

VITAL SIGNS



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MEDICAL SOCIETY

Every physician matters,
each patient counts.



VOLUME 20, ISSUE 7, SEPTEMBER 2015

The Mind-Body Disconnect: Realigning Behavioral and Medical Health Care

BY VICKI RITTERBAND
VITAL SIGNS STAFF WRITER

In 2010, Lisa Halpern had back-to-back emergency abdominal surgeries. Her hospital physicians took her off her medications for schizophrenia, which they believed would interfere with her post-operative recovery. They also ignored her eating disorder, she said, which resulted in dramatic weight loss during her hospitalization, landing her in a residential eating disorders program post-discharge.

“They did amazing work with the surgery — I can’t thank them enough for saving my life,” says Halpern, director of recovery services at Vinfen, a provider of community-based services to people with disabilities. “But they weren’t concerned about my being off my medications. They did not think it was their job to worry about my eating disorder or schizophrenia.” It was Halpern’s outpatient psychiatrist who put her on a different antipsychotic medication that would not exacerbate her stomach problems.

Despite a preponderance of evidence that illnesses of the mind and body are inextricably linked, behavioral and medical health care too often run on parallel tracks. Halpern’s experience was very typical in Massachusetts, according to a groundbreaking report on behavioral health released recently by Massachusetts Attorney General (AG) Maura Healey — the fourth in a series looking at health care cost trends and drivers in the state. The study examined the way behavioral health benefits are administered and reimbursed

and how those processes meet the state’s goals of health care reform: delivering care that’s well coordinated, high quality, and cost-effective. The conclusion? Behavioral health care in Massachusetts is poorly coordinated with medical care, underfunded, opaque about issues of cost and capacity and unable to measure quality because of a paucity of “robust” metrics, Healey’s report found.

Separate and Not Equal

As a psychiatrist, Rohn Friedman, M.D., is all too familiar with the issues highlighted in the report. He, like the AG, believes that much of the blame lies with the fact that many Massachusetts health plans “carve out” behavioral health benefits and subcontract their management to managed behavioral health care organizations that have separate administrative and claims systems. While the original intent of the carve-outs was to rein in psychiatric costs, the unintended consequences have been numerous and harmful to patients, he says.

First, the majority of mental health services require prior authorization, forcing patients who may be in crisis to jump through hoops. Then the provider networks tend to be quite narrow and finding a provider who accepts new patients can be challenging. Finally, for the many patients with both psychiatric and medical problems, communication between the two sides of their care is virtually nil. “You can’t analyze data to understand the connection between a patient’s medical and psychiatric care

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Physicians Task Force Announces Opioid Recommendations

2,500 Complete MMS CME on Opioids, Pain Management

The AMA Task Force to Reduce Opioid Abuse, which includes the MMS, recently announced the first of several recommendations to reduce the public health crisis facing the country.

The nation’s largest physician organization said the coalition, comprised of 27 physician organizations including the AMA, American Osteopathic Association, 17 specialty and 7 state medical societies, and the American Dental Association, has been formed to identify and implement the best practices to engage physicians in curbing opioid abuse.

The task force is focused on several areas: prescription monitoring programs, physician education, reducing the stigma of substance use disorder, enhancing access to treatment, and expanding access to naloxone.

“This is a welcome development in the fight against opioid abuse,” said MMS President Dennis M. Dimitri, M.D. “It will combine the strengths of the nation’s major medical organizations, bring greater and more constant attention to this public health crisis, and supplement specific approaches already underway by

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smart and safe

“We Have a Lot of Work to Do”

Vital Signs Talks with U.S. Rep. Seth Moulton



Seth Moulton

MMS Director of Federal and Community Relations Alex Calcagno recently sat down with U.S. Rep. Seth

Moulton. Congressman Seth Moulton was born and raised in northeastern Massachusetts. After graduating from Harvard in 2001 with a degree in physics, Moulton joined the U.S. Marine Corps and served four tours in Iraq as a Marine Corps infantry officer, including two tours as a platoon commander and two tours as a Special Assistant to General David Petraeus. He was elected to Congress in 2014 and serves on the House Armed Services Committee and the House Budget Committee.

VS You are a new member of Congress, a Democrat from Massachusetts. What has that experience been like so far?

REP. MOULTON I think it’s very difficult but many of us have come to Washington with a mandate from our constituents to work together with our colleagues across the aisle. The reality in Washington is that not many people do. The institution is set up to be very partisan; you don’t spend much time with people on the other side of the aisle. Most meetings, most social gatherings are essentially divided by party. So what I have been doing is reaching out to Republicans and getting to know them.... I went on

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PRESIDENT'S MESSAGE



Our Patients and Opioids

The opioid abuse crisis continues to be a top priority for us.

I am pleased to report significant progress both in Massachusetts and on the national level. Our state leaders have created an action plan and comprehensive approach to this complex problem. It reframes addiction as a medical disease while recognizing the physician's duty to ensure access to medication for patients in need.

The plan also supports initiatives that physicians have urged for some time and embrace wholeheartedly: more drug take-back days, increases in the co-prescribing and bulk purchasing of the life-saving drug naloxone, more treatment programs, eliminating insurance barriers to treatment, and improvements in the state's prescription monitoring program.

The MMS is actively reaching out to patients, focusing on the critical areas of proper storage and disposal of medications and an upcoming radio public service campaign that will continue through the end of the year.

But we as physicians can do better. More than half of enrolled prescribers don't routinely use the prescription monitoring program, and most patients say their doctors still don't discuss the risks of addiction when prescribing pain medication.

An estimated 75 percent of those 12 years of age and older who use opioids for nonmedical reasons are using drugs prescribed to someone else.

As those closest to the patients, as the ones who prescribe their medicines and treat their pain, perhaps one of the best things we can do is raise patient's awareness of their responsibility to properly store and dispose of their medications.

— Dennis M. Dimitri, M.D.

Realigning Behavioral and Medical Health Care

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because they're in separate silos," said Dr. Friedman, president of the Massachusetts Psychiatric Society. "That flies in face of the era we're in now — where the focus is on coordinating and integrating health care overall." The disconnect between the two is even more illogical considering that many psychiatric illnesses are managed by primary care providers.

The PCP Perspective

Every day in his Worcester office, internist George Abraham, M.D., appreciates how mental illness can profoundly affect physical health and vice versa. He estimates about one out of every five of his patients also suffers from a psychiatric illness; that number is even higher if he includes people who experience an episodic behavioral health issue, such as depression after a loved one dies. And the opposite is also true: on Tufts Medical Center's inpatient psychiatric unit, between 30 and 40 percent of patients also have a significant medical illness, according to chairman of psychiatry Paul Summergrad, M.D.

"You don't want to silo out each organ system and illness because they're so intertwined," said Dr. Abraham. "Depression affects how patients control their diabetes, how motivated they are to exercise and how compliant they are with medication. And conversely, one side effect of some behavioral health medications is weight gain." While poor communication among different segments of the health care system is not unusual, it's especially bad when dealing with the world of behavioral health, making it challenging to coordinate a patient's care, says Dr. Abraham. "We get

no notes, no records. We don't know what medications our patients are on and we have to depend on our patients to tell us."

Perverse Incentives

There is also a compelling financial argument for better integrating behavioral health and medical care, according to the AG's report. Massachusetts commercial and public payers spend on average 2–2.5 times as much on patients who have a chronic disease plus a behavioral health condition than on those who have only a chronic medical condition. But because managed behavioral health care organizations are only on the hook for behavioral health care costs, they have little incentive to better coordinate care with the medical side, the study concluded.

Dr. Friedman sees this misalignment of financial incentives manifested in the long waits psychiatric patients often experience in the emergency room until an inpatient behavioral health bed opens up.

"From the standpoint of the mental health carve-outs, if the patient is staying in the ER for five days, they're not paying for much of anything because the patient is in a 'medical' hospital," explained Dr. Friedman.

If you invest more money in the mental health side, you'll more than recover the costs on the medical side, but you can't see that if the two columns are in completely different systems," he said.

Integrated Care Models as Solution

Pilots of an approach called integrated medical-behavioral health care have shown to improve outcomes and save money and more of them should be launched, according to Dr. Summergrad. The approach plays out differently depending on the context, but it

generally means bringing behavioral health care resources into a primary care office. For example, a care manager from the PCP's practice would keep tabs on patients with depression, calling them to make sure they're taking their medication and not suffering side effects. The PCP manages the depression treatment, supervised by a psychiatrist who is available for consults. If the patient's depression is not responding, the patient would be referred to specialized treatment, but the PCP and the psychiatrist would be on a shared EMR system, so all providers know what's going on.

Integrated medical-behavioral health care does exist in Massachusetts. For example, Boston Medical Center is piloting the use of social workers, psychiatric nurse practitioners and patient navigators in its family medicine practices. The Massachusetts Child Psychiatry Access Project, offers pediatricians and family practice physicians quick access to consultative services over the telephone with child psychiatrists. And meanwhile, MassHealth is beginning to promote integrated care through its Primary Care Payment Reform Initiative, which gives primary care providers risk adjusted capitated payments that encourage behavioral health integration.

As for Halpern, she has devised her own solution to the problem of fragmentation: she created her own multi-disciplinary care team, comprising an internist who specializes in eating disorders, a nutritionist, a psychiatrist and a therapist. "They communicate on email regularly and I'm the leader of the team," she said.

See related story on page 4.

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After the Oct. 1 Deadline: Key Considerations for ICD-10 Implementation

BY JILLIAN PEDROTTY
PPRC SPECIALIST

With the implementation of ICD-10 on the horizon, physician practices should be gearing up for the conversion taking place October 1.

CMS, in conjunction with the AMA, recently announced that it will allow for flexibility in the claims auditing and quality reporting process for the first year until the medical community becomes acclimated to the new coding system. For one year, Medicare claims will not be denied or audited solely on the specificity of the ICD-10 diagnosis codes provided, as long as the physician submitted an ICD-10 code from an appropriate family of codes. CMS will also establish an ICD-10 ombudsman and communication center to assist physicians during the transition, and will authorize advanced payments if Medicare contractors are unable to process claims within established time limits due to

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.

problems with ICD-10 implementation.

But it is still vital for practice managers to be prepared to implement ICD-10 and make payment and other metric comparisons between pre-ICD-10 and post ICD-10 implementation. The following are some key considerations:

- **Beware of Payment Delays:** It is important to note that reimbursement may be delayed as payers get accustomed to the new coding system. Focus on consistent and proper documentation, which directly impacts accurate code assignment, billing, and payment timing.

- **Watch Reimbursement:** During the adjustment phase, it will be extremely important to monitor reimbursement across plans. Assigning a point person to monitor reimbursement with particular attention to reconciling payments to charges submitted will help to measure the impact of implementation to the practice. If payments are taking longer than usual for any particular payer, consider reaching out to the payer to investigate the reason and determine if there are any operational process changes at the practice level that would help.

- **Monitor System Glitches:** Identifying and addressing possible glitches in your practice's electronic systems is critical and can help deter potential operational problems. Having a plan in place that all staff are aware of in the event that problems do occur is extremely crucial. Consider who the point person should be, what the appropriate chain of escalation looks like and being sure that all staff are aware in order to facilitate working through the challenge in a timely manner.

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LAW AND ETHICS

BY LIZ ROVER BAILEY
MMS ASSOCIATE COUNSEL

In Massachusetts, a minor (someone under 18 years of age) cannot enter into a contract and cannot give consent. Therefore, a 17-year-old patient cannot consent to medical treatment, and a physician must obtain permission from the patient's parent or guardian before providing care.

Fortunately, as with many general rules, exceptions exist, so that some sorts of care may be provided to a minor even without the consent of the parent or guardian. These exceptions, which are based on the status of the minor or the sort of care provided, include the following:

Exceptions based on the minor him- or herself:

- **Mature minor** — A minor can consent to any medical treatment other than abortion if the doctor reasonably believes the

Your Practice and Treating Minors

minor can give informed consent to the treatment and it is in the minor's best interest not to notify the parents or guardians.

- A minor in the armed forces may consent to any treatment except abortion.
- A minor living separate or apart from parents/guardians and managing his or her own affairs may consent to any treatment except abortion.
- A minor who is a parent may consent to any treatment for him- or herself or his or her child, except abortion.
- A minor who is pregnant may consent to any treatment except abortion.
- A minor who is (or has been) married may consent to any treatment.

Exceptions based on the type of care:

- Emergency care does not require parent/guardian consent

if withholding treatment would endanger the minor.

- **Drug abuse** — Minors 12 or older who have been found to be drug-dependent by at least two doctors may consent to treatment for substance abuse, except for methadone maintenance therapy.
- **Alcohol abuse** — If the minor is intoxicated and applies for treatment at a detoxification facility, or is brought to the facility, the minor may receive treatment at the facility, except that he or she may be released to the parent or guardian.
- **Sexually transmitted diseases** — A minor who reasonably believes he or she is suffering from or has been exposed to a disease classified as dangerous by the Department of Public Health may seek treatment for that disease.

- **Mental health treatment** — Minors who are 16 or older may consent to admission at a mental health treatment facility.
- **Family planning services** — Sexually active minors of child-bearing age may access family planning services offered through the Department of Public Health without the consent of a parent or guardian.
- **Abortion** — A minor who is married, divorced, or widowed can obtain an abortion without the consent of a parent or guardian. Otherwise, she may seek parental consent, or the consent of a judge of the Superior Court.

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.

Compañeros en Salud: MMS Foundation Grant Recipient Delivers Rural Primary Care in Mexico

In the spring of 2015, Cynthia So-Armah — a second-year resident in internal medicine at Brigham and Women's Hospital — received a \$1,500 grant from the Foundation's International Health Studies Grant program. Below is a synopsis of her international experience of March/April 2015.

BY CYNTHIA SO-ARMAH, M.D.

I arrived to Chiapas, Mexico, at the beginning of the monthly course that *Compañeros en Salud* (CES) offers to its *pasantes* (Mexican medical doctors completing their one-year social service obligation). CES works in 10 rural communities, supporting 10 *pasantes* with clinical supervision, monthly classes and global health training, while supplementing the meager income, medications, and supplies that the government offers. I was struck by how bright and driven the *pasantes* were, all of them choosing to live far from home in isolated communities while being on call 24/7 for their patients.

The bulk of my work in Chiapas was centered on supervising and supporting the *pasantes* in three remote communities, where the *pasantes* provided care for the entire population. The challenges were many, including how to structure a clinic day when appointments are merely a suggestion, often with 1 *pasante* seeing up to 30 patients without an assistant to help register patients and take vital signs.

What I offered to the *pasantes* was accompaniment, feedback

on clinical skills and management, and dedicated teaching on relevant topics. I learned a great deal from the *pasantes*, as I was

As I observed the *acompañantes*, I came to a few conclusions about what makes a successful program. *Acompañantes* are not a substitute



forced to challenge myself to make diagnostic decisions without laboratory testing or radiology imaging. I was also invited to speak about hypertension on the CES hour of a local radio show, fielding calls about myths around hypertension and its treatment.

CES and the *pasantes* have worked to support a program of *acompañantes* (community health workers), lay people from the community who visit patients in their homes to ensure they are taking their medications correctly, while providing social support and uncovering challenges patients are facing that may not be apparent during clinic visits.

for doctors, but work best in close communication with doctors. Their roles and capabilities must be clearly defined. Furthermore, while incentives allow *acompañantes* to dedicate time to their work and show appreciation for the support that they provide, they should be chosen based on intrinsic characteristics of volunteerism, interest in supporting patients through tough social circumstances, and compassion for those struggling.

The friends and colleagues I met during this trip will be invaluable resources as my future trajectory in global health unfolds. Thank you for helping to make this experience possible!

MMS to Offer CME on Carbon Monoxide Poisoning

The MMS has a new CME module about the dangers of carbon monoxide poisoning. The course was pioneered by Theodore Macnow, M.D., a pediatric emergency medicine fellow at Boston Children's Hospital. The module will be available online to provide physicians with the best possible tools to learn.

Annually, there are 50,000 emergency department visits, and an estimated 3,000 deaths due to carbon monoxide poisoning.

"It is responsible for more deaths than any other gas. Chronic carbon monoxide poisoning can be occult and mimic many other conditions and is associated with myriad long-term morbidities," said Dr. Macnow.

More information on the new course is available at www.massmed.org/environment.

AG Report: Behavioral Health Bed Shortages

If you're a general acute care hospital in Massachusetts, it's likely your behavioral health program operates in the red — and that's an economic reality that has resulted in a shortage of beds for psychiatric patients. Among the 18 acute care hospitals that reported behavioral health margins between 2010 and 2013, their cumulative inpatient margin was negative 39% for their commercial

"There's no reason hospitals should be paid less for this care..."

— Paul Summergrad, M.D.

and government business and negative 82% for outpatient, according to a recent Massachusetts Attorney General report examining behavioral health cost trends and drivers.

"Many hospitals have chosen to not provide psychiatric care — particularly inpatient care — because they can't get reimbursed to cover their costs, even though everyone agrees that patients really need this care and are often waiting in those same hospitals' emergency rooms for a psychiatric admission," says Paul Summergrad, M.D., chairman of the department of psychiatry at Tufts Medical Center and immediate past president of the American Psychiatric Association. "There's no reason hospitals should be paid less for this care and it's up to insurers, the legislature, and regulators to do something about this."

It's tough to even get a handle on the size of the access problem because managed behavioral health care organizations often keep their data close — not just access data, but statistics on cost and quality as well. Additionally, the lack of consistent payment data and methodologies makes it difficult to compare prices across different providers and identify trends, according to the AG's report.

See *Vital Signs* cover for related story.

Opioids

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Massachusetts elected officials and physicians.”

AMA Board Chair-Elect Patrice A. Harris, M.D., said the AMA Task Force is “committed to working long-term on a multi-pronged, comprehensive public health approach to end opioid abuse in America.” The initial approach of the collaboration will focus on several areas: prescription monitoring programs, physician education on safe prescribing of opioids, assessment and treatment of pain, reducing the stigma of substance use disorder, enhancing access to treatment, and expanding access to the life-saving drug naloxone.

“The efforts of the task force,” Dr. Dimitri said, “can only add strength to our efforts in the Commonwealth.” He said the AMA’s effort is benefiting from the expertise of its Massachusetts representative, Richard S. Pieters,

M.D., immediate past president of the MMS. Dr. Pieters is a radiation oncologist at UMass Memorial Health Care, board certified in hospice and palliative care, and a cancer pain specialist.

Dr. Dimitri said the Commonwealth has taken substantial strides in addressing the epidemic in the state. Gov. Charlie Baker and Attorney General Maura Healey have made the crisis a top priority and the Governor’s Opioid Working Group has issued an action plan with a number of recommendations that are in the process of being implemented.

Dr. Dimitri said the those recommendations — among them improving the prescription monitoring program, reducing stigma by reframing addiction as a medical disease, implementing treatment programs, and making naloxone more accessible — have been supported by Massachusetts physicians for some time.

The MMS has been reaching out to both prescribers and patients to educate them about safe prescribing and proper storage and disposal of prescription medications with a comprehensive opioid education and addiction prevention program called Smart and Safe.

Since making all MMS continuing medical education courses on opioids and pain management free to all prescribers in late May, nearly 2,500 health professionals have taken one or more courses in the first two months.

To meet demand, the Society added nine courses on the topics since last year, when only 400 completed such courses in a comparable period.

Dr. Dimitri also cited improvements, now in progress, to the state’s prescription monitoring program that will make it easier for physicians to use. One key change: reducing the time for pharmacy reporting of opioid

prescriptions from two weeks to 24 hours, an action that should reduce “doctor shopping” by patients.

The new Massachusetts state budget includes \$111 million for substance abuse services, and the Gov. Baker has requested another \$27.8 million in supplemental spending for treatment and prevention. U.S. Health and Human Services has also announced a \$100 million effort for medication-assisted treatment, and Massachusetts will share in that program.

Creative new approaches have come from law enforcement as well. Gloucester’s Angels Program has enrolled nearly five dozen people into treatment since it began June 1, and the program has led to similar efforts in other communities.

[Read more news and updates at www.massmed.org/opioids.](http://www.massmed.org/opioids)

U.S. Rep. Seth Moulton

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two fact-finding missions for the Armed Services Committee and spent an awful lot of time getting to know the Republicans that were on those missions with me. I think that if you can develop a personal relationship with someone across the aisle then you can often have a professional relationship. One Republican reached out to me about a budget issue recently because he knows I am veteran. And I reached out to a Republican and we wrote an op-ed together. So the early signs are a little optimistic.

VS We know that veterans’ issues [are] obviously something of interest to you. Are there specific areas in terms of veteran health care?

REP. MOULTON: I’m particularly concerned about veteran’s health care; I get my health care from the VA (Department of Veteran’s Affairs) and have made a pledge to continue to do so until we can get the system back on track. I have a lot of friends and colleagues from serving that are not getting the best care and I think

that veterans deserve the best care. So there are a lot of improvements that we need to make in the system but there are some parts of the VA that work very well. My primary care physician for many years in Boston was one of the best primary care physicians I have ever had, but then it would take months to get an appointment if he referred me to someone else. The bureaucracy itself is broken and is really constructed for a different era. We have a lot of work to do.

VS Do you have specific ideas about initiatives you want to work on, particularly in health care?

REP. MOULTON One place that I am particularly concerned about is mental health care. So many veterans are coming back with mental injuries that weren’t survivable a decade ago and so the system isn’t set up to adequately handle them.

VS Tell us about your work on the medical device tax repeal effort.

REP. MOULTON I have said from the beginning that the Affordable Care Act (ACA) is a huge step in the right direction for

America. But I don’t think the ACA is perfect and this is an example of one of the tweaks that I think needs to be made. The problem with the medical device tax is that it disproportionately affects the small innovative companies that are actually driving the innovation that’s in the long run going to help lower health care costs. The 2.3 percent tax might not seem like much but it doesn’t come out of profits, it comes out of revenue and for a small company that doesn’t have a big compliance team, they need to hire people just to implement the tax and so the actual cost to the company is much higher than the 2.3 percent. It needs to change now. I’m working with my Democrat and Republican colleagues to try and find some offsets for the revenue because we can’t ignore that.

VS Do you have bipartisan support?

REP. MOULTON We do have bipartisan consensus on this issue. We have 400 med tech companies in Massachusetts, about 23,000 people directly employed and there are about 75,000 people that are indirectly employed. So it’s huge.

VS Has anything surprised you so far about your experience in Congress?

REP. MOULTON You can make a difference if you’re willing to reach out and I think you have to pick your battles. I’m a freshman in a minority party but I have been able to have an impact on some issues, mainly because I’m careful about where I focus my efforts. ISIS and Ukraine are the topics in people’s minds right now, everyone’s very concerned and I think with good reason. That’s why I went out on those two fact-finding missions. It is unusual to get on Armed Services as a freshman.

VS What drove you to run for national office?

REP. MOULTON I’m happy to answer that. It really is because of my time in the war. I saw some of the consequences of failed leadership of Washington when I was in Iraq and I would like to have a small part in fixing that. But I did not grow up wanting to be a politician. This is all new.

PHYSICIAN HEALTH MATTERS

Physician Health: What Does Personal Finance Have to Do With It?

BY STEVE ADELMAN, M.D.
PHS DIRECTOR

Many of the distressed medical students, residents, and practicing physicians who make their way to us at Physician Health Services are contending with financial stresses and challenges that contribute — in a significant way — to their personal and professional difficulties. Here are six common pitfalls we've observed at PHS, along with some advice about how to avoid them.

1 Excessive Debt
It is not uncommon these days for newly minted physicians to leave medical school with a debt burden in the range of \$200,000–\$300,000. Debt of this magnitude can be crushing in the early stages of a career, with the downstream consequences lasting decades. Young people should consider educational options, such as excellent state medical schools, as well as

employment options that offer potential loan repayment.

2 Following the Money Instead of the Passion
Although some specialties are far more lucrative than others, it is important to pursue a career in medicine that is, in part, governed by what Sigmund Freud referred to as “the deep inner needs of our nature.” Going for the gold can often backfire, so beware.

3 Wanting to Have It All
Life is all about trade-offs. Maximizing one's earnings may not square with spending quality time with one's children, or with distinguishing oneself academically in a teaching hospital. Physicians who take on too much may be more susceptible to occupational stress and burnout than those who learn to pace themselves without reaching for the stars. Pay attention to the larger picture, especially your home life.

4 Not Living within Your Means
Most financial planners will tell you that the expense side is as important as the revenue side of personal finance. Lavish primary residences, vacation homes, fancy cars, and private schools are luxuries, not necessities. A problematic expense item that comes up frequently involves physicians' financial support of their adult children, which sometimes lasts into the fourth decade. Foster financial independence in your children from an early age. Ron Lieber's book, *The Opposite of Spoiled*, is a must-read for every physician raising a family.

5 Assuming a Long and Lucrative Career
The saddest physicians are those struck down by serious medical, psychiatric, or family problems in mid-career. Protect yourself and your family with adequate and competitively priced disability, long-term care, and life insurance policies.

6 Inadequate Retirement Planning
Aim to maximize your annual contributions to your retirement plan every year, and confer with wise domain experts to determine a balanced investment strategy that will allow your nest egg to grow. Many physicians think that we know more about investing than we actually do. Try your best to become financially literate. The National Association of Personal Financial Advisors offers a “How to” Guide on its website, www.NAPFA.org.

In conclusion, managing your finances effectively throughout your career can be a source of joy, security, and well-being.

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

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

Charles River — Family Outing. Clambake aboard the Lexington. Sun., Sept. 13, noon–3:00 p.m. Location: Charles River Boat Company, Rowes Wharf, Boston.

Essex South — Clambake. Sat., Sept. 12, 1:00 p.m. Location: Wingersheek Beach, Gloucester.

Middlesex — Jazz Brunch with Balloon Artist. Sun., Sept. 27, 11:00 a.m.–1:00 p.m. Location: MMS Headquarters, Waltham.

Middlesex Central — Delegates meeting. Thurs., Sept. 17, 7:45 a.m. Location: Emerson Hospital, Concord. 5th Tuesday Program. Tues., Sept. 29, 11:45 a.m. Location: Emerson Hospital, Concord.

Middlesex North — Fall Outing. Thurs., Sept. 17, 5:30 p.m. Location: Kimball Farms, Westford.

Norfolk — Executive Committee Meeting. Wed., Sept. 9, 6:00 p.m. Location: MMS Headquarters, Waltham.

Suffolk — Student, Young Physician, Resident Reception. Thurs., Sept., 10, 7:00–9:00 p.m. Location: Clery's, Boston.

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

SOUTHEAST REGION

Norfolk South — Executive Committee Meeting. Tues., Sept. 15, 6:30 p.m. Location: Abby Park Restaurant, Milton.

Plymouth — Executive Committee Meeting. Wed., Aug. 26, 6:00 p.m. Location: MMS Southeast Regional Office, Lakeville.

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

Worcester — 24th Annual Women in Medicine Breakfast. Fri., Sept. 25, 7:30 a.m. Location: Beechwood Hotel.

Worcester North — Legislative Breakfast. Fri., Oct. 2, 7:30–9:00 a.m. Location: Doubletree, Leominster.

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.

Senator
Thomas P. Kennedy,
1951–2015



Massachusetts Sen. Thomas Kennedy, a Brockton Democrat and longtime advocate for improved health care for all residents of the Commonwealth, died June 28, 2015. He was 63.

Sen. Kennedy served in the state House of Representatives for more than 30 years. A paraplegic since age 19, he became an effective voice in Beacon Hill for the disabled and the elderly. He improved disability access in his home city of Brockton and sponsored many bills to improve the lives of the disabled and patients across the state. Sen. Kennedy's voice will be missed.

Six Resolutions Submitted on Behalf of New England at AMA 2015 Annual Meeting

BY ALAIN CHAOUI, M.D.
MMS AMA DELEGATION CHAIR

Your MMS AMA Delegation offered six resolutions at this Annual Meeting that were accepted by the New England Delegation and ultimately submitted on behalf of New England.

- 127 Controlling Rapidly Escalating Generic Medication Prices — **adopted as amended**
- 234 Preserving Free Speech and Confidentiality in the Physician-Patient Relationship — **adopted**
- 525 Medical Consequences of Nuclear War and the Need to Abolish Nuclear Weapons — **adopted as amended**
- 526 Recycling Pharmaceutical Profits to NIH Funding — **referred for decision**
- 601 Engaging and Empowering our Members — **not adopted**
- 711 Protecting against Forced Network Exclusivity of Specialist Physicians — **adopted as amended**

In addition, the MMS sections submitted the following resolutions to their individual section meetings.

OMSS Assembly Meeting

- Mixed Medical Staff Governance and the Election Process — **referred for report back**
- Increasing Collaboration between Physicians and the Public to Address Problems in Health Care Delivery — **adopted**

as amended and then adopted at AMA HOD #612

- Quality Measure Oversight — **adopted as amended and then referred at AMA HOD #716**
- Protecting Physician Led Health Care — **substitute 12 adopted in lieu and then referred to AMA HOD #238 adopted as amended**

RFS

- Evaluation of Factors during Residency and Fellowship that Impact Routine Health Maintenance — **adopted as amended and will be forwarded to AMA HOD at I-15**

MSS

- Business of Medicine as a Core Component of Medical Education — **AMA POLICY D-295.958 reaffirmed in lieu of this resolution language**
- Medical School Admissions Deferral and Student Mental Health — **not adopted**

In addition to our delegation members, the Delegation mentored five MMS Ambassadors at this meeting, allowing them to learn more about organized medicine at the national level. If you wish to know more about this mentoring program, please contact mjussaume@mms.org.

Read more about the meeting at www.ama-assn.org.

2015 Interim Meeting of the MMS House of Delegates

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



- Online registration opens in late September.
- Submit your resolutions at massmed.org/resolutions by October 20.
- Deadline for hotel rooms is November 3. Please visit massmed.org/IM15reservations or call the hotel at (617) 969-1000.
- Other Interim Meeting events include: A Town Hall Meeting with the Presidential Officers, the Annual Oration, the bi-annual Ethics Forum, and the 10th Annual Research Poster Symposium.



Residents/Fellows and Medical Students: Research Poster Abstracts Due October 13

The 10th Annual Research Poster Symposium, sponsored by the MMS Resident and Fellow and Medical Student Sections, will take place on Friday afternoon, December 4, at MMS Headquarters in conjunction with the MMS Interim Meeting. The symposium offers a venue for residents, fellows, and medical students to display their research and compete for cash prizes in four categories: basic research, clinical research, clinical vignettes, and health policy/medical education. The deadline for submission of abstracts is Tuesday, October 13.

For detailed submission guidelines and more information, go to www.massmed.org/postersymposium or call Colleen Hennessey at (800) 322-2303, ext. 7315.

Upcoming Events

Networking Event for LGBT Health Care Providers

Sponsored by the MMS Committee on Lesbian, Gay, Bisexual and Transgender Matters

THURSDAY, OCTOBER 15, 2015 AT 7:00 P.M.

CLUB CAFÉ, 209 COLUMBUS AVENUE, BOSTON, MA

A price fixed menu for \$15 per person (includes tax and tip). Drinks are extra.

At this event, Jesse M. Ehrenfeld, M.D., will receive the MMS 2015 Lesbian, Gay, Bisexual and Transgender Health Award, an honor recognizing an individual who has made outstanding contributions to LGBT health. To read more about Dr. Ehrenfeld's accomplishments, visit www.massmed.org/lgbt.

To RSVP, contact Erin Tally at etally@mms.org or (781) 434-7413.

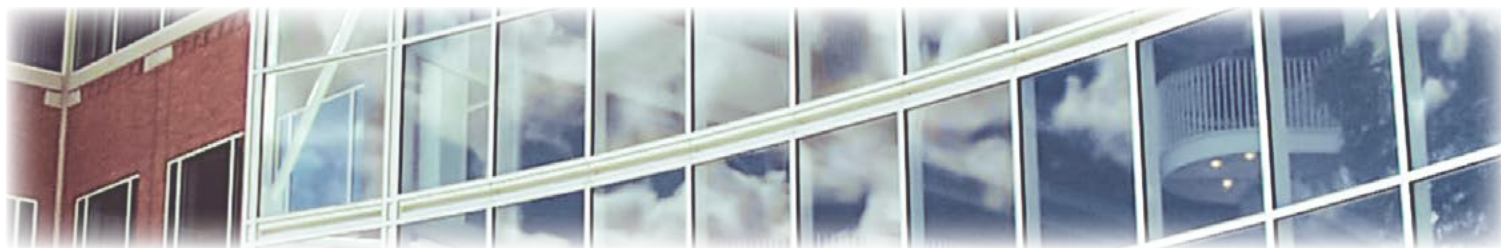
Medical Student Mentoring Night

OCTOBER 8, 2015, 5:30 TO 9:00 P.M.

MMS HEADQUARTERS, WALTHAM

Once again, the MMS Committee on Women in Medicine is pleased to host the Annual Medical Student Mentoring Night. This event is open to both pre-medical and medical students. Various workshops with topics of interest to both medical and pre-medical students will be offered.

This event is free and includes raffles, dinner, and networking opportunities. For questions, contact Dr. Helen Cajigas at heca2013@gmail.com.



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MASSACHUSETTS
MEDICAL SOCIETY

VITALSIGNS

VOLUME 20, ISSUE 7, SEPTEMBER 2015

860 Winter Street, Waltham, MA 02451-1411

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MMS AND JOINTLY PROVIDED CME ACTIVITIES

LIVE CME ACTIVITIES

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

Women's Leadership Forum: Leadership at Every Level

Sat., September 26, 2015 *Save the Date*

Patient Experience Summit — A Leadership Certificate Program

Wed., September 30, 2015, and Tues., October 27, 2015

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 *Save the Date*

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 Health Information Technology
- Module 2 — Making Meaningful Use Meaningful
- Module 3 — Meaningful Use 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
- 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



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.