SGR Reform Fails in Congress; With Payment Patch Comes 1-Year ICD-10 Delay

Delay is an Opportunity to Prepare Your Practice

BY TALIA GOLDSMITH
PPRC ADVISOR

With the mandate to implement ICD-10 delayed until October 1, 2015, practices have an unexpected opportunity to prepare for a seamless adjustment when the change takes place. CMS officials have repeatedly warned physicians to anticipate productivity hits and revenue losses in the initial three to six months post implementation due to the steep learning curve associated with the use of ICD-10.

Evidence shows that virtually every other country that has implemented ICD-10 experienced some level of productivity impact. Canada, which has a government-run (single-payer) health care system and used a more specific code set when implementing ICD-10 back in 2001, took a 50 percent slash in productivity that lasted approximately six months. Minimizing the negative impact of ICD-10 implementation on your practice is important, and taking the time to prepare now is key.

MMS, AMA Vow More Repeal Efforts in 2015

BY ALEX CALCAGNO
MMS DIRECTOR OF FEDERAL RELATIONS

Despite strong protests from much of organized medicine, last month Congress approved a one-year extension of the current Medicare physician payment formula. The vote dashed hopes for a permanent repeal of the flawed sustainable growth rate formula, or SGR. The new legislation averts a 24 percent cut in Medicare payments, which was scheduled to take effect on April 1. For the rest of the 2014 calendar year, physicians will get a 0.5 percent increase. Rates will be flat for the first three months of 2015, at which time another cut is scheduled to take effect.

The SGR legislation also mandated a one-year delay of the implementation of the new ICD-10 diagnosis code set until Oct. 1, 2015. The MMS, AMA, and many other medical societies vocally opposed the SGR patch, and had advocated for months for a complete repeal of the payment formula. “We’re very disappointed that Congress has again failed to fix this issue,” said MMS, AMA, and many other medical societies vocally opposed the SGR patch, and had advocated for months for a complete repeal of the payment formula.

Clinical Decision Support: Data You Can Use Today

BY DEBRA BEAULIEU-VOLK
MMS STAFF WRITER

During a typical shift in early 2014, a patient presented to the emergency department at Brigham and Women’s Hospital suffering from shortness of breath and chest pain severe enough that doctors considered it may have been a pulmonary embolism — a potentially fatal blood clot in the lung. The patient was pregnant, forcing Jonathan M. Teich, M.D., to make a fast decision: Go with the standard CT scan with contrast and risk radiation to the fetus, or try another test that may miss the diagnosis.

Historically, a physician faced with this dilemma would need to dig up a paper or book on the subject, which, if even accessible, might be a few years out of date. “There would be information out there that says this test is better than that test in this circumstance, but I would have to go out and find it,” explained Dr. Teich, who is also chief medical informatics officer of the health sciences division of Elsevier Publishing. “And chances are, because it takes time and because it takes me out of my game, I might not do it.”

Fortunately, Dr. Teich didn’t have to guess about the best way to diagnose his patient. “As I go to the order set while I’m writing orders, which I have to do anyway, embedded in my work flow is a decision tree and the information is right there, explaining in this circumstance to do this ultrasound first and what to do next if it’s negative,” he said.

This is just one example of how clinical decision support tools can supply doctors with fast access to clinical information that commonly applies to specific cases, helping them make the best decision without breaking stride.

At the MMS annual meeting from May 15 to 17, Dr. Teich and other expert faculty will present the educational program, Data-Driven Clinical Decision Making and Improving Quality of Care. The program will describe various ways these tools can benefit physicians in their everyday practice, along with plenty of first-hand advice about how to implement clinical decision support effectively, without information overload or workflow disruption.

Individualizing Care

In addition, attendees will learn about how decision support systems can help them provide more individualized care, said presenter Martin Kohn, M.D., chief medical scientist at Jointly Health. “The other goal for the transfer of information in healthcare is to make more personalized decisions that are specific to the individual patient,” he said. “Not all diabetics are the same, for example. There are unique characteristics of every patient that might mean their management should be different from the typical. Precision medicine means we’re going to make better use of all of the kinds of information that are available to us to gain the insights we need to make those personalized decisions.”

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Looking Back, Looking Forward

As my presidency draws to a close, I wanted to reflect on the long and eventful year we have shared together.

In my first President’s Message I wrote, “We must ensure that all of our physicians have the opportunity to succeed.” I was speaking of the changes buffeting our profession from every corner, including technical and regulatory requirements, payment model challenges, and unprecedented health care system consolidation and contraction. I spent much of this year around the state speaking to other physicians about clinical integration and ACOs, and my hopes that medicine can be improved in collaboration with physicians, not at their expense.

My final message is that we need to ensure a fair playing field for all physicians. Hospital systems throughout the state are fiercely competing for finite health care dollars. We must ensure that in the midst of this ultra-competitive environment, there will be a robust, diverse population of physicians to ably serve the patients of the entire community, not just those aligned with a specific hospital or organization.

Access and equity cannot be sacrificed on the altar of this competition, as consolidation has not generally led to improved access, efficiency, or lower costs.

As I prepare to leave this post, I want to extend my deepest thanks to all of the physicians who work so hard and volunteer their time to this medical society. It has truly been an honor serving as your president.

Thank you,

— Ronald W. Dunklap, M.D.

Clinical Decision Support

Part of making clinical support work for you is choosing the correct tool, noted Dr. Teich, who co-authored the book, Improving Outcomes with Clinical Decision Support: An Implementer’s Guide. According to the book, these are the 10 different ways clinical decision support can be presented to users:

- Immediate Alerts (after orders and prescriptions)
- Event-driven alerts and reminders (e.g., after test results come back)
- Order Sets, Care Plans, and Protocols
- Parameter Guidance (patient-specific dosing)
- Smart Documentation Forms
- Relevant Data Summaries
- Multi-patient Monitors and Dashboards
- Predictive and Retrospective Analytics
- Filtered Reference Information and Knowledge Resources
- Expert Workup Advisors (artificial intelligence programs)

Different types can be useful in different situations, said Dr. Teich. For example, filtered reference information may be very useful when you are first working up a new patient with an unfamiliar set of symptoms and signs, whereas order sets can be useful when you have an overall game plan but want to make sure you get all the details right and not forget important things to do.

Overcoming Myths and Challenges

One of the first challenges in realizing the benefits of these technologies, however, is in overcoming misconceptions about the purpose of clinical decision support. “It can be a somewhat threatening or contentious subject,” said Dr. Kohn. “Some people describe clinical decision support or using data analytics as an effort to force physicians into cookbook medicine, take away their autonomy, or compensate for the incompetence of physicians.”

These are all flawed assumptions, he said. In contrast to 40 years ago when just getting the clinical information one needed was a challenge, today anyone can go online with a search and get 100,000 hits in a tenth of a second. “The environment has changed,” Dr. Kohn said. “We now have access to huge amounts of information that exceed our ability to process, understand, and use.”

Most importantly, physicians should understand that these tools offer decision support, not decision making, added Dr. Teich. “It’s not an expert commander saying this is what you do. It’s kind of like a really conscientious medical student who says, ‘Hey, I just read this paper and here’s some info that might help.’”

Finally, Dr. Teich says that physicians’ fears that clinical decision support tools increase their malpractice risk are unwarranted. “We often hear general concerns in which physicians ask, ‘If I have a decision support tool, does it make me more liable if I do or don’t do what it says?’” he explained. “What the wisdom seems to show from experience is that people hold you responsible for doing the right thing, regardless of where you got the information from.”

Most often, organizations reduce their malpractice risk by implementing decision support tools, he added.

Overall, these experts are aiming in their presentation to help physicians recognize the practical value of clinical decision support. “Some of the things you are already doing are a form of decision support, but there may be ways to do it better,” Dr. Teich said. “Our overall goal is to help you practice with the greatest quality, safety, and cost-effectiveness as possible, and this is one important tool that can make a difference.”

For more information about the 2014 MMS Annual Meeting from May 15 to 17 at the Seaport Hotel and World Trade Center visit www.massmed.org/annual2014.
What Physicians Should Expect as Newly Insured Seek Care

Some Patients May be Unfamiliar with Co-Pays, Referrals

BY LEIF BRIERLEY
MMS HEALTH POLICY ANALYST

As the Affordable Care Act continues to roll out, physicians around the country have tried to prepare for the expected tide of newly insured patients seeking care. However, due to the technical problems with both state-based exchanges and Healthcare.gov, insurance enrollment has fallen far short of projections. Given the uncertainty surrounding the rollout of the Massachusetts Connector insurance website, what should Bay State physicians expect?

With the enrollment deadline extended until mid-summer, practices may not notice a dramatic increase in newly insured patients for some time. However, for those new enrollees who do begin to utilize care, the majority will be those eligible for Medicaid and other public programs, or will be eligible for substantial tax credits.

A portion of this population may be unfamiliar with insurance concepts such as co-payments or referrals. Many may not have had regular care in the past. As a result, practices should be prepared to offer guidance to newly insured patients to help facilitate their entry into the health care system.

The Connector is conducting a state-wide outreach and education campaign specifically targeting this population to ensure they can maximize the benefits of their new insurance while also understanding their financial responsibilities, as applicable.

Because the Connector’s IT system has performed poorly so far this year, the state has reverted to processing paper applications by hand. To deal with the backlog, the state received a waiver from CMS to extend the enrollment deadline until June 30.

In the meantime, as of March 1, only 12,965 individuals had enrolled in a plan through the Connector, or only 5 percent of the target enrollment population, according to data reported to the Kaiser Family Foundation.

The impact of the newly insured population on access to care and wait times for appointments remains to be seen. Results from MMS’s 2014 Access to Care Study (pre-ACA implementation) showed stable or shorter wait times in certain specialties.

The 2014 Access to Care Study, due out next month, will provide a snapshot of patients’ experiences with wait times as they grapple with the new influx of patients. Results on this key health reform issue will be reported at www.massmed.org as soon as they are available.
Learn How to Close the Health Care Gender Gap

Men’s Health Symposium is June 11

Why is there a gender gap in life expectancy? Certainly, unhealthy male behavior plays a role. Men are more likely to use tobacco products, abuse alcohol, and often make unhealthy lifestyle decisions. Men are more likely to have risky driving practices, including not wearing a seatbelt, speeding, and driving while intoxicated. Men are more likely to push themselves to unhealthy limits to succeed at their job at the expense of regular exercise, healthy dietary habits, and sleep.

Men also tend to avoid going to the doctor, and those that do tend to under-report their symptoms.

What can health care providers do to improve the state of men’s health? Come to the 12th Annual Symposium on Men’s Health, Head-to-Toe: Top Topics and Bottom Lines in Men’s Health, Wednesday, June 11, 2014, at MMS headquarters in Waltham, and learn from the leading experts in the field of men’s health how to optimize your male patients’ health.

MCPAP for Moms: Addressing Perinatal Depression for Maternal/Child Health

BY KATHLEEN BIEBEL, PH.D., AND NANCY BYATT, D.O., MCPAP FOR MOMS

One out of every eight women experiences depression during pregnancy or in the first year postpartum. Undiagnosed and untreated perinatal depression can have devastating effects on mothers, infants, children, and families. One mother who suffered from postpartum depression for more than a year without treatment recounted, “My daughter was born and she felt like a stranger. I was so excited to have her, but when she came…All I wanted to do was avoid her. I had no idea what I had and stayed like that for over a year. I feel so guilty that I was not available to my daughter in that first year.”

Considering this mother’s experience, it is not surprising that perinatal depression negatively impacts birth, infant, and child outcomes. It can also be tragic; maternal suicide causes 20 percent of postpartum deaths in depressed women.

Despite the availability of effective evidence-based treatments and frequent contact with medical providers, most perinatal patients who screen positive for depression do not receive treatment. Providers are hampered by fear of liability, discomfort, and lack of resources. These barriers are magnified by stigma, fear, and discomfort among mothers.

A new statewide program, Massachusetts Child Psychiatry Access Project (MCPAP) for Moms, aims to minimize these barriers by helping providers effectively prevent, identify, and manage depression in pregnant and postpartum women. The program draws on the successful outcomes of the MCPAP, created in 2005 to help pediatricians manage children’s psychiatric needs.

MCPAP for Moms has three core components:

1. Trainings and toolkits for providers based on evidence-based guidelines for depression screening, triage and referral, risks and benefits of medications, and discussion of screening results and treatment options

2. Real-time psychiatric telephone consultation and care coordination for health care providers serving pregnant and postpartum women, including obstetricians, pediatricians, adult primary care physicians, and psychiatrists

3. Linkages with community-based resources, such as mental health care, support groups, and other resources to support pregnant and postpartum women

Funded by the state mental health department, MCPAP for Moms is currently conducting trainings and webinars across Massachusetts. Starting in July, providers will be able to call a toll-free number to speak with a care coordinator, who works with the provider to determine their needs — psychiatric care consultation, community care coordination, or both — and assist in care delivery and coordination for their patients.

For more information contact: MCPAP for Moms. Nancy Byatt, D.O., M.B.A., F.A.P.M., medical director, Nancy.Byatt@umassmemorial.org; Kathleen Biebel, Ph.D., program director, Kathleen.Biebel@umassmed.edu.
Q&A with the State Health Policy Commission’s Carole Allen, M.D.

BY WILLIAM RYDER, ESQ
MMS LEGISLATIVE COUNSEL

Vital Signs recently caught up with Carole Allen, M.D., to learn about her first year with the Commonwealth’s Health Policy Commission (HPC), the new state agency tasked with establishing the annual health care cost growth benchmark and examining the impact of changes on providers and access.

We first interviewed Dr. Allen just over a year ago, shortly after her appointment to the HPC. She received the Special Award for Excellence in Medical Service from the MMS in 2011 for providing “exceptional care and dedication to the medical needs of his or her patients and the general public.”

We invited Dr. Allen to return to the forum I was impressed with the young physicians I met. They are interested in social determinants of health and they are thinking in diverse ways of how systems of practice could be changed.

VS: Do you have concerns that the complexity of the information sought by the Commission will make it difficult for the contribution of small physician groups to be accurately conveyed?

Allen: I hope not. For example, with the patient-centered medical home initiative, our aim is to engage a variety of practices and help them all develop skills to move them on a continuum toward more efficient care at lower cost. Small practices are struggling and we hope to help them move forward. I don’t think our actions will contribute to harming small practices.

VS: Today’s hearing concentrates on defining patient-centered medical homes. The HPC is going over ground here that has been covered by the National Committee for Quality Assurance (NCQA) and others. Will this create competing systems?

Allen: Our goal is for our state certification to be consistent with the requirements of national certifying bodies such as NCQA, with less administrative burden for the practice. We are striving to identify the highest value elements of a patient- or family-centered medical home (e.g., care coordination) and emphasize these.

VS: How do you see the goal of administrative simplification working with these new reporting systems, particularly on the information groups must provide on their internal structures and contracts?

Allen: We have made a promise to minimize new administrative requirements, while acting within the terms of the statute, and it is my sincere hope that we are able to do that. Whenever possible we will seek data from other sources in order to burden practices as little as possible.

VS: Final thoughts?

Allen: Recently at the American Academy of Pediatrics leadership forum I was impressed with the young physicians I met. They are interested in social determinants of health and they are thinking in diverse ways of how systems should work in the future. So I see a lot of hope for their practices and patients.

SGR Reform

continued from page 1

the deeply flawed Medicare payment formula,” said MMS President Ronald Dunlap, M.D. “The legislation is sound policy that was supported by both parties, in both chambers of Congress. Yet, because its leaders were unable to overcome partisan differences over how to pay for it, we now have the 17th SGR patch in the last 11 years.”

“The bitter irony is that every patch makes the problem worse. Congress could have solved the problem years ago by enacting a permanent repeal, and would have saved taxpayers tens of billions of dollars,” said Dr. Dunlap.

“The campaign to fix Medicare must continue, for the sake of the millions of seniors and military families who depend on the program for their health care. We’re deeply grateful to the members of the Massachusetts congressional delegation for their steadfast support for true Medicare payment reform, and pledge to work with them to achieve this goal — once and for all,” he said.

AMA President Ardis Dee Hoven, M.D., also expressed disappointment with Congress for its failure to permanently repeal the SGR.

“Congress has spent more taxpayer money on temporary patches than it would cost to solve the problem for good,” said Dr. Hoven. “This bill perpetuates an environment of uncertainty for physicians, making it harder for them to implement new innovative systems to better coordinate care and improve quality of care for patients.

“Remarkable progress was made this past year in reaching a bipartisan, bicameral agreement on policy to repeal the SGR, and the AMA encourages Congress to continue its work and resolve outstanding issues. On behalf of Medicare patients and physicians across the country, it is critical that we achieve permanent Medicare physician payment reform,” she said. “We will continue our efforts to secure a permanent SGR repeal this year.”

The MMS would like to thank the many physicians who contacted our congressional delegation to urge rejection of the measure.

Read a summary of the bill’s provisions and download the bill’s full text at www.massmed.org.
Avoiding the Slippery Slope

BY DEBRA GROSSBAUM
PHS GENERAL COUNSEL

As a general rule, most doctors are rule followers. They are typically aware of the basis for structured parameters and are willing to take the steps necessary to do things properly. However, doctors are also generally pressed for time, resources, and compensation.

These deficits may lead even the best physicians to succumb to shortcuts, some of which may seem quite harmless, but which may lead to unforeseen and quite consequential outcomes.

Technology

One area of potential risk is in the area of technology. While we now revel in this age of immediate communication, we may not be fully focused on the potential pitfalls of computer and cell phone communications. For example, a physician was trying to wrap up the last few patient calls of the day when he chose to use his cell phone instead of his office line, so he could talk while heading out of the office. He didn’t consider that by calling on his cell, he was disclosing his personal number to several patients. At least one patient took this as a suggestion that the call was more of a personal nature than was intended, and another later used the number to contact the doctor for inappropriate questions at inappropriate times. While such calls would otherwise be vetted by a receptionist, this physician now found himself in quite an uncomfortable position that was clearly unintended. Similarly, physicians may use personal email addresses to zip out quick responses when pressed for time. However, by doing so, not only is the patient receiving the doctor’s personal contact information, but there is also a likelihood that the personal email account lacks the type of encryption required for physician/patient communications. While the communication may seem benign, just the fact that a patient has come to you as a physician may be sufficient to constitute a confidentiality violation if disclosed without proper encryption.

Collegial Consults

Another prevalent, but dangerous, dynamic is the proverbial “curbside consult.” Most physicians acknowledge that care should be provided in the context of a formal doctor/patient relationship, with an exam and patient record. Many doctors also feel justified in seeking a quick prescription from a friend when pressed for time, especially when the medication is common, or the asking physician appears confident that it is an appropriate use. However, the risks here may be much more extensive than considered. Ultimately, the physician who is providing the prescription will be held responsible for the care, so if the colleague is abusing the medication, or has a negative drug reaction, the well-meaning colleague may be liable. Also, sometimes the medication or the formal consult can interfere with necessary medical care. One physician casually and regularly provided a colleague with medication to treat what was assumed to be a migraine headache. Ultimately it was learned that the physician-patient was suffering from symptoms of a brain tumor. The tumor went undetected for the duration of the time that the colleague provided the analgesic without conducting a complete exam.

Prescriptive Practice

Patients can be very persuasive when it comes to seeking medications. They may describe pain, psychological distress, insomnia, or a variety of other symptoms that are hard to quantify, confirm, or refute. With little time, and an anxious patient, it can seem easiest to just write a quick prescription. While medication is often necessary, it is important to take the time to use all of the resources available to support the necessity of a prescription, especially for substances that are potentially abused. Even when time is short and pressure is on, it is essential to check the state’s online Prescription Monitoring Program. This can provide critical information as to whether the patient has already obtained medications elsewhere. Also, whenever possible, gather objective data to confirm or rule out a diagnosis before prescribing. This might include MRI, comprehensive physical exam, or even an independent pain consult. While patients might balk at these extra steps, taking them at the front end may preclude a cascade of subsequent consequences.

We are all faced with daily demands competing for our time, and we have to make quick decisions to best allocate our time and resources. When doing so, as a physician, it is helpful to be mindful of the importance of protocol and the purpose of such protocol before agreeing to take steps, even baby steps, away from the rulebook. It is well worth the time.

Physician Health Services, Inc. can be reached at (781) 434-7404, or at www.physicianhealth.org.

Mentor Students by Facilitating a Medical School Course

Boston University School of Medicine is looking for physicians to volunteer as facilitators for its Integrated Programs, a problem-based learning course required for all first- and second-year medical students at the school.

Help guide the students to make the correct diagnoses as they integrate information from other classes and independent study groups. Share your valuable medical knowledge and expertise as you observe their clinical reasoning skills develop. The volunteer meets with small groups of 6 to 8 students for two hours each week for 10 to 12 weeks from September to December.

Dr. Megan Young, course director, will conduct an orientation and training session at MMS headquarters on Tuesday, June 10, from 9:30 a.m. to 1:00 p.m. She will provide more details of the course and the facilitator’s role. Lunch will be served.

To register to attend the information session, please contact Carolyn Maher at cmaher@mms.org or (781) 434-7311.

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.

Richard S. Blacher, M.D., 90; Waban, MA; University of Rochester, 1948; died January 16, 2014.

John E. Doherty, M.D., 84; Wellesley, MA; Tufts University School of Medicine, 1954; died August 30, 2011.

Lauren V. Farber, M.D., 47; Wellesley, MA; Tufts University School of Medicine, 1998; died November 18, 2013.

Edwin Gordy, M.D., 88; Newtonville, MA; Jefferson Medical College, 1948; died November 20, 2013.

H. Royden Jones Jr., M.D., 76; Wellesley, MA; Northwestern University Medical School, 1962; died June 4, 2013.

Milton R. Olson, M.D., 84; North Easton, MA; Jefferson Medical College, 1954; died November 16, 2012.

Todd A. Pritz, M.D., 63; Saint Louis, MO; Tufts University School of Medicine, 1979; died January 15, 2014.

Rose M. Scuderi, M.D., 84; Lawrence, MA; Georgetown University School of Medicine, 1957; died April 29, 2013.

William F. Siebert Jr., D.D., 58; Yarmouth Port, MA; Kansas City University College of Osteopathic Medicine, 1981; died December 12, 2013.

Nicholas L. Tilney, M.D., 77; Boston, MA; Cornell University Medical College, 1962; died March 13, 2013.

H. Royden Jones Jr., M.D., 76; Wellesley, MA; Northwestern University Medical School, 1962; died June 4, 2013.

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NEJM Group Announces the Launch of NEJM Knowledge+

BY THE NEJM KNOWLEDGE+ TEAM

NEJM Group is excited to announce the launch of NEJM Knowledge+ Internal Medicine Board Review, a self-assessment and continuous-learning solution that employs the very latest adaptive learning technologies to increase learning efficiency and knowledge retention.

Designed specifically for Internal Medicine and Internal Medicine subspecialists, the product includes:

• Over 4,000 questions covering nearly 1,500 key learning points
• Two timed practice exams that simulate the actual board exam
• Desktop, iPad, and iPhone access — wherever and whenever it’s convenient for you
• Opportunity to earn 250 CME credits
• Opportunity to earn 80 ABIM MOC points
• Robust, multi-faceted progress and performance reporting system

We partnered with Area9 — a physician-led pioneer in adaptive learning — to create this first-of-its-kind platform with smart technology that actually continuously assesses your knowledge, study habits, and schedule, selecting from thousands of learning opportunities and presenting just what you need to become fully prepared. NEJM Knowledge+ presents questions based on what you know already, what you need to study more, what you are struggling to master, what you think you know better than you do, and what you might be forgetting. For a fun and informative look at how we’ve used adaptive learning check out our animated video at http://knowledgeplus.nejm.org/our-products/adaptive-learning.

NEJM Knowledge+ is planned as a family of products to support self-assessment, learning, and board certification in internal medicine and other specialties. Future review products in other specialties will all be designed to help clinicians efficiently self-assess their learning needs, meet their certification requirements, prepare for the board exams, and incorporate lifelong learning into their schedules more easily.

To learn more about NEJM Knowledge+, visit our marketing site at http://knowledgeplus.nejm.org. You’ll find lots of great information, videos, our question of the week, blog, and more.

As an MMS member, you will receive a 25 percent discount on NEJM Knowledge+ Internal Medicine Board Review: To take advantage of this exclusive member discount visit: http://knowledgeplus.nejm.org/offer23.

The Massachusetts Medical Society designates this enduring material for a maximum of 250 AMA PRA Category 1 Credit™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

NEJM Knowledge+ Internal Medicine Board Review has been accepted by the American Board of Internal Medicine for 80 points toward the Self-Evaluation of Medical Knowledge (Part 2) requirement of Maintenance of Certification (MOC).

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

Charles River — District Delegates Meeting. Tues., May 6, 6:00 p.m. Location: MMS headquarters, Waltham. Resolution Review.

Essex South/Essex North — Delegates Meeting. Wed., May 7, 6:00 p.m. Location: Beverly Depot, Beverly. Resolution Review.


Middlesex Central — Delegates Meeting. Thurs., May 1, 7:45 a.m. Location: Emerson Hospital, Concord. Resolution Review.

Middlesex West — Legislative Breakfast. Fri., May 2, 7:30 a.m. to 9:00 a.m. Location: The Board Room, Leonard Morse Hospital, Natick.

Norfolk — Delegates Meeting. Wed., May 7, 6:00 p.m. Location: MMS headquarters, Waltham.

Suffolk — Delegates Meeting. Wed., May 7, 6:00 p.m. Location: MGH, East Garden Room.

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

Southeast Regional Caucus. Wed., May 7, 6:00 p.m. Buffet dinner followed by meeting. Location: LeBaron Hills Country Club, Lakeville. The delegates from the Barnstable, Bristol North, Bristol South, Norfolk South, and Plymouth District Medical Societies will meet to review and discuss the resolutions prior to the annual meeting.

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

Hampden — Annual District Meeting. Tues., May 6, 6:30 p.m. Location: Delaney House Restaurant, Holyoke. Speaker: Richard Michelson, Michelson Galleries. Delegates/Executive Committee Meeting. Tues., May 13, 6:00 p.m., Location: HDMS office, West Springfield.

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.
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MMS SPONSORED AND JOINTLY SPONSORED CME ACTIVITIES

LIVE CME ACTIVITIES
Go to www.massmed.org/calendar. Unless otherwise noted, event location is MMS headquarters, Waltham.

EHR Next Chapter:
Best Practices, Checklists, and Guidelines
Wed., April 20, 2014, 8:00 a.m. to 3:00 p.m.

Using Lean Methodologies to Improve Your Practice Performance Webinar
Wed., April 23, 2014, 12:30 p.m. to 1:30 p.m.

2014 MMS and Rhode Island Medical Society Directors of Medical Education Conference
Thurs., May 1, 2014, 8:00 a.m. to 2:30 p.m.

Enhancing Community Resiliency Conference and Webinar
Wed., May 21, 2014, 5:15 to 9:00 p.m.

12th Annual Symposium on Men’s Health
Wed., June 11, 2014, 8:00 a.m. to 5:00 p.m.

SAVE THE DATE
New Trends in Women’s Health:
What Every Provider Should Know
Fri., November 14, 2014

ONLINE CME ACTIVITIES
Go to www.massmed.org/cme.

Risk Management CME
End-of-Life Care
• Principles of Palliative Care and Persistent Pain Management (6 modules)
• End-of-Life Care (3 modules)
• Communication and Conflict Resolution in End-of-Life Care
• The Importance of Discussing End-of-Life Care with Patients
• Legal Advisor: Advance Directives

Pain Management
• 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

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
• 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 Antplatelet Drugs: A Review of Recent Clinical Trials
• Acid Suppression Therapy: Neutralizing the Hype

TO REGISTER FOR ANY OF THESE ACTIVITIES, CALL (800) 843-6356.

CME CREDIT: These activities have been approved for AMA PRA Category 1 Credit™. For additional information, contact the Department of Continuing Education and Certification at (800) 322-2303, ext. 7306, or go to www.massmed.org/cmecenter.