VITAL SIGNS

Massachusetts Medical Society

Every physician matters, each patient counts.

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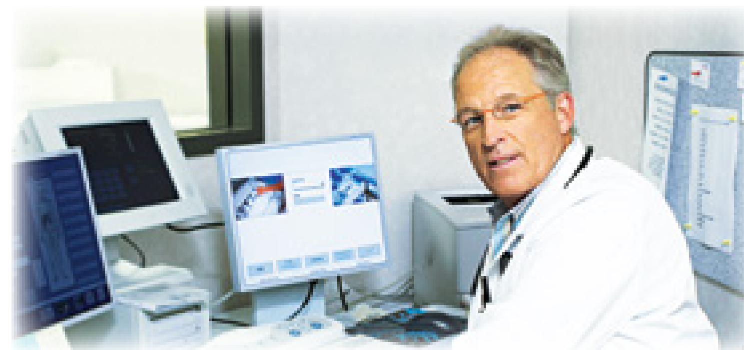

MACRA: What Physicians Should Know

New Tracks for Medicare Payment Begin 2019

BY DEBRA BEAULIEU-VOLK
VITAL SIGNS STAFF WRITER

After 17 years of frustration and disappointment, Medicare's flawed sustainable growth rate formula, long known as SGR, is finally history.

The premier feature of the new Medicare Access and CHIP Reauthorization Act, or MACRA, is that it creates a new payment system for physicians that fosters innovative delivery models while improving the myriad of disjointed penalty and measurement programs that plague the current fee-for-service (FFS) system.

"We no longer have the threat of 20–30 percent cuts in payment hanging over our heads," said MMS President Dennis M. Dimitri, M.D. "We have finally and completely replaced the flawed SGR formula."

Merit-Based Incentive Payment System

The law places physicians on one of two new tracks for Medicare payment beginning in 2019.

The first option, referred to as the merit-based incentive payment system, or MIPS, is closer in nature to FFS reimbursement, but it's going to be a new-and-hopefully-improved model for FFS, according to Alex Calcagno, MMS Director of Federal Relations.

Under MIPS, the Centers for Medicare & Medicaid Services will incrementally adjust its fees based on scores in clinical quality, meaningful use of electronic health records, efficiency, and practice improvement. Under the model, physicians will be compared either to their peers in the same specialty or to themselves to determine how they have maximized resources from year to year.

The good news is that this change will streamline several disparate quality reporting programs onto one. "The vast array of incentive and quality programs that currently exist in CMS have been very confusing to physicians," noted Dr. Dimitri. "Most of them are reaching the point where they can have negative impacts on physician payments, so the consolidation of much of that pay-for-performance will hopefully be simpler with less risk for payments to be cut."

However, the particulars of how that will look have yet to be determined. "We are just beginning the process, but in a perfect world we envision all these programs will be one coordinated system, and its metrics will be meaningful, valid, and scientifically verifiable," explained Calcagno.

Keeping some form of FFS reimbursement intact is important to sustaining the country's and Massachusetts' current base of physicians who are currently caring for patients, she added, noting that alienating physicians who weren't interested in bearing risk would create an insurmountable access crisis.

Alternative Payment Model

For physicians that are already comfortable with or attracted to

continued on page 5

A "Tipping Point" for Health Information Exchanges?

BY NICHOLAS SARGENT
MMS COMMUNICATIONS STAFF

Health Information Exchanges (HIEs) are software systems put into place to allow physicians using different EMRs or operating in different networks to communicate with one another and securely share patient information.

But the technology currently doesn't have enough participating doctors to achieve a "tipping point" and let it live up to its full potential.

The Mass HIway, the Massachusetts' state-run HIE built several years ago with matching federal and state funds, allows users to send HIPAA-compliant messages and patient information through a secure online messaging service called DIRECT Messaging. DIRECT Messaging is also used by several private HIEs that have partnered with the HIway to connect as many providers as possible. Independent exchanges include Wellport in Newburyport and eLINC, created to service Winchester Hospital and its surrounding communities. Both of these work with anyone connected to the HIway.

Both eLINC and Wellport have added additional clinical functions to their messaging systems. eLINC connects a community of doctors across 76 practices, provides services that include: DIRECT Messaging, instant delivery of lab and radiology results, as well as discharge and other reports from various hospital departments; improved communication among physicians; and, Emergency Department notifications to reduce patient readmission and more effectively manage patient care. It will be possible to connect with over two dozen EMRs systems for secure messaging. The collaboration between eLINC and the state also resulted in improvements to the DIRECT Messaging system. "The state has done an excellent job; they're very competent, and we partnered with them to expand their original vision of how DIRECT worked. We were happy to work with the state and they were willing to let us push the envelope,"

continued on page 2

New Mass. Opioid Guidelines

The Massachusetts Board of Registration in Medicine has unanimously voted to incorporate the MMS's recently developed "Opioid Therapy and Physician Communication Guidelines" into its new updated set of prescribing guidelines.

The new guidelines will be incorporated into existing Board policies and standards that have been in place for many years, as well as new advisories.

Last month, Gov. Charlie Baker announced the names of the 16 experts on the Massachusetts Opioid Drug Formulary Commission tasked with recommending

continued on page 4

PRESIDENT'S MESSAGE

Smart and Safe

With the end of the summer vacation season (which I hope you all enjoyed), a busy autumn is beginning at MMS.

We continue to be active partners in addressing the issue of opioid abuse in Massachusetts, and there have been several important developments.

The Board of Registration in Medicine has unanimously voted to incorporate the MMS's "Opioid Therapy and Physician Communication Guidelines" into its new updated set of prescribing guidelines. In the first week of September, MMS officials and deans from the state's medical schools met with Gov. Charlie Baker and Commissioner of Public Health Monica Bharel, M.D., to discuss approaches to developing innovative and collaborative curriculum consisting of core competencies for medical students on pain management, addiction, and safe opioid prescribing.

We were able to articulate to top state officials the challenges physicians face in helping patients with chronic pain, while also offering solutions on reducing the numbers of unneeded opioids. I'd like to call your attention to a wonderful piece on page 6 of this issue by Mark Green, M.D., describing this delicate balance.

Football fans may enjoy our new "Smart and Safe" public education campaign with Boston FM radio station 98.5 The Sports Hub and New England Safety Devin McCourty. We'll be playing these radio spots throughout the regular football season as part of our plan for educating the public about the potential dangers of opioids in their homes and engaging them in the solutions

I appreciate all the feedback about our efforts to reach prescribers and the public. Please keep it coming.

— Dennis M. Dimitri, M.D.

"Tipping Point" for HIEs

continued from page 1

said Jay Caturia, Winchester Highland's senior EHR project analyst.

eLINC has also pioneered a repository system that, according to Winchester Highland's Electronic Health Record (EHR) Director Eddy Rospide, allows users to create a "longitudinal view of the same case over time — basically a whole record that is made up of contributions from different providers, using different EMRs, to create a consolidated patient record." eLINC also provides integration services like EMR vendor engagement, HIPAA training, and patient authorization training.

HIway Partners

The other HIway partner is the Wellport Health Information Exchange. It was created by a medical community in the Merrimack Valley, a community that was an early pioneer in developing a community-based HIE. Although it is not as widespread as eLINC, the system was built by and for doctors, and their HIE also has a timeline system, shows full medical history/progress notes for the last three years, and is able to flag any issues that may have gone untreated too long or have worsened over time. Wellport can also use the DIRECT messaging system from HIway to email any particular part of the patient record to another doctor. Dr. Joe Heyman (former president of the MMS and current CMO of Whittier IPA, the company behind the Wellport HIE) would like to expand their system beyond the Merrimack Valley. "Our vision here is to make the HIE available to anyone who wants to subscribe, and give them access to full and robust clinical information," he said. Despite Massachusetts's relatively high and growing EHR penetration rate, more doctors and more patients need to be part of a HIE, whether it is private or the HIway. Dr. Joe Heyman says the current state of things is "like a chicken-and-egg thing — if the patients aren't in, the docs won't use it; and if the physicians aren't in it, it's harder to convince the patients to do it." Dr. Heyman commented that despite its usefulness, the HIway is "not a very well-used system — some physicians aren't even aware they have DIRECT addresses, especially in larger networks."

> **Resources**
>
> For more information about the HIEs discussed here, visit
>
> http://mehi.masstech.org/education/resources-tools/hie-toolkit
>
> www.elinc.biz
>
> www.masshiway.net/HPP/HowtoJoin/StepstoEnroll/index.htm
>
> www.wellporthealth.net/about.html

Slow Adoption

Massachusetts' status as a health information opt-in state is also a factor in the slow adoption rate, as patients need to fill out a consent form in order to have their information made available on a multi-network HIE.

Dr. Heyman said that for the Wellport HIE, their consent form can be a barrier. "I think it can be greatly improved, for example, to have the patients opt-in directly online," he added. "Consent can be an issue, but there is good guidance available to clarify what DIRECT Messaging entails for doctors and patients," according to Laurance Stuntz, the director of the Massachusetts eHealth Institute.

HIE Functionality Increasing

Despite the issues with early adoption, however, HIEs are only going to become more prevalent. The HIway has connected with major health systems and EMRs like Beth Israel, Partners Healthcare, and athenahealth, while eLINC is interfacing with MediTech, athenahealth, and Practice Partners. Many EHR vendors have only recently enabled full connectivity with HIEs, but now built-in connections and enhanced HIE-EMR functionality are becoming more common.

The cost of getting involved with an HIE varies depending on the complexity of the system, the size of the network, and several other factors; the eHealth Institute has compiled a price sheet for the cost of getting plugged into the HIway. The cost scales with the size of the practice or health network involved; a "Tier 1" provider, like a large hospital or commercial lab, will pay around $120,000 for full hardware integration into the HIway, while a "Tier 5" network (small practices of only one or two doctors) will only pay about $400. Anyone can sign up for a DIRECT webmail address for $5, regardless of his or her practice size.

What is the future of HIEs? That will vary from system to system, but Rospide and Caturia firmly believe that complete interoperability is both the "next big hurdle and next generation" of HIE technology. They envision a future where information can be easily and safely shared across all HIE systems throughout the state. Stuntz believes that the HIway will continue to expand; while it will never be as specialized as a private HIE, it will "focus on the highest-value systems that can be broadly applicable across many different geographies and providers."

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EDITOR: Erica Noonan
STAFF WRITERS: Deb Beaulieu-Volk, Vicki Ritterband

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

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

PRESIDENT: Dennis M. Dimitri, M.D.
EXECUTIVE VICE PRESIDENT: Corinne Broderick
DIRECTOR OF COMMUNICATIONS: Frank Fortin

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What You Need to Know about Price Transparency Regulations

BY KERRY ANN HAYON
PPRC DIRECTOR

Price transparency regulations that require physicians and hospitals to provide cost information for procedures and services to requesting patients has been in effect since January 1, 2014; however, there has lately been an increased focus from the media regarding this topic.

A recent *Boston Globe* article found overall awareness of the price transparency regulations and knowledge on handling patient requests for cost of services to be relatively low. Furthermore, conversation with physicians and practice managers reaffirm that cost information requests from patients is sparse.

Refining internal processes for handling these requests may be challenging, given the reportedly low volume of patient requests for cost information. It is important to make sure that your practice is ready to help in the event that a patient wants to know how much a service will cost. Here are the key points and considerations:

Requirements:

- If asked, providers have two working days to disclose allowed amount, defined as the contractually agreed amount paid by a carrier to a health care provider, or charge of an admission, procedure, or service.
- Providers must give patients or insurers any information — such as CPT codes — that their insurer needs to calculate what their out-of-pocket costs will be.
- Providers who participate in insurance contracts must provide "sufficient" information about the proposed procedure or service to allow a patient to use the insurer's toll-free telephone number/website established to disclose costs.

What Physicians Should Do:

- Provide the patient with the CPT codes for all anticipated services and procedures. Patients will provide those codes to their health plan to obtain the contracted costs for the professional services, facility fees, and out-of-pocket costs related to the request.
- Patients should also be given the phone number of the facility's billing office, which may be able to provide additional information about facility costs.
- Cooperate with health plans' requests for further information in a timely fashion, to help the health plans make the most accurate estimates possible for your patients.
- Create a documented process for handling patient requests, make sure your staff understand the requirements, and know how to handle patient requests for information.

Useful Resources:

Web resources located at **www.massmed.org/prices** contain additional helpful information including a link to a downloadable cost transparency worksheet that may be useful in providing the necessary information for patients to successfully obtain out-of-pocket cost from their health plans.

For additional questions, contact the PPRC Help Center at (781) 434-7702 or **www.massmed.org/pprc.**

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Important Changes in Massachusetts Earned Sick Time Law

The Massachusetts Medical Society has released a resource that informs employers in physician practices of the recent Earned Sick Time Law. Effective July 1, 2015, all Massachusetts employers must allow their employees to accrue and use sick time leave. The law broadly defines an *employer* as "an individual, corporation, partnership or other private or public entity… who engages the services of any employee for wages, remuneration, or other compensation." Alternatively, an *employee* is defined as "any person who performs services for an employer for wage, remuneration, or other compensation."

It is important to note that only employees whose "primary place of work" is in Massachusetts are eligible to earn sick time. Additionally, only employers that maintain an average of 11 or more employees on their payroll during the preceding year must offer paid sick leave. Employers with fewer than 11 employees only need to provide unpaid sick leave. To help explain this concept and view what it looks like in practice, please refer to the resource on the MMS website.

The rate at which sick time is earned is **1 hour of sick time for every 30 hours of work**. Forty hours per benefit year is the maximum amount of allowed sick time to be accrued within a year and unused hours can rollover to the following year. Exempt or salaried employees accrue based on their "normal work week," meaning the hours outlined in their employment contract.

Sick time accrued may be used for the following reasons:

1 Caring for their own physical or mental illness, injury, or medical condition

2 Caring for a physical or mental illness, injury, or medical condition of their child, spouse, parent, or spouse's parent

3 Attending their own routine medical appointment

4 Attending a routine medical appointment for their child, spouse, parent, or spouse's parent

5 Addressing the psychological, physical, or legal effects of domestic violence

6 Travel necessitate by any of the above

Employers violate the law if they interfere, restrain, or deny employees' to use earned sick time or by taking adverse action against employee for using their sick time. The severity of the violation defines the severity of penalties, which can include civil fines, written warnings/citations, criminal prosecutions, and/or private civil lawsuits. To comply with the Earned Sick Time Law, employers must do the following:

1 Provide their employees with notice of the Earned Sick Time Law

2 Comply with the Earned Sick Time Law's record keeping requirements

3 Review their existing policies and establish new ones

4 Consult with legal counsel to discuss their specific need related to the Earned Sick Time Law

Save the Date

Second Annual PPRC Talks Program

NOVEMBER 3, 2015, 8 AM–NOON
MMS HEADQUARTERS, 860 WINTER ST., WALTHAM

MMS is pleased to announce its second annual *PPRC Talks Program*. This exciting live program will offer insight into the various disruptive innovations in the health care marketplace and how they are expected to impact physician practices.

Opioid Guidelines
continued from page 1

whether drug products shall be placed on the Massachusetts Additional List of Interchangeable Drugs.

The group will assess and evaluate Schedule II and III opioids for four components — accessibility, cost, effectiveness, and abuse-deterrent properties. When a chemically equivalent drug with abuse-deterrent properties is available, the Commission may consider establishing it as an "interchangeable" drug as an alternative to the non-deterrent formula.

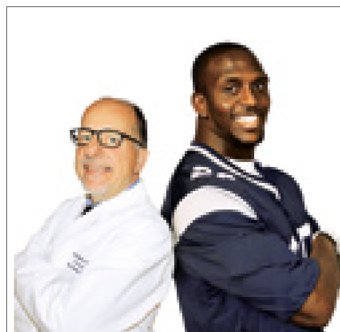
In recent weeks, Gov. Baker, along with Commissioner of Public Health Monica Bharel, M.D., also met with MMS officials and representatives from the state's four medical schools to discuss a physician-led approach in developing training and best practices for medical students on pain management and safe opioid prescribing.

Gov. Baker said he was "pleased with the quality of the dialogue" and saw the meeting as the first of several discussions with physicians about their role in addressing the opioid epidemic.

Commissioner Bharel said the meeting resulted in agreement to develop core competencies to educate future doctors on safe prescribing and pain management.

MMS President Dennis M. Dimitri, M.D., said physicians constantly face the "challenge of patients with ongoing pain, but the pressure of time, inadequate systems to help the physician and patient deal with pain, and the lack of alternative methods of pain relief covered by insurance put physicians in a tight box" where options to relieve pain were limited and opioids may be the only option readily available.

Dr. Dimitri added that doctors now recognize the impact of the number of opioids in the community and that too many have been allowed to be prescribed. He pledged MMS support of the Governor's effort. "We're very glad to participate in this process," he said.



"Smart and Safe" Radio Campaign on 98.5 FM The Sports Hub featuring New England Safety Devin McCourty and MMS President Dennis Dimitri, M.D.

In addition to policy developments at the state level, the MMS, Boston FM radio station 98.5 The Sports Hub, and New England Safety Devin McCourty recently launched a radio campaign to educate the public about steps they can take to help bring the opioid overdose epidemic under control.

Running every week until the end of the regular football season, the messages feature McCourty and Dr. Dimitri.

The "Smart and Safe" radio campaign is part of the Society's comprehensive program to address prescription drug abuse and opioid overdoses in the Commonwealth. The MMS is a strategic partner of the Medicine Abuse Project of the Partnership for Drug Free Kids. The project has produced two award-winning television commercials that highlight the needs to safeguard medications.

MMS made its CME courses on opioids and pain management free to all prescribers in late May, as part of its multi-pronged efforts to curb opioid abuse. Since then, these courses have been accessed more than 3,200 times.

Learn more at **www.massmed.org/SmartandSafe**.

ACIP issues 2015–16 Flu Vaccine Recommendations

In August, the Advisory Committee on Immunization Practices (ACIP) published its 2015–16 Influenza Vaccine Recommendations from the Advisory Committee on Immunization Practices.

"There are three best practices to fight the flu," said Susan Lett, M.D., a member of ACIP, and medical director of the state immunization program, "Get flu vaccination for your patients, your staff, and yourself. Treat flu presumptively in high risk patients, and basic infection control measures prevent spread. These measures include hand and respiratory hygiene and staying home when sick."

Dr. Lett highlighted the key points from the ACIP recommendations:

- Seasonal flu vaccine is recommended for everyone 6 months of age and older.
- Begin administering influenza vaccine as soon as the vaccine is available. Vaccination should not be delayed to procure a specific vaccine formulation.
- This year there is no preferential recommendation for anyone age-appropriate and approved flu vaccine formulation over another.
- For 2015–16 flu season, CDC and ACIP now recommend annual influenza vaccination for children 2 through 8 years of age with either nasal spray flu vaccine (i.e., LAIV) or flu shot (i.e., IIV), with no preference expressed when either one is otherwise appropriate and available.

The recommendations also include guidance on dosing for children 8 years and younger:

- Children 6 months–8 years of age who have previously received 2 or more total doses of trivalent or quadrivalent influenza vaccine as of July 1, 2015, only need 1 dose for 2015–16. The 2 previous doses do **not** need to have been given during the same season or consecutive seasons.
- Children 6 months–8 years of age who have previously received only 1 dose or no doses of influenza vaccine need 2 doses of vaccine to be fully protected for the 2015–2016 season.

New Vaccine Information Statements (VIS) for both IIV and LAIV for the 2015–16 influenza season are available. Find them, and additional information, at **www.cdc.gov/flu**.

For questions about flu vaccine recommendations, call the MDPH Immunization Program at (617) 983-6800 and ask to speak to an immunization epidemiologist or nurse. For questions about state-supplied flu vaccine availability, contact the Massachusetts DPH Vaccine Management Unit at (617) 983-6828.

Physician Practices Invited to Join Massachusetts Adult Immunization Coalition

The Massachusetts Adult Immunization Coalition invites physician practices to join more than 200 members representing state agencies, local public health, physician practices, community health centers, health plans, pharmacies, vaccine manufacturers, long-term care, elder care organizations, consumer advocacy groups, hospitals, home health, and college health services.

Quarterly meetings in person and by phone include presentations from the state immunization program, updates on supply issues from vaccine manufacturers, and discussion of timely issues important to members, such as flu season analysis, challenges in adult immunization, best practices, pandemic planning, and more.

For more information, visit maic.jsi.com, or contact Robyn Alie at (781) 434-7371 or ralie@mms.org.

MACRA
continued from page 1

the higher potential rewards of a risk-based system, however, an alternative payment model (APM) offers a guaranteed five percent annual payment increase from CMS over the first six years of the program.

But as with MIPS, many details about the APM are still unknown. "We don't know what those risk-based models are yet," noted Calcagno. "According to the law, participants will have to bear a 'substantial amount of risk,' but that's still undefined."

The law does provide funding for quality-measure development, at $15 million per year from 2015 to 2019, while physicians are to be given their leading role in developing quality standards. In fact, there is call in the legislation for various physician specialty societies to be actively engaged in the development of appropriate metrics, Dr. Dimitri noted.

A Transitional Time for Medicine

Because each practice is unique, there are no uniform steps they should be taking to prepare for the changes that will begin to take place in 2019. Rather, this is a time for practices to familiarize themselves with the options, become involved in developing quality measures, and examine them closely to make an informed decision about which payment model to adopt in the coming years (though physicians will be allowed to switch models from year to year).

Practices that are not already aligned may want to use this time to take a close look at being part of an accountable care organization, independent practice association, or becoming a patient-centered medical home, noted Dr. Dimitri, as these steps set the groundwork for involvement in alternative payment models and quality reporting.

Daunted by the complexity of the transition process, some practices have indicated that they may opt to take small pay cuts and forgo the potential for bonuses they could earn by participating in quality reporting programs, Dr. Dimitri said.

"Those practices will want to see what comes out of the support package [funded at $20 million per year from 2016 to 2020] that's being put together to provide technical assistance for small practices. And the medical society is going to keep a close eye on that so we can be sure practices that feel in jeopardy will be informed about how they can access that technical support and make the changes that will help them to survive fiscally soundly in the future."

At the moment, it's up to medical societies and health care systems to make sure the programs are implemented as Congress envisioned them and to help physicians get from A to Z, according to Calcagno. "Our job is going to be to help them make the transition and decide what's best for them and their patients," she said.

More on MACRA

Don't forget that MACRA includes other important provisions, such as a two-year extension of the Children's Health Insurance Program (CHIP). The law also extends funding for the CHIP and the National Health Service Corps, keeping the funding amounts for fiscal year 2016 and 2017 at the current fiscal year 2015 level. The last two "are both very important for creating an appropriate future work force of physicians as we go down the line," said MMS President Dennis M. Dimitri, M.D.

MMS Gearing Up for a Busy Fall on Beacon Hill

BY RONNA WALLACE
MMS LEGISLATIVE CONSULTANT

The MMS has been busy weighing in on a multitude of proposed legislation that may impact physicians and their patients.

One bill that has already seen two public hearings is "An Act Improving Medical Decision Making, sponsored by Rep. Chris Markey and the late Sen. Tom Kennedy. The purpose of H.107 and S.853 is to expedite the medical decision making process for patients without decisional capacity in order to ensure access to necessary care in a timely manner. These identical bills would grant family members legal authority to consent to medical treatment for patients who are unable to consent for themselves in situations where there is agreement about the need for standard treatment. The MMS presented oral and written testimony at separate hearings before the Committee on Children and Families and the Judiciary Committee. Joining the Society in support of these bills was Rebecca Weintraub Brendel, M.D., J.D., a psychiatrist at Harvard Medical School and Partners Healthcare.

At print time, H.107 and S.853 were pending and awaiting further action.

The following MMS bill filings have also had a public hearing and are awaiting further action by lawmakers:

- **H.417 "An Act Improving Students' Access to Life Saving Treatments."** This legislation would allow students to possess and self-administer glucose testing strips and insulin. The proposed language would also address the need for others to help students with diabetes by administering injection of glucagon. Joining the MMS in support of H.417 was the American Diabetes Association.
- **H.1200 "An Act Relative to the Valuation of Professional Practices in Divorce Proceedings."** This bill would ensure that professional corporations, including physician office practices, be valued at fair market value, as defined consistently with federal statutes governing other transactions involving physician practices.
- **S.601 "An Act to Provide for the Privacy of Information Submitted by Hospital Medical Staff."** This bill would safeguard the confidentiality of hospital medical staff members' personal and financial information disclosed pursuant to hospital conflict of interest policies.

Public hearings on other MMS bills are expected this fall. Legislation to promote physician-led health care teams; to increase the safety of bicyclists; expand consumer protections for MassHealth recipients; and to reduce administrative burdens for health care providers are all likely to have public hearings scheduled before the holiday recess in late November.

To date, the MMS has testified on approximately 40 pieces of legislation in the current session. One priority issue for the MMS and the state legislature that is expected to move this fall is opioid abuse. The MMS shares the Legislature's concern with the growing epidemic of prescription drug abuse, and will continue to work closely through the coming months with Gov. Charlie Baker's administration, the Executive Office of Health and Human Services Opioid Taskforce, and the Senate Opioid Taskforce, among other state and national groups.

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

PHYSICIAN HEALTH MATTERS

Helping, Not Hurting, Patients in Pain

*Our society's opioid crisis places enormous stress and strain on physicians. As we endeavor to do no harm, it can be difficult to provide effective treatment to chronic pain patients who may expect to be treated with opioid medications. Mark Green, M.D., is a board-certified addiction psychiatrist who led a comprehensive, interdisciplinary pain program at Kaiser Permanente in Colorado. Here in Massachusetts, he is the founder and principal of The Psych Garden (**www.psychgarden.com**), an addiction psychiatry practice providing a variety of consultative and treatment services.*
— PHS Director Steve Adelman, M.D.

BY MARK GREEN, M.D.

Doctors often wrestle with dilemmas. The profession has tried to establish ethical guidelines for resuscitation and end-of-life care following the desire of the patient.

But when it comes to treating chronic pain, it is even stickier. The patient may want relief of pain with opiates whilst the doctor feels that these drugs should be withheld or tapered, but then the patient is left in misery and pain. There is a clash between the wish of the patient, our desire to relieve suffering, and our duty to do no harm. In this column I want to suggest some ways to tease out this conflict and help both the patient and the doctor feel better about doing the right thing, even when that is hard.

Pain Is Powerful

Pain is such a powerful behavioral motivator and everything is tuned towards its alleviation. The stress hormone system is put on alert and manifests as anxiety and insomnia. Attention is tuned towards the pain, with brain and spinal cord components contributing to obsessions, hypersensitivity, and inability to focus on other life goals. Anything analgesic or distracting from pain becomes experienced as reward, sought out and repeated so that opiates are intensely reinforced while other reinforcers, such as relationships and family can pale. Such is the experience of the chronic pain patient.

As doctors we want to help. How can we refuse patients the medicines that they feel relieves their suffering? We now know that opiates have limited analgesic role in chronic pain, that over-using opiates can increase disability, decrease functioning, and contribute to another terrible disease — addiction. It's important to understand that the drugs of abuse are in this class because they have special qualities. They invoke tolerance, which means the body mounts compensatory responses to their presence that oppose their action. For example, opiates first suppress the stress response, which then rebounds back. On the behavioral level, people can temporarily avoid distress but there is a rebound, demanding a predictable relief. It's like throwing a shovel to a man stuck in a pit. They feel helped and can be distracted. The doctor can feel she or he has done something, but really, to what end? At what point, and for whom, will they be the shovel that only helps that patient in the hole dig himself deeper?

Risk of Losing Control

Several scales try to estimate risk of losing control of opiates and doctors must attempt to categorize risk level considering past or present history of addiction (because it is too easy to reawaken a long-dormant beast), family history (because genetics make drugs more compelling and reinforcing), psychiatric history (because emotional pain is also profoundly, and temporarily relived by opiates, making them more reinforcing), and disability claims (because we all need incentives to keep us on the track of functioning, especially when that path can brings pain). We can be wrong, because both the question and the answers can be inexact, and because anyone can lose control. Conversely many can erect sufficient safeguards and external contingencies to limit drift towards the abyss. But doctors need to see this ongoing assessment as crucial in the process of helping a patient. For is our goal to provide mere instant relief or the overall long-term well being of the patient? For that matter, what is our responsibility to public health, to limit the enormous leakage of opiates onto the street, which has contributed to the alarming rise of opiate-related morbidity and mortality?

Tip of the Iceberg

This is my mentality when I'm with a patient: I am keeping in mind the harm that I could do by prescribing, and trying to act on behalf of the patient. I hear a request for opiates as the conscious tip of the iceberg, and try to dive down to see the motivational forces beneath. It always amazes me that patients welcome this deeper level of concern and caring for their wellbeing. When we talk about addiction risk and about how opiates ramp up the stress system and can cause hyperalgesia and a cycle of suffering, they generally accept that opiates may be a poor choice, or that we must carefully monitor for the emergence of aberrant behaviors. When I review that, with taper of opiates, pain often decreases whilst functions improves, we can start on a new path of hope, even if pain may be there. Many have already noticed that escalating doses of opiates have not brought satisfaction. They can see they are in a hole and need help an escape. I don't offer them nothing: There are so many non-opioid approaches to chronic pain including medications, physical and psychological interventions. We can work together towards meeting deeper recovery goals. It's at this point that some patients declare themselves. They are not interested in recovery but in getting drugs. That is an important diagnosis, with a quite different treatment plan. I will not be facilitating their demise. To me, this is the essence of being a physician: collaborating with the totality of the patient, believing in health and doing no harm.

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**.

Please be sure to join us!

PHYSICIAN HEALTH SERVICES, INC.

Caring for the Caregivers X

ENHANCING THE QUALITY OF YOUR PROFESSIONAL LIFE

MASSACHUSETTS MEDICAL SOCIETY

OCTOBER 30, 2015

Massachusetts Medical Society Headquarters at Waltham Woods, Waltham, Massachusetts

For more information, contact PHS at 781.434.7404 or go to www.massmed.org/cme/events.

12th Annual Fall Forum for Free Health Care Programs

Free Medical Programs and Mental Health: How Can We Deliver What Is Needed?

Join our discussion on this important topic.

Wednesday, October 14, 2015, 6:00–8:30 p.m.
MMS Headquarters, 860 Winter St., Waltham.

For more information and to RSVP, contact Carolyn Maher at cmaher@mms.org, or (781) 434-7311.

Senior Volunteer Physician of the Year Award

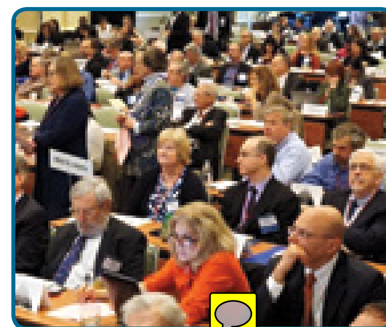
Nomination deadline is Oct. 30

The MMS Committee on Senior Volunteer Physicians is seeking nominations for the 2016 Senior Volunteer Physician of the Year Award.

For the criteria and additional information, visit www.massmed.org/volunteeraward, or contact Carolyn Maher at cmaher@mms.org, or (781) 434-7311.

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.
- Submit your resolutions at **www.massmed.org/resolutions** by October 20.
- Hotel deadline is November 3. Please visit **www.massmed.org/IM15reservations** or call the hotel at (617) 969-1000.

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

Charles River — **Delegates Meeting.** Wed., Sept. 30, 6 p.m. Location: MMS Headquarters, Waltham.

Middlesex West — **Fall District Meeting.** Thurs., Oct. 22, 6 p.m. Location: Framingham Country Club, Framingham. Speaker: MMS President Dennis Dimitri, M.D. “Opportunities for Physician Advocacy in 2015–2016.”

Norfolk — **Fall District Meeting.** Wed., Oct. 7, 6 p.m. Location: Sheraton Needham Hotel, Needham. Speaker: Noah Wilson-Rich, Ph.D. “Urban Beekeeping and Honey Health”.

Suffolk — **Fall District Meeting.** Tues., Oct. 6, 6 p.m. Location: Downtown Harvard Club, Boston. Speaker: Lisa Rosenbaum, M.D. Topic: “Can Beliefs about Conflicts of Interest Create a Conflict of Interest?” CME credit available.

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

SOUTHEAST REGION

Barnstable — **Fall District Meeting.** Tues., Oct. 6, 6 p.m. Location: Coonamesett Inn, Falmouth. Guest Speaker: Sheriff James M. Cummings. **Legislative Breakfast.** Fri., Oct. 16, 7:30 a.m. Location: Cape Cod Hospital, Hyannis.

Bristol South — **Fall District Meeting.** Wed., Oct. 28, 6 p.m. Location: Venus de Milo, Swansea. Guest Speaker: MMS President Dennis Dimitri, M.D.

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 p.m. Location: Crowne Plaza Pittsfield.

Worcester — **10th Annual Louis A. Cottle Medical Education Conference.** Tues., Oct. 26, 5:30 p.m. Location: Beechwood Hotel. Guest Speaker: Heather Forkey, M.D., clinical director for the Foster Children Evaluation Program at the UMASS Children’s Medical Center. **Fall District Meeting and Awards Ceremony.** Mon., Oct. 6, 5:30 p.m. Location: Beechwood Hotel, Worcester.

Worcester North — **Legislative Breakfast.** Fri., Oct. 2, 7:30–9:00 a.m. Location: Doubletree, Leominster. **Fall District Meeting.** Wed., Oct. 21, 6 p.m. Location: Oak Hill Country Club, Fitchburg. Speaker: Stephen Boos, M.D. Topic: Recognizing and Responding to Child Abuse.

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

STATEWIDE NEWS AND EVENTS

Arts, Humanism, History, and Culture Member Interest Network — **Executive Committee Meeting.** Wed., Oct. 7, 6 p.m. Location: MMS Headquarters, Waltham. **Bird Banding.** Sat., Oct. 17, 9:00 a.m.–noon Joppa Flats, Newburyport.

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.**

Robert J. Carey, M.D., 86; Arlington, MA; Boston University School of Medicine, 1954; died November 7, 2014.

Menahem Cooperstein, M.D., 100; Taunton, MA; Boston University School of Medicine, 1941; died April 7, 2015.

Brian CF Dalton, M.D., 84; Rockport, ME; Royal College of Surgeons, Ireland, 1953; died March 3, 2015.

William L. Glass, M.D., 76; Lakeville, MA; Boston University School of Medicine, 1961; died July 3, 2011.

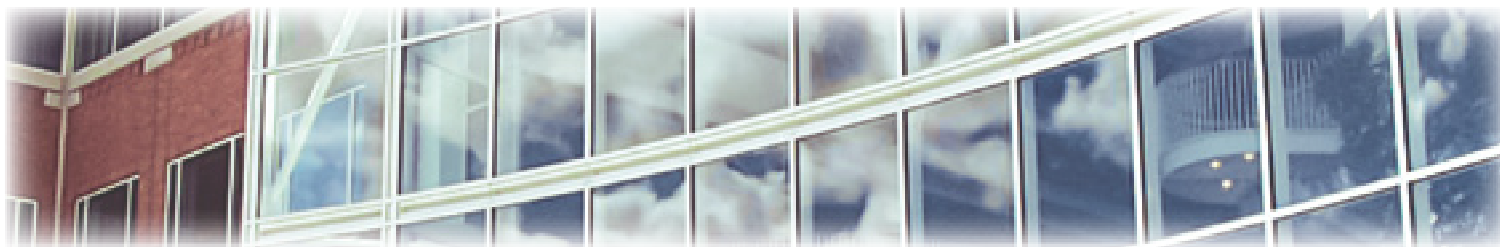
Charles H. Hemminger III, M.D., 85; Northampton, MA; Jefferson Medical College of Thomas Jefferson University, 1956; died April 15, 2015.

Robert E. Klotz, M.D., 85; Derry, NH; University of Cincinnati College of Medicine, 1952; died February 4, 2013.

Cynthia S. Kretschmar, M.D., 69; Brookline, MA; Yale University School of Medicine, 1978; died May 27, 2015.

Francis A. Lombardo, M.D., 86; Winchester, MA; Tufts University School of Medicine, 1953; died June 18, 2015.

John S. McGovern Jr., M.D., 90; Brewster, MA; Tufts University School of Medicine, 1953; died April 2, 2015.



IN THIS ISSUE

1 > MACRA: What Physicians Should Know
> A "Tipping Point" for HIEs?
> New Opioid Guidelines

2 > President's Message: Smart and Safe

3 > Price Transparency Regulations
> Changes to Mass. Earned Sick Time Law

4 > 2015–16 Flu Vaccine Recommendations
> Join Mass. Adult Immunization Coalition

5 > Busy Fall on Beacon Hill

6 > Helping, Not Hurting, Patients in Pain
> Caring for the Caregivers on Oct. 30

7 > MMS Interim Meeting Dec. 4–5
> Senior Volunteer Physician Award Nominations Due
> Across the Commonwealth
> In Memoriam

Massachusetts Medical Society

VITALSIGNS

VOLUME 20, ISSUE 8, OCTOBER 2015

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MMS AND JOINTLY PROVIDED CME ACTIVITIES

LIVE CME ACTIVITIES

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

Patient Experience Summit — A Leadership Certificate Program
Tues., October 27, 2015 -– Session II

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

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

NEW! Understanding Clinical Documentation Requirements for ICD-10

NEW! Carbon Monoxide Poisoning

Risk Management CME

Electronic Health Records Education (3 modules)
- Module 1 — Guide to Heath Information Technology
- Module 2 — Making Meaningful Use Meaningful
- Module 3 — Meaningful Use Stage 2

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
- Principles of Palliative Care and Persistent Pain Management (2 modules)
- Opioid Prescribing, Risk Management of Opioid Therapy and the Opioid Abuse Epidemic (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
- Prostate Cancer and Primary Care — NEW
- Cancer Screening Guidelines (3 modules)
- 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?
- Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
- Effective Chart Review for Quality Improvement

Additional CME Courses
- 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
- Aggregating the Evidence on Antiplatelet Drugs: A Review of Recent Clinical Trials
- Acid Suppression Therapy: Neutralizing the Hype
- Preventing Overuse of Antipsychotic Drugs in Nursing Home Care
- A Roadmap to Bring an End to HIV and STDs in Massachusetts (3 modules)

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.