VITAL SIGNS

MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

VOLUME 20, ISSUE 9, NOVEMBER 2015

U.S. Attorney General: Cooperation Key to Opioid Fight

Hundreds Attend the MMS Opioid Misuse and Addiction Summit

BY DEBRA BEAULIEU-VOLK
VITAL SIGNS STAFF WRITER

As part of her keynote address before the Opioid Misuse and Addiction Summit, U.S. Attorney General Loretta Lynch said collaboration and cooperation among law enforcement and medicine is the key to progress in battling the epidemic of opioid addiction.

"This is a vital public health issue that was for far too long seen only through the lens of law enforcement," she said before the Oct. 2 gathering, hosted by the MMS and the U.S. Attorney's office at MMS Headquarters. "As physicians, you see the true human cost of these addictions."

She described the four points of the White House approach: enforcement, disposal, monitoring, and education. Because prescription drug abuse is a common precursor to abuse of heroin, a federal multi-agency Heroin Task Force will bring a plan to Congress by year's end, Lynch said.

"We do have reasons for optimism. We can strengthen families and save lives," said Lynch. "This is about mending the basic fabric of our communities."

The forum featured a wide variety of experts discussing how to effectively aid patients suffering

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2015 Opioid Misuse and Addiction Summit

Photo by Doug Bradshaw

Left: DPH Commissioner Monica Bharel, M.D. (right), moderates the health care panel discussion of challenges and roles for physicians in addressing the opioid problem. **Right:** U.S. Attorney General Loretta Lynch delivered the forum's keynote address to hundreds of health care leaders, physicians, law enforcement officials, pharmacists, and patients.

Physicians Speak Out: Stop Meaningful Use Stage 3

BY ERICA NOONAN
VITAL SIGNS EDITOR

Physicians are typically first in line when it comes to technology that can help them treat patients.

As early adopters of electronic health records and enthusiastic supporters of the earliest stages of Meaningful Use, typical physicians are eager to try new things and work with new tools.

"Doctors are digital omnivores," said AMA President Steve Stack, M.D., an emergency department physician. "We adopt technology at a blistering pace when we work, and when it helps us take care of patients."

That is why the physician-led movement to delay the implementation of Meaningful Use Stage 3 is so relevant, he said. With only 12 percent of eligible physicians and 38 percent of eligible hospitals nationwide able to meet the requirements of MU Stage 2, the move to the next stage is untenable and the pressures are driving physicians out of practice.

More than 100 physicians attended the AMA's *Break the Red Tape* town hall meeting September 29. Hosted by MMS Vice President Henry Dorkin, M.D., at MMS Headquarters in Waltham,

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Improving the Patient Experience: MMS Certificate Program with Cleveland Clinic

BY VICKI RITTERBAND
VITAL SIGNS STAFF WRITER

By 2009, Cleveland Clinic CEO Delos "Toby" Cosgrove, M.D., knew that something had to change. A few personal experiences had driven home the importance of compassionate health care. That realization, coupled with his organization's disappointing scores on patient satisfaction surveys, spurred his decision to embark on a three-year organization-wide effort to put the patient experience front and center.

Earlier this fall, Cleveland Clinic, in collaboration with the MMS, brought its lessons learned to the two-day Patient Experience Summit: A Physician Leadership Certificate Program. The goal of the program, which included both didactic and skills training sessions, was to teach participants relationship-centered communication strategies to improve the patient and physician experience — which the literature says is directly linked to quality and safety.

The major lessons conveyed to the audience were:

- Patient experience isn't the same as patient satisfaction
- Effective communication is a primary driver of patient experience

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PRESIDENT'S MESSAGE

Planning for the Future

It has been an exciting and productive month for the MMS.

On Oct. 2, we hosted the Opioid Misuse and Addiction Summit, in collaboration with the U.S. Department of Justice. We were honored to have U.S. Attorney General Loretta Lynch deliver the keynote speech to an assembly of 300 physicians, health care experts, legislators, and law enforcement leaders. I encourage you read the coverage and watch video clips of the speakers on our website at **www.massmed.org/opioid-summit**.

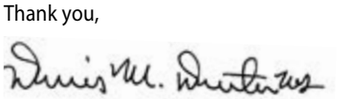
Your officers also continue to focus on the stewardship and future plans for the Society. This is particularly critical because our Executive Vice President Corinne Broderick will retire in May of 2016.

Corinne has been an exceptional EVP and her leadership over the last 14 years has strengthened the Society's position as a leader in health care, brought us to record high membership, and created great financial stability.

An EVP search committee has been appointed, and the committee members have selected the search firm Spencer Stuart to assist with this important search. With input from the trustees and other MMS leadership, a description of candidate qualities and MMS priorities has been developed to help inform the search process.

I'd like to invite any of you to reach out to Spencer Stuart at this time if you would like to recommend a candidate or be considered as a candidate for the EVP position. You may contact the Spencer Stuart search team at mmsevp@spencerstuart.com.

Thank you,



— Dennis M. Dimitri, M.D.

Patient Experience

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- Good communication is linked to numerous positive consequences for patients and caregivers
- What physicians say to patients is often less important than how they say it
- Patient satisfaction surveys can be very effective if used correctly

The Cleveland Clinic's Transformation

Cleveland Clinic Chief Experience Officer, neurologist Adrienne Boissy, M.D., kicked off the program talking about some of the ways her organization transformed itself, beginning with Dr. Cosgrove's edict to make patient experience a strategic priority.

The Clinic trained all of its 44,000 employees — from housekeepers to nurses to department heads — to put themselves in their patients' shoes and communicate better. Dr. Cosgrove created the first patient experience czar in the country — the role Dr. Boissy now fills — and made patient survey data about individual caregivers and units available to everyone. Same-day appointments became common, nurses began rounding hourly and countless small changes were instituted, including posting the caloric content of food and redesigning the "johnny."

"Hospital choice is based on the emotional experience," Dr. Boissy told attendees. "These are things that often come out at the Thanksgiving table during a conversation about how Aunt Mae was treated." Boissy's assessment is confirmed by a 2007 McKinsey and Company report she cited, looking at the factors influencing hospital choice. Respondents deemed patient experience — clean rooms, on-time appointments, good communication — twice as important as a facility's clinical reputation.

Dr. Boissy emphasized that patient experience isn't always synonymous with patient satisfaction. "As an MS specialist, my role is not to make my patients happy," she noted. "My patents often hate coming to see me because they have to watch people come into the waiting room on gurneys and in wheelchairs and wonder if they'll be like that eventually. My role is to walk with them on this incredible journey." She added that cancer patients have some of the highest patient satisfactions scores.

Communication is King

When Cleveland Clinic analysts dug into the patient satisfaction scores of respondents who gave the organization low ratings, they found that poor communication — patients not feeling listened to or communication gaps among staff — was at the root. Communication problems are also the most common issue brought to the Clinic's ombudsman office and its ethics committee, according to Dr. Boissy.

Co-presenter Kathleen Neuendorf, M.D., medical director of the Center for Excellence in Healthcare Communications at the Cleveland Clinic Foundation, talked about the critical importance of communication and how the content of doctors' conversations with patients is less important than the delivery, quoting Maya Angelou: "… people will forget what you said, people will forget what you did, but people will never forget how you made them feel."

And there's countless studies confirming the downstream effects of good communication, pointed out Dr. Boissy, including improved treatment adherence and health outcomes, enhanced physician and patient satisfaction and reduced caregiver burnout and malpractice claims. The inextricable link between patient satisfaction, a byproduct of effective communication, and quality and safety must be an important part of the message to hospital staff, emphasized Dr. Boissy.

Don't Forget the Doctors

Dr. Boissy talked about the clear link between patient satisfaction and staff satisfaction and that fostering caregiver engagement should be an important institutional goal. She cited a study showing that the amount of time physicians spend working on the activities most meaningful to them was strongly related to their risk of burnout. "Putting patients first doesn't mean putting caregivers second," she asserted. "It's important that we put a lot of attention on both sides."

Dr. Neuendorf said that at Cleveland Clinic, the ideal care is what they call relationship-centered care. "It's not all about me — the physician — or you — the patient —, but rather what we're doing together," she said. This type of care requires emotional connection, mutual respect for the other's experience and expertise, a shared commitment to the patient's health and well being, and an understanding

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Your Two Cents

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

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Patient Experience

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of the patient's perspective and psychosocial context. It doesn't require friendship, agreeing on everything, or unlimited time, she said.

But can relationship-building be taught? she asked. "How can I ask a physician to do one more thing and how effective is it to tell people they're poor communicators and their patient surveys are telling me this?" It's important to emphasize to physicians that relationship-centered communications training ultimately improves their own experience and has related benefits as well, including saving the provider time, she said.

Patient Experience by the Numbers

Carmen Kestranek, senior director of intelligence within the office of patient experience at Cleveland Clinic, offered insights into his organization's use of patient surveys, including the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). HCAHPS is the patient satisfaction survey mandated by the Centers for Medicare and Medicaid Services.

Among Kestranek's suggestions:

- For internally developed patient surveys, shoot for between 30 and 40 questions
- Patients are more likely to respond to a survey post-discharge if their physician mentions it to them beforehand
- Ensure that reporting methodologies are standardized. Provide dashboards so clinicians can easily drill down into the data and see their specific strengths and weaknesses
- Provide several years of patient experience data so individuals and units can see their progress
- Encourage internal transparency so individuals and units can compare performance. He admitted there was a lot of pushback when Cleveland Clinic began publicizing scores. But once scores became transparent, they rose significantly, according to Dr. Boissy
- Hold meetings to discuss survey results and strategize improvements

The importance of patient satisfaction surveys will continue to grow, said Kestranek, and by 2017 will affect a greater portion of hospitals' Medicare revenue.

LAW AND ETHICS

PMP Program Now Widely in Use; Pharmacy Updates Increased

BY WILLIAM FRANK, ESQ.
MMS ASSISTANT COUNSEL

Mass. Department of Public Health officials were anticipating that all physician prescribers of Schedule II–V controlled substances will be enrolled in the Massachusetts Online Prescription Monitoring Program (PMP) by this fall.

Although previously voluntary, as of January 1, 2013, physicians are automatically enrolled in the PMP when obtaining a new Massachusetts Controlled Substance Registration or renewing an existing one.

Every 24 Hours

The PMP shows a patient's prescription history for the prior 12 months, via a secure website hosted by the Commonwealth of Massachusetts. Data is reported into the PMP by all Massachusetts pharmacies and by out-of-state pharmacies delivering to patients in Massachusetts. In July, a provision of the budget increased the frequency at which pharmacies must upload prescription information from every 7 days to every 24 hours.

Operational since 1992, the PMP is intended to serve as a tool that supports safe prescribing and dispensing and assists in addressing prescription drug misuse and abuse. Use of PMP by prescribers may enable the early identification of behaviors suggestive of drug misuse, abuse or diversion and trigger early intervention.

Exceptions Preserved

Further, by viewing a patient's prescription history, a provider may avoid duplication of drug therapy or possible drug interactions, and coordinate care by communicating with other providers to improve clinical outcomes and overall patient health.

Once enrolled in the PMP, physicians must utilize the website prior to prescribing a narcotic in schedule II or III or a benzodiazepine to a patient for the first time. Exceptions to this requirement include prescribing for hospice patients, emergency department personnel writing for fewer than five days' supply of narcotics or benzodiazepines, emergency care where use of the PMP will likely result in patient harm, all inpatient services, the provision of medication for immediate treatment, instances when it is not possible to use the PMP such as when the system is down or where the prescriber is practicing at a site outside their control without current access to the Internet, prescriptions for patients under the age of 96 months, and for prescribers with waivers granted by the DPH.

More Reforms in the Future

In practice, physicians should either access the PMP themselves prior to seeing a patient with a prescription falling under the regulation requirements, or delegate such patient history inquiries to the database to duly authorized and registered staff members. Guidance for interpreting this PMP data can be found at the DPH website, **www.mass.gov/dph/dcp/onlinepmp**. These requirements should be incorporated into medical practice to ensure compliance with the law.

In recent months, leaders in the administration of Gov. Charlie Baker have acknowledged the limitations in the usability of the aging PMP, making it difficult for many physicians to easily and efficiently access the information in the system, and have pledged to make reforming the PMP a top priority over the next year.

The "Law and Ethics" column is provided for educational purposes and should not be construed as legal advice. Readers with specific legal questions should consult with a private attorney.

Opioid Summit

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from addiction and prevent new dependencies from forming. One place to start, experts agreed, is by reducing the amount of prescription opioid medication in our environment.

Many who misuse these pills obtain them not from doctors, but from friends and family members, with and without their knowledge, noted Wilson Compton, M.D., deputy director of the National Institute on Drug Abuse.

Curbing painkiller prescriptions will require a change in the United States' current "quick-fix culture," said Massachusetts Attorney General Maura Healey, noting that prescribing of opioids has grown exponentially in the last 15 to 20 years.

A physician panel, moderated by DPH Commissioner Monica Bharel, M.D., highlighted the dire need for treatment. "As a front-line physician," she said. "I've been frustrated by the lack of services….When you wheel a patient in for service and there's no room, there has to be a better way."

There is a window when people are ready for treatment, but physicians are stymied that treatment is not available, or there's a weeks-long waiting list. "People die on waiting lists," said Sarah Wakeman, M.D., leader of an initiative to address opioid addiction at Massachusetts General Hospital. "Treatment works. Most people will recover. We have to keep them alive long enough for them to get treatment."

Take Advantage of the PMP

Law enforcement officials pointed to the utility of the state's prescription monitoring program (PMP) as a tool to identify and thwart doctor-shopping. "The tool is right there," said George Zachos, chief of Medicaid Fraud Unit and Massachusetts assistant attorney general. "If the physicians and pharmacists are using [the PMP] properly, it should never get to us."

Identifying a potential case of addiction, diversion, inappropriate prescribing, or other misuse is just a piece of the puzzle. Most physicians and pharmacists don't currently have the tools to take the next step and have difficult conversations with patients, panelists noted.

But simply refusing to prescribe may perpetuate the problem by failing to address underlying addictions or increasing the chances patients will turn to heroin to self-medicate. Rather, experts advised using the opportunity to engage patients and offer or refer treatment for substance use disorders as soon as possible.

There are times, of course, when the benefits of opioid treatment outweigh the risks, and a prescription is helpful and appropriate for the patient. But because so many devastating addictions begin with a legitimate short-term prescription, physicians and pharmacists should be sure not to miss this critical opportunity to educate patients, according to Nancy Coffey of the U.S. Drug Enforcement Administration. Her blunt advice to physicians and pharmacists: "Take the extra 10 seconds to advise patients, 'This is powerful. Treat it that way. Put it where no one will have access.'"

MMS Public Health Manager Robyn Alie contributed to this report.

Watch more coverage of the forum and read about MMS's opioid addiction prevention campaign Smart and Safe at **massmed.org/opioid-summit**.

2016 MMS Anti-Tobacco Poster Contest Now Accepting Entries

The MMS and MMS Alliance will mail Anti-Tobacco Poster Contest kits in early November to Massachusetts elementary schools, pediatricians, and family physicians.

The annual contest is open to children in grades one through six. Participation encourages children to avoid tobacco and to encourage their friends and family to do the same.

In addition to entry information, the contest kit includes a 2016 calendar featuring the 12 winning entries from last year's poster competition.

Entries must be received by February 19, 2016.

Children submitting the 12 winning posters will each be invited to a formal State House ceremony, receive a $50 gift certificate, and be recognized on the MMS website and in news releases sent to local media outlets.

Photo by Jill Cricones

MMS Student Health and Sports Medicine member Steven Qi, M.D. (back left), and MMS President Dennis Dimitri, M.D. (back right), recognize the winners of the 2015 Anti-Tobacco Poster Contest.

MMS Foundation Grant Proposal Deadline is Jan. 15

BY JENNIFER DAY
MMS AND ALLIANCE CHARITABLE FOUNDATION DIRECTOR

The MMS and Alliance Charitable Foundation is accepting letters of inquiry for its Community Action and Care for the Medically Uninsured/Underinsured grants until January 15, 2016. These grants support physician-led volunteer initiatives that provide free care to uninsured patients and increased access to care for the medically underserved, as well as community health initiatives that target public health issues such as partner violence, substance use, and mental health.

Last year, the Foundation awarded 18 grants, totaling $234,000 and ranging from $5,000 to $28,500. Those submitting successful letters of inquiry will be invited to submit full grant proposals by March 1.

For more information, visit **www.mmsfoundation.org.**

Speaking Out

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the meeting gave participants an equal opportunity to describe how misguided federal regulations had profoundly impacted their practices.

Most had stories of lost productivity, useful patient health initiatives put aside for lack of time and resources, and tens of thousands of dollars spent per practice annually on information technology fees in attempts to meet Meaningful Use requirements. Many questioned why physicians are held responsible and penalized when software programs from outside vendors fail to work properly.

"We treat the patient and save the lives. We shouldn't have to write the software code for the EHR and be told we are a failure because the EHRs can't talk to each other. The penalty programs are on us, not the vendors," said Dr. Stack.

Matthew Gold, M.D., a neurologist asked, "In what other system are the end users penalized? Quality measures need to be specialty specific and relate to patient care. Too much time is taken for things that are irrelevant and take away from patient care." Several participants mentioned colleagues who have stopped practicing medicine because of Meaningful Use rules, leaving thousands of Massachusetts patients — many senior or disabled in western Massachusetts — struggling to find a primary care provider.

Past MMS President Ronald Dunlap, M.D., a cardiologist, estimated imposed Meaningful Use requirements had slowed his staff down by 30 percent. "Our productivity has been hammered by this," he said.

MMS Secretary-Treasurer Alain Chaoui, M.D., a family physician, described himself as an "early and enthusiastic" EHR adopter. "I thought Meaningful Use was in the best interest of patients in 2011 and I did everything I could to comply with Meaningful Use stages 1 and 2," said Dr. Chaoui. "Even with my best intentions to take care of my patients, the pressures have landed solely on the medical profession. I don't see pressures on the vendors to make them compliant and interoperable."

The AMA's *Break the Red Tape* campaign.

Lloyd Fisher, M.D., a pediatrician and director of infomatics for Reliant Medical Group, said Meaningful Use Stage 2 failed to take into account practice demographics, penalizing physicians with large numbers of Medicare and Medicaid patients. "We don't need a disincentive to treat the neediest patients. They need to change the rules," he said.

The AMA's campaign pushes for delay for Stage 3 rules until at least 2017, and major improvements in EHR interoperability. "This is the wrong time for Meaningful Use Stage 3," said Dr. Stack. "We need to take time to learn from the stages we already have and do Stage 3 right."

Watch the full webcast of the town meeting and hear the stories of more physicians at **www.breaktheredtape.org**.

STATE UPDATE

EHR and Scope of Practice Bills Move Forward

BY RONNA WALLACE
MMS LEGISLATIVE CONSULTANT

MMS President Dennis M. Dimitri, M.D., presented testimony on two important bills before the Health Care Financing Committee in late September. One bill would provide additional time for health care providers to comply with the interoperable electronic health record mandate contained in the cost containment bill from 2012, and would delay the current 2017 deadline date to 2022.

"While physicians are much further along on interoperable records than many other professions, 2017 is not achievable for all of us and much less so for other providers. This date was arbitrary and aspirational when established and needs to be recalculated to a more reasonable goal," Dr. Dimitri told lawmakers.

At that same hearing, Dr. Dimitri voiced the MMS's opposition to a bill that would require the legislature to refer scope of practice bills to the Health Policy Commission (HPC) for review, evaluation, and recommendation. As currently drafted, the bill would mean that if recommended by the HPC, the legislature would have little discretion and the bill would automatically be placed on the calendar without further legislative review, even if significantly rewritten by the HPC, which the legislation currently allows.

The MMS does not oppose a fair, objective, patient-centered review of scope of practice legislation, but H.993 (An Act Relative to Health Policy Commission Reviews of Scope of Practice Proposals) is written to favor non-physician health care providers and drastically restricts legislative discretion and jurisdiction for virtually all scope of practice bills.

Continuing to top the MMS agenda is opioid abuse reduction and education. Legislation has already passed the Senate and is pending before the House. The MMS supports most of the provisions in the Senate bill, many of which were borne out of discussions between MMS officers and staff and Senate health care leaders. MMS leaders support the concept of "partial fill," which would allow patients to elect to receive a portion of their total narcotic prescription from the pharmacy — at a lower copayment — with the option to return to the pharmacy to receive the remainder of the prescription if necessary. The MMS feels strongly that this initiative would significantly reduce the amount of unused drugs sitting in the medicine cabinet for those patients that choose to take advantage of this option.

Another provision supported by the MMS included in the Senate bill is a drug stewardship program. Similar to a partial fill program, the drug stewardship program targets safe storage and disposal by requiring the pharmaceutical industry to put forth programs intended to reduce the amount of unused drugs in the home. Programs would supplement current police station drop-off programs and could include mail order, drop-off day events, and additional drop-off locations in more welcoming or convenient locations.

Lastly, the Senate is proposing language to require the Prescription Monitoring Program to "push" information to physicians on where they stand in the bell curve of prescribing, compared to their colleagues in similar specialties and practice settings. Prescribers who exceed mean or medians within their category would be sent notice of their percentile ranking. The MMS supports this concept of informed prescribing patterns after modifications were made to strengthen liability protections for physicians. The information would be confidential and sent only to the practitioner. The information would not be public record, not subject to disclosure, not admissible as evidence in a civil or criminal proceeding, and would not be the sole basis for investigation by a licensure board.

PHYSICIAN HEALTH MATTERS

Ownership: What Does It Mean for Docs?

This month's Vital Signs *piece is written by a guest contributor, Les Schwab, M.D. Les practices internal medicine at Concord Hillside Medical Associates, and he is also the medical director of a hospice program. Inspired by his career experience as chief medical officer at Harvard Vanguard Medical Associates, Les has been trained and certified as a professional coach. In that role, he assists practicing physicians in their ongoing quest to stay true to the calling of medicine as they balance the demands of professional effectiveness with personal needs and family life. Physicians interested in learning more about professional coaching are encouraged to contact Physician Health Services at (781) 434-7404. Dr. Schwab is on the faculty of our upcoming CME program,* Managing Workplace Conflict: Improving Leadership and Personal Effectiveness. — *PHS Director Steve Adelman, M.D.*

BY LES SCHWAB, M.D.

In this era of our profession's continuous and accelerating transformation, physicians are often exhorted to take an "ownership" attitude toward their practices. That seems to be shorthand for taking pride in, and accountability for, the clinical practice. Even as practice structures and patient expectations change, we are urged to approach the enterprise as if we were materially in possession of it.

In fact only a hardy few are equity owners of medical practices in Massachusetts today and even they must deal with unprecedented incursions into the autonomy of their enterprise by third parties, such as insurance companies, medical technology/EMR, public reporting, etc. The majority of us who are employed actually "own" nothing at all, in a formal sense, of the platforms of our work — its physical infrastructure, its finances, the employment of our staff.

Most particularly, none of us own the health of our patients; that is theirs, and we are permitted a supportive role. There is the disconnect. How might we experience that sense of ownership if we technically own so little of the components of the job?

What we do own, however, are our relationships with all of our various partners in our work — our patients, our staff, our colleagues and, yes, with those managers and leaders who oversee the infrastructure and chart our course in a challenging environment. More properly, we own our presence in those relationships. That is ours, and ours to use to affect those relationships and make them advantageous — or not.

The real disconnect then, could be the inattention to optimizing that which we really do own, and lack of emphasis placed on creating more satisfying and productive relationships. So much health care attention is paid to technology, measurement, finance, workflow, and documentation — and so little to how well we collaborate and communicate with the partners on whom our mutual success and satisfaction depends.

We all know human relationships are complex. The needs of the parties change, mutual understanding is not a given, and conflict is an inevitable and natural occurrence. Our training and our practice environments do not provide much attention to how well these work out, and even less intention to have them work out better, for the good of all.

We all know good and bad, functioning and dysfunctional relationships, and we all know what it is like to be present in them.

We might yet use that presence that we singularly own to making our partnerships better. We can be more observant, we can learn from a rich body of knowledge about communication and organizational development if our organizations are asked to provide it. We can experiment with new and more effective transactions with our partners if the resources are made available. Then we could be in possession of something dynamic and expansive, and experience ownership of which we could truly be proud.

For more information on services offered by Physician Health Services, Inc., please contact Education and Outreach Director Jessica Vautour at (781) 434-7404 or visit **www.physicianhealth.org**.

IN MEMORIAM

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

Paul A. Oskar Jr., M.D., 79; Naples, FL; Loyola University of Chicago–Stritch School of Medicine, 1961; died April 5, 2015.

Stanley R. Parker Jr., M.D., 87; Steilacoom, WA; Tufts University School of Medicine, 1954; died October 15, 2014.

Arthur A. Pava, M.D., 94; New York, NY; Yale University School of Medicine, 1951; died September 2, 2013.

Iver S. Ravin, M.D., 99; Auburndale, MA; Boston University School of Medicine, 1940; died May 11, 2015.

Ira. M. Reiskin, M.D., 80; Newton Center, MA; State University of New York Syracuse, 1964; died February 15, 2015.

C. Burns Roehrig, M.D., 91; Lafayette, NJ; University of Maryland School of Medicine, 1949; died January 17, 2015.

Col. Jules M. Seletz, M.D., 81; Marblehead, MA; Chicago Medical School University of Health Sciences, 1958; died September 27, 2012.

Leslie Silverstone, M.D., 91; Chestnut Hill, MA; University of London Faculty of Medicine, 1946; died March 21, 2015.

James A. Smith, M.D., 91; Tulsa, OK; Howard University College of Medicine, 1948; died July 31, 2014.

William N. Stecher, M.D., 90; Waynesville, NC; University of Pennsylvania School of Medicine, 1948; died May 20, 2015.

Gene H. Stollerman, M.D., 83; Wellesley Hills, MA; Columbia University School of Colleges and Surgeons, 1944; died August 1, 2014.

Consuelo K. Tagiuri, M.D., 95; Lexington, MA; University of California, 1944; died May 25, 2015.

Gordon C. Vineyard, M.D., 79; Chestnut Hill, MA; Harvard Medical School, 1963; died May 5, 2015.

2015 Interim Meeting of the MMS House of Delegates

Friday and Saturday, December 4–5
MMS Headquarters and the Newton Marriott Hotel




- Online registration is now open at **www.massmed.org/interim2015/register**. Plan to attend these exciting Interim Meeting events: *A Town Hall Meeting with the Presidential Officers, the Annual Oration, the bi-annual Ethics Forum, and the Tenth Annual Research Poster Symposium* which offers a venue for residents, fellows, and medical students to display their original research.
- Hotel deadline is November 3. Please visit **www.massmed.org/IM15reservations** or call the hotel at (617) 969-1000.

Morse Stroll Dedicated in Worcester

Morse Stroll, a walking path honoring MMS Past President Leonard Morse, M.D., was dedicated at Elm Park in Worcester on August 27.

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

Charles River — **Nasir A. Khan, M.D., Lectureship.** Wed., Nov. 4, 6:00 p.m. Location: MMS Headquarters, Waltham. Guest Speaker: Paul Summergrad, M.D. Topic: Integrating Medical and Psychiatric Care. This lecture has been approved for 2.0 *AMA PRA Category 1 Credits*™. **Delegates Meeting.** Thurs., Nov. 19, 6:00 p.m. Location: MMS Headquarters, Waltham. Delegates will meet to review and discuss the resolutions for 2015 Interim Meeting of the House of Delegates.

Middlesex West — **Delegates Meeting.** Mon., Nov. 30, 6:00 p.m. Location: MacPherson Hall, Framingham Union Hospital, Framingham.

Norfolk — **Delegates Meeting.** Wed., Nov. 18, 6:00 p.m. Location: MMS Headquarters, Waltham. Delegates will meet to review and discuss the resolutions for 2015 Interim Meeting.

Suffolk — **Delegates Meeting.** Wed., Nov. 18, 6:00 p.m. Location: MGH-East Garden Room, Boston. Delegates will meet to review and discuss the resolutions for 2015 Interim Meeting.

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., Nov. 18, 6:00 p.m. Location: LeBaron Country Club, Lakeville. The delegates from Barnstable, Bristol North, Bristol South, Norfolk South, and Plymouth District Medical Societies will meet to review resolutions.

Norfolk South — ***17th Annual Anti-Smoking Program*, "Smoking: Don't Go There."** Mon., Nov. 16 through Fri., Nov. 20, 2015. Location: Elementary and middle schools on the South Shore. **Family Event.** Sat., Nov. 7, 2:00 p.m. tour, Location: Plimoth Plantation, Plymouth. 5:00 p.m. 17th Century Dinner, Location: Gainsborough Hall, Plimoth Plantation, Plymouth.

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

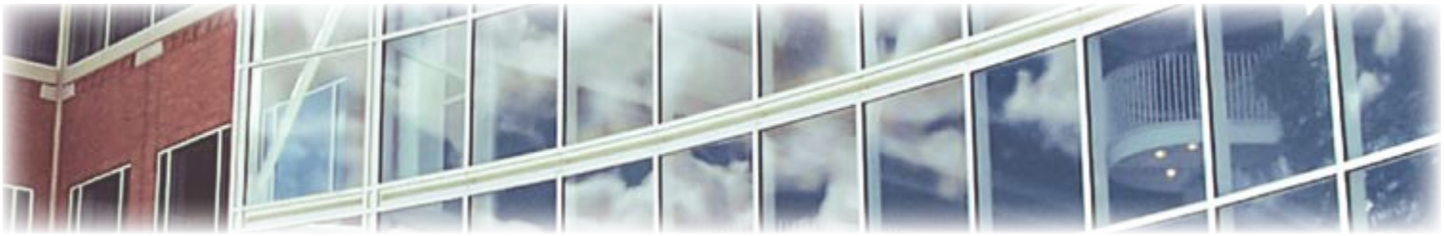
WEST CENTRAL REGION

Berkshire — **Fall District Meeting.** Tues., Nov. 3, 6:00 p.m. Location: Crowne Plaza, Pittsfield. Guest Speaker: Kenneth LaBresh, M.D. Topic: Guidelines for the Treatment of Elevated Blood Cholesterol Levels. This lecture has been approved for 1.25 *AMA PRA Category 1 Credits*™.

Hampden — **Fall District Meeting.** Tues., Nov. 10, 5:30 p.m. Location: Delaney House, Holyoke. **Executive Committee Meeting.** Tues., Nov. 24, 6:00 p.m. Hampden District Office, West Springfield. **Delegates Meeting.** Tues., Nov. 24, 6:30 p.m. Location: Hampden District Office, West Springfield.

Worcester — **A Night at the Movies.** Thurs., Dec. 17, 5:30 p.m. Location: Washburn Hall, Mechanics Hall. Film title: *Sicko* by Academy Award-winning filmmaker Michael Moore. This 2007 comedy/documentary presents a scathing analysis of the failures in America's health system. Combining powerful personal testimonies with shocking statistics, Moore pulls the curtain back on the greed and other undesirable influences impacting the American health care system. Group discussion and holiday celebration will follow.

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.



IN THIS ISSUE

MASSACHUSETTS MEDICAL SOCIETY

VITAL SIGNS

VOLUME 20, ISSUE 9, NOVEMBER 2015

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MMS AND JOINTLY PROVIDED CME ACTIVITIES

LIVE CME ACTIVITIES

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

Caring for the Caregivers X: Enhancing the Quality of Your Professional Life
Fri., October 30, 2015

2015 Women's Health Forum — Women's Health Across the Life Span: Adolescent to Geriatric
Fri., November 6, 2015

Initiating a Conversation with Patients on Gun Safety — Live Webinar
Wed., November 18, 2015

Managing Workplace Conflict
Thurs., November 19 and Fri., November 20, 2015

Cutting-Edge Advances in Women's Cardiovascular Care
Sat., March 19, 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 (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
- Managing Pain Without Overusing Opioids
- The Opioid Epidemic (6 modules) — MMS 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
- Intimate Partner Violence
- Understanding Clinical Documentation Requirements for ICD-10
- ICD-10: Beyond Implementation
- Prostate Cancer and Primary Care
- Cancer Screening Guidelines (3 modules)
- Preventing Falls in Older Patients: A Provider Toolkit
- 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

Additional CME Courses
- Carbon Monoxide Poisoning
- Genetically Modified Foods: Benefits and Risks
- Just a Spoonful of Medicine Helps the Sugar Go Down: Improve Management of Type 2 Diabetes
- Weighing the Evidence on Obesity

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.