they're misusing email — for example, by emailing too often or using it for urgent matters. And sometimes it's necessary to switch communication modes midstream. If it becomes clear that a conversation that began via email is getting too complicated, suggest a phone call or an office visit.

Despite the occasional bumps, Dr. Sands is a huge fan of email communication with patients. "I can make a patient happy by simply typing a few words and solving his or her problem. It's a huge boost to patient satisfaction."

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EHR
continued**E Explain**

As you work with the EHR, explain to the patient what you're doing so the computer doesn't feel like a barrier to the relationship. "It does take time to type in a prescription or order a lab, so instead of leaving patients sitting there idly, tell them you're looking for the prescription or searching for the labs you want to order," says Dr. Garber. "They'll know exactly what you're doing and feel like they're still connected to you."

Pediatrician Eugenia Marcus, M.D., whose Newton practice went electronic in 1996, finds that the EHR can sometimes communicate things that are difficult for a physician to say. "Pediatricians don't like to call a child 'fat,' but the EHR can," says Dr. Marcus. She'll show the parent and child where the child falls on a weight graph in relation to normal, overweight, and obese values and let them draw their own conclusions. "That way it's not taken as me being judgmental — it's them being confronted with data," she says.

L Log Out Lest We Suffer the Consequences

Although password-protected screen savers are the norm with today's EHRs, it's still a good idea to log out after each patient

encounter, says Dr. Garber. "You want to make sure patients understand that you value security and that their information is protected." **VS**

Email Tips

- Establish a turnaround time for returning messages.
- Do not use email for urgent matters.
- Inform patients about privacy issues. Patients should know things like who processes the messages and that emails will become part of their medical record.
- Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health) permitted.
- Instruct patients to put the category of a transaction in the subject line so messages can be easily forwarded to the appropriate person.
- Double-check all "to" fields prior to sending messages.
- Send messages to inform patients of the completion of their requests.

Source: Kane B, Sands D. Guidelines for the Clinical Use of Electronic Mail with Patients. *Journal of the American Medical Informatics Association*, 1998.

Front Lines

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Dr. Gaziano's years of success in pioneering affordable global payment models that were easily scalable to almost any practice — even solo practitioners who are not yet using EHR systems — attracted the AMA's interest, he said.

"This is a great way to communicate with lots of people and move pilots and innovations out there past the grassroots level," he said. All of the Innovator Committee efforts are informed by physicians who have tested their theories in the real world, said Dr. Gaziano. "It is encouraging that the thought leadership is coming from physicians, and that

the practicing community is making such a major contribution," he said.

He said many health care providers are still not fully connecting with the dramatic and permanent upheaval in the field. "I find myself telling people who think these changes are 'typical' that we are actually in a once-in-200-years irreversible change," he said. "Health care is now 20 percent of the GDP. There has not been a change [in our lifetimes] that has impacted so many people and livelihoods, and also has so much potential for improved quality and satisfaction." **VS**

Transitioning Smoothly to Version 5010

The transition to ICD-10 is already proving challenging as physician practices across the country experience system delays and cash flow problems associated with the HIPAA Version 5010 platform conversion.

Despite the recently announced Centers for Medicare and Medicaid Services (CMS) deadline extension to June 30, 2012, many payers — in Massachusetts and nationally — began requiring physicians to submit 5010 transactions starting January 1, 2012.

While the CMS will not impose any enforcement action for the first two quarters of 2012, it still maintains that all HIPAA-covered entities should make every effort to comply with the new standards by January 1 of this year.

The Massachusetts Medical Society has been working closely with public and private payers to communicate concerns associated with

transition to the 5010 platform. Many payers have designated teams working to remediate issues; however, practices experiencing specific problems submitting 5010 transactions can

contact a network relations representative or the Society's Physician Practice Resource Center (PPRC) for guidance on who to contact at the plan level.

Despite the ongoing national delays in ICD-10 implementation, the MMS urges physician practices to be prepared and move forward with ICD-10 planning.

The PPRC is providing members with ongoing support related to Version 5010 and ICD-10 by offering a set of tools that members can access by visiting www.massmed.org/ICD10 or by contacting the PPRC at (781) 434-7702. **VS**

— Talia Goldsmith



PHYSICIAN PRACTICE RESOURCE CENTER

PPRC Question of the Month

Each day, the Physician Practice Resource Center (PPRC) receives numerous calls and emails from physicians on a variety of topics. Over the past few weeks, this was the most commonly asked question:

It's my understanding that there are new Board of Registration in Medicine education requirements for licensure in end-of-life care and opioid prescribing. Does the MMS offer any courses or training that meet the board's new requirements?

Effective February 1, 2012, physicians applying to renew or obtain a license must complete at least three CME credits of education and training in pain management and opioid education and two credits in end-of-life care.

The new educational requirement impacts even those that may not prescribe opioids since it applies to all physicians who prescribe controlled substances (Schedules I through VI). According to state regulations, education must include training in

effective pain management, identification of patients at high risk for substance abuse, counseling patients about side effects, and the addictive nature and proper storage and disposal of prescription drugs. The end-of-life care requirement also applies to all physicians in the state.

For both requirements, credits will qualify as either category 1 or category 2 and will count toward risk management study.

The MMS offers multiple online CME options and live educational events that meet these new requirements. Course offerings include "Safe and Effective Opioid Prescribing for Chronic Pain," "Managing Risk when Prescribing Narcotic Painkillers for Patients," "The Unintended Consequences of DNR," and "The Importance of Discussing End-of-Life Care with Patients." **VS**

For more information and additional options, please visit the MMS Online Continuing Education website at www.massmed.org/cme.

New Sunscreen Labeling Rules

In June 2012, new federal sunscreen labeling requirements will take effect. Prior rules on sunscreens dealt primarily with protection against ultraviolet B (UVB) rays, which cause sunburn, and did not address ultraviolet A (UVA) radiation. UVA rays cause skin cancer and premature aging of the skin. The key points of the new requirements are as follows:

- Sunscreens that pass the FDA's test for UVA protection relative to UVB protection will be designated as providing broad-spectrum protection. Previously, a sunscreen's SPF was based only on its UVB protection.
- Only broad-spectrum sunscreens with an SPF value of 15 or higher can claim to reduce the risk of skin cancer and early skin aging if used as directed with other sun protection measures. Other sunscreens can only claim to help prevent sunburn.
- Sunscreen cannot be identified as "sunblock," "waterproof," or

"sweatproof," or claim protection is instant or lasts for more than two hours without FDA approval.

- Clear labeling on the front must indicate the duration of water resistance (up to 40 or 80 minutes). Sunscreens that are not water resistant must direct consumers to use a water-resistant sunscreen if swimming or sweating.
- All sunscreens must include standard "drug facts" information on the back and/or side of the container.

The American Academy of Dermatology recommends everyone apply water-resistant sunscreen with broad-spectrum protection of SPF 30 or higher on dry skin 15 minutes before going into the sun, as well as lip balm with an SPF of 30 or greater, and reapply every two hours or after swimming or sweating heavily. **VS**

Take a Harbor Walk with MMS at the Annual Meeting



Photo by Doug Bradshaw

MMS members walked along Boston Harbor at the 2010 Annual Meeting health walk.

Take a break with a walk along Boston Harbor at 2:30 p.m. on Friday, May 18, during the MMS Annual Meeting at the Seaport Hotel and World Trade Center.

Learn how to transform health care in the morning, and walk for your own health in the afternoon!

Members of the Committee on Nutrition and Physical Activity will be available to answer your physical activity and nutrition questions.

Members, friends and family are welcome to attend this free activity.

To sign up, contact Robyn Alie at (781) 434-7371, or ralie@mms.org.

Providing Medical Care in an Emergency Shelter Setting

June 5, 2012 — A Massachusetts Medical Society CME Event

5:15 PM Registration and Light Dinner

6:00 PM Welcome and Opening Remarks

Paul Biddinger, M.D., F.A.C.E.P. (Facilitator)
Mary Clark, J.D., M.P.H.

6:40 PM Federal Perspective on Health Needs in Emergency Shelters
Kate McCarthy-Barnett, Ed.D.

7:10 PM Triage and Basic Care in Emergency Shelters
Mary-Elise Manuell, M.D., M.A., F.A.C.E.P.

7:40 PM Stress Responses and Mental Health Issues in Emergency Shelters
Laurie Jackson, M.Ed., L.M.H.C.

8:10 PM Practical Experiences: Caring for Those in Need — Lessons from an MRC in Action
Nina Martin-Anzuoni, R.N.

8:35 PM Panel Discussion

9:00 PM Program Adjournment

To register, visit www.massmed.org/emergency2012.

MA Responds and MRC volunteers: use code MSARMRC2012 for free registration.

CME Credit/Accreditation

The Massachusetts Medical Society designates this live activity for a maximum of 3.0 AMA PRA Category 1 Credits™.

Sponsored by the Massachusetts Medical Society in collaboration with the Massachusetts Department of Public Health and the Medical Reserve Corps Units of Massachusetts



STATE UPDATE

DPH Official: Prescription Program Is a Tool, Not a “Blunt Instrument”

Editor's Note: Madeleine Biondolillo, M.D., bureau director for health care quality and safety at the Department of Public Health (DPH), is approaching her first full year at the Massachusetts DPH. She is an MMS member with a background in geriatric service provision and primary care.

Vital Signs recently interviewed Dr. Biondolillo about the Drug Control Program and the Prescription Monitoring Program (PMP), which fall under her oversight at the DPH.

VS: Can you give us some background on the PMP?

Dr. Biondolillo: The program was created as a joint effort of the MMS and DPH 25 years ago to identify Schedule II prescriptions. In 2010, the Legislature created the opportunity for there to be an electronic version. Massachusetts is leading the way in making the technology available to prescribers so they can have it in their armamentarium of tools to provide care to patients. Online access started in December 2010. About 2,000 prescribers have enrolled since then and every pharmacy is enrolled. The database includes prescriber and patient data on all prescriptions filled in Massachusetts for federally scheduled medications.

We've taken a paper-based tool and automated it for better access. Physicians we speak to all the time who use this in their care are almost uniformly

thrilled with it... particularly those who do pain management and emergency care. There are also a lot of primary care physicians who feel they would benefit greatly from this tool. In general, it gives the opportunity to work with patients when the physicians have a concern, either on the basis of their own judgment or when they use the system and find a reason for concern in a patient's history.

We do screens and define areas of questionable activity to be four or more prescriptions from different prescribers filled at three or more pharmacies. That benchmark was defined in collaboration with the medical review group, which balances issues of patient privacy and needs with diversion concerns.

VS: What role does the medical review group play?

Dr. Biondolillo: These are physicians, dentists, and a podiatrist brought together on a quarterly basis to look at data and case report studies of prescriber utilization of the PMP, reports of which information is accessed by law enforcement, and they set the threshold on questionable activity.

Right now, data show that two-thirds of one percent of patients fall into the questionable category and they account for four percent of prescriptions.

VS: What can the program do to identify the scope and areas of the problem in Massachusetts?

Dr. Biondolillo: Depending on how the data is viewed, we will be able to see where patients live, and for providers, to determine if they are in an at-risk location. The data will help us allocate treatment and law enforcement resources.

The technology is about to be upgraded to allow expanded capabilities in many areas. We have the opportunity to link data sources together with the trauma registry and ambulance trip records (to identify overdoses). We're planning to reduce our lag time for the data down to about 10 days as a priority and to improve batch lookups, which will allow a physician or their designee, such as a nurse, to screen all patients scheduled for a particular day.

The providers who are using the system now, such as emergency physicians, are looking up lots of people. When you get used to doing it, it takes seconds. When you do the risk-benefit analysis of not doing it, if it takes about 10 or 15 seconds, it's completely worth doing. I agree that it would be best to integrate and automate the search process, but if batch lookups are delegated, it has to be to a licensed health care provider, such as a nurse, over whom the department has regulatory authority and who has

patient privacy and confidentiality responsibilities.

VS: What about efforts to make it automatic for prescribers to be eligible to access the system?

Dr. Biondolillo: You mean when they renew their licenses? We're very amenable to that and anything that will increase the ability of the system to be used. There is a tension between the rights of privacy of the patients and ease of use of the system, but because there are such protections in license renewals, it seems feasible to make that happen.

Integration into EHR systems when you're considering writing a prescription is absolutely ideal, and I believe the technology is available. We're very interested in this. We're doing a test pilot with a local hospital integrating its EHR into the database. We're also trying to embed screening tools in the system that will show appropriate referral to treatment if patients trigger screens.

This is a tool that is part of a compendium of things to deal with this issue. If we don't use it right, it will be a blunt instrument; if we use it correctly, it will be a good start, but you absolutely have to have a conversation with the patient and the physician as to what is going on.

We know we have a crisis, and we have to be more sophisticated than we've been. **VS**

— William Ryder

FEDERAL UPDATE

Awaiting the Supreme Court's Ruling on ACA

The U.S. Supreme Court recently completed its historic session on arguments challenging the Patient Protection and Affordable Care Act (ACA).

The court agreed to hear oral arguments on four critical issues:

- Whether the court should rule on the case before the tax penalty for not having health insurance goes into effect in 2014
- Whether using the commerce clause as the basis for the

individual mandate was constitutional

- Which parts of the law the court should preserve, if any, if the individual mandate is found unconstitutional
- Whether or not the penalties for states failing to comply with Medicaid expansion are too severe

The court is expected to issue its ruling in late June.

Observers of the proceedings were not surprised that the justices' questions and comments

followed ideological lines, with liberals defending the law and conservatives opposing its constitutionality. One fundamental issue is whether the significant insurance reforms, including elimination of preexisting condition clauses, recession, and the ban on lifetime caps, would continue without the individual mandate.

The future of the law has already been and continues to be a major focus of the presidential and congressional elections for

both parties. As important as the nation's highest court's decision is, the 2012 elections will also have a significant impact on the next steps for this law and our nation's response to making affordable health care available to citizens.

We are in a unique position in Massachusetts. Regardless of the Supreme Court's decision on the ACA, the Massachusetts state law mandating health coverage will almost certainly be unaffected. **VS**

— Alex. Calcagno

PHYSICIAN HEALTH MATTERS

More on Making a PHS Referral: Mandated Reporting, Confidentiality, and the BRM

Editor's Note: Last month we covered how to help a colleague. Here are some more frequently asked questions.

If I go to or refer someone to Physician Health Services, Inc. (PHS), will the Board of Registration in Medicine (BRM) know?

Not necessarily. PHS is independent from the Massachusetts Board of Registration in Medicine. Many physicians are referred directly to PHS without any BRM involvement. Other physicians are referred to PHS concurrent with a BRM report, while other referrals originate from the BRM itself.

When someone contacts PHS, the director will promptly speak with the referring person or referred physician. The director and associate directors assess the situation and guide the individual. These communications are confidential in accordance with state and federal laws, and participation with PHS is voluntary. In order for information to be released to anyone, the participant must sign a consent form. Even in situations where the BRM is involved and PHS is authorized by the client to report information to the BRM, PHS provides only

factual information regarding the physician's participation in the program or compliance with a contract.

When does PHS report to the Board of Registration in Medicine?

When physicians enter into monitoring contracts with PHS, they are required to adhere to the provisions of that contract. Non-compliance with contract provisions are reported to the Physician Health and Compliance Unit of the BRM.

Under what circumstances might I be mandated to report a colleague? How do I make this determination?

The mandated reporting law states that a health care provider must report to the Massachusetts Board of Registration in Medicine if there is a reasonable basis to believe that a physician has violated any of the rules or regulations of the licensing board. Following are examples of such violations:

- Habitual use of drugs or alcohol
- Impaired as a result of using drugs or alcohol or a mental health condition

- Using illicit drugs
- Self-prescribing or diverting drugs
- Engaging in behaviors that violate the board's Disruptive Physician Policy

There is one exception to this mandated reporting law for applicable matters involving drugs or alcohol (see below). If someone contacts PHS, they are encouraged to review their reporting obligations. PHS is available to direct health care providers to the relevant statute and regulations regarding these requirements.

Can I call PHS in lieu of reporting a physician to the licensing board?

The only exception to the mandated reporting law, which is for drug- and alcohol-related matters, states that a referral to PHS may be made in lieu of a report to the licensing board if the following conditions are met:

- Circumstances involve drugs and/or alcohol.
- No allegation of patient harm or other violation of the law exists.
- The physician agrees to participate in PHS.
- The mandated reporter receives confirmation from PHS within 30 days that the physician is compliant with the PHS program.

Currently this exception does not apply to mental health matters. While there are legislative

efforts to expand this exception to include mental health conditions, to date, the exception is limited to drug- and alcohol-related problems.

Does physician-patient confidentiality preclude me from making a referral to PHS?

There are physician-patient confidentiality obligations, but there are also mandated reporting obligations. No formal rules exist to address these competing obligations. Matters should be addressed on a case-by-case basis, considering not only the competing legal obligations, but also the overall ethical obligations and patient safety.

How do I balance the competing requirements of reporting while maintaining confidentiality?

Seek consultation from PHS, and consider consulting an attorney. You should also work closely with the physician about whom you have concerns. Communicate your concerns regarding an obligation to report, and ask that they comply with your recommendations to avoid the need for you to make a report or compromise confidentiality.

Look to next month's issue of *Vital Signs* for more questions and answers related to PHS's outcomes, engaging the reluctant physician, and more. **VS**

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

MMS Is Updating Our Member Database



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Visit www.massmed.org/email, enter your member number located on your Society ID card, and follow the instructions on the screen.

Any questions? Call our Membership Department at (781) 434-7495.



Link In with MMS

Connect with your peers by joining our members-only LinkedIn group at www.massmed.org/linkedin.

Seeking Senior Volunteers to Share Knowledge

June 12 Information Session

The Society's Committee on Senior Volunteer Physicians offers an avenue for senior physicians seeking a rewarding volunteer opportunity. Boston University School of Medicine (BUSM) is looking for physicians to volunteer as faculty facilitators for the *Integrated Problems* (IP) course.

A problem-based learning course taken by all BUSM students, the IP course focuses on the discussion of clinical cases to help students develop methods for learning, teaching, and integrating information. Groups of six to eight students meet with a facili-



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tator for two hours each week between early September and early December. The volunteers serve as facilitators and answer questions as needed; however, they are not teachers in the traditional sense.

If you are looking for a fulfilling way to apply your medical knowledge and experience through involvement with medical students, please join us for an information session at MMS headquarters on Tuesday, June 12, from 9:30 a.m. to 1:00 p.m. **VS**

Questions about the BUSM program? Contact Carolyn Maher at cmaher@mms.org or (800) 322-2303, ext. 7311.

NEJM Editor Shares Tips on Getting Published

Tuesday, May 22, 6:30 p.m.,
Via Live Webinar

Getting research published can require almost as much effort and persistence as conducting the research itself. The good news for authors is that there are ways to improve your odds of publication. This information and more will be shared during a webinar entitled "How to Get Published," led by NEJM Deputy Editor Caren G. Solomon, M.D. This webinar is sponsored by the Massachusetts Medical Society Committee on Young Physicians. **VS**

For more information, contact Colleen Hennessey at chennessey@mms.org or (781) 434-7315.

Osteoporosis Management June 14 Forum

According to the National Osteoporosis Foundation, approximately 10 million Americans have osteoporosis, and another 34 million are at risk. It is estimated that broken bones will occur in approximately 50 percent of women older than 50 years of age due to osteoporosis. Usually the loss occurs gradually, and often a person will have a fracture before becoming aware that the disease is present. A woman's chance of breaking a hip is equal to her combined risk of developing breast, uterine, and ovarian cancer.

Given the aging population, the number of people with osteoporosis-related fractures will increase. Approximately 2 million fractures and \$19 billion in costs were attributed to osteoporosis in 2005. By 2025, it is predicted that osteoporosis will be responsible for approximately 3 million fractures and \$25.3 billion in costs each year.

The MMS will host a symposium in June to address a variety of topics related to this issue, including the biology and epidemiology of osteoporosis and the various treatment options available, including the role of vitamin D, the use of parathyroid hormones, and determining which patients should receive bisphosphonates. After attending this program, physicians and other health care providers will be better prepared to counsel patients on lifestyle and other health factors that contribute to the prevention of osteoporosis, and they will be equipped with the most up-to-date resources to better diagnose and treat bone disease. **VS**

ACROSS THE COMMONWEALTH

District News and Events

Bristol South — Annual District Meeting. Thurs., May 10, 6:00 p.m. Location: Venus de Milo, Swansea. Speaker: Ali Khan, M.D., M.P.H., assistant surgeon general, U.S. Public Health Service, and director, CDC Office of Public Health Preparedness and Response.

Charles River — Annual District Meeting. Wed., May 2, 6:00 p.m. Location: Wellesley Country Club, Wellesley. Entertainment: Odaiko New England. **Delegates Meeting.** Tues., May 8, 6:00 p.m. Location: MMS headquarters, Waltham. Delegates will meet to review and discuss resolutions for the 2012 MMS Annual Meeting.

Essex South/Essex North — Joint Delegates Meeting. Wed., May 9, 6:00 p.m. Location: Beverly Depot, Beverly.

Hampden — Annual District Meeting. Tues., May 8. Registration: 5:30 p.m. Speaker: Dr. Jeremy Lazarus, president-elect, AMA. Location: Chez Josef, Agawam. **Grand Rounds with Dr. Lazarus.** Wed., May 9, 8:00 to 9:00 a.m. Location: Baystate Medical Center, Springfield. **Joint Delegate and Executive Board Meeting.** Tues., May 15, 6:00 p.m. Location: HDMS West Springfield office. For more information, call (413) 736-0661 or email hdms@massmed.org.

Middlesex — Legislative Breakfast. Fri., May 4, 7:30 a.m. Location: MMS headquarters, Waltham.

Middlesex North — Annual District Meeting. Wed., May 2, 6:00 p.m. Location: Vesper Country Club,

Tyngsborough. Guest speaker: Elizabeth A. Snelson, Esq.

Middlesex West — Delegates Meeting. Wed., May 9, 6:00 p.m. Location: Framingham Union Hospital, MacPherson Hall, Framingham. Delegates will meet to review and discuss resolutions for the 2012 MMS Annual Meeting.

Plymouth — Legislative Breakfast. Fri., May 4, 7:30 to 9:00 a.m. Location: J. Joseph Moakley Conference Room, Good Samaritan Hospital, Brockton. **Spring Annual Meeting.** Wed., May 9, 6:00 p.m. Location: Fireside Grille, Middleboro. Speaker: David Gallo, Ph.D., director of special projects, Woods Hole Oceanographic Institution. Topic: The Secrets of the Sea: Exploring Neptune's Realm.

Southeast Region — Regional Caucus. Thurs., May 3, 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 resolutions prior to the 2012 MMS Annual Meeting.

Suffolk — Delegates Meeting. Thurs., May 10, 6:00 p.m. Location: Massachusetts General Hospital, East Garden Room, Boston. Delegates will meet to review and discuss resolutions for the 2012 MMS Annual Meeting.

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.

Diagnosis and Management of Osteoporosis

Thursday, June 14, 2012

8:00 a.m. to 12:00 p.m.

MMS Headquarters, Waltham

This activity has been approved for AMA PRA Category 1 Credit™.

For more information or to register, visit www.massmed.org/osteoporosis.

Reality Medicine Meeting



Physicians and medical students gather at the March 16 program "Reality Medicine for Minority Physicians in Massachusetts," hosted by the MMS Committee on Diversity in Medicine. From left to right: Robin DaSilva, MMS Past President Alice Coombs, M.D., Robert Fuller, M.D., Zuzana Mendez, M.D., Patricia Falcao, M.D., MMS Vice President Ronald Dunlap, M.D., Joyce Sackey, M.D., Ali Kareem, Aidee Herman, M.D., Angela Coombs, and Mardoche Sidor, M.D.

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VOLUME 17, ISSUE 5, MAY 2012

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

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

Thurs., May 17, 3:30 to 5:30 p.m.

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

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

Fri., May 18, 12:30 to 2:00 p.m., Seaport Hotel, Boston

Providing Medical Care in an Emergency Shelter Setting

Tues., June 5, 6:00 to 9:00 p.m.

Diagnosis and Management of Osteoporosis

Thurs., June 14, 8:00 a.m. to 12:00 p.m.

Addiction Medicine for All Providers

Thurs., June 21, 4:00 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

Monday, June 11

ONLINE CME ACTIVITIES

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

- *Legal Advisor*: Identifying Potential Drug Dependence
- 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
- Seven Steps to Health Literacy

- The Changing Nature of Informed Consent: Informing Patients and Avoiding Litigation
- A Path to ACOs
- Protecting Your Patients' Data
- Avoiding Failure-to-Diagnose Suits
- Getting It on Record and Getting It Right
- Social Networking 101 for Physicians
- Terminating the Doctor-Patient Relationship
- *Legal Advisor*: 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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