MMS Presses Forward in Opioid Battle

A Balanced Approach
The MMS worked aggressively this past year in the State House to promote a balanced approach to the opioid crisis that respects the government’s desire to limit over-prescribing while also ensuring that physicians maintain the ability to properly manage a patient’s pain. The MMS has stressed that the education of physicians and prescribers is imperative to reducing abuse and misuse. Making our CME courses on opioids and pain management free to all prescribers was a critical step the MMS took.

In a span of 14 months, from May 26, 2015, to August 1, 2016, a total of 17,063 of the Society’s CME courses in pain management and safe opioid prescribing were completed by 5,905 individuals. The MMS is offering 18 courses, with titles such as New Opioid Prescribing Guidelines in

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What’s At Stake: Recreational Marijuana Ballot Question

Speaker of the House Robert A. DeLeo, the Massachusetts Hospital Association, the Association for Behavioral Healthcare, the Massachusetts Chiefs of Police, the Massachusetts Association of Superintendents, among others.

What’s at stake, the MMS believes, is the health of the people of Massachusetts, particularly its adolescents and children.

“We’re very concerned about the lack of research with regard to the individual and public health effects of marijuana,” said MMS President James S. Gessner, M.D. He added that “the studies that have been done and the experiences in Colorado and Washington state, where recreational marijuana is legal, show serious public health consequences.”

Studies have shown negative effects on cognition and brain development in youth and young adults who use marijuana. “We are very worried about how this law would affect our young people,” added Dr. Gessner.

While the ballot question would ban sales to people under 21, “those kinds of laws have massively failed. First, kids are the group that is most interested, and second, they’re better customers,” said Sharon Levy, M.D., adding that it’s much harder to restrict kids’ exposure to the Internet advertising of today’s world. Dr. Levy is director of the Adolescent Substance Abuse Program at Boston Children’s Hospital, where marijuana use disorder is the most common reason for referral to the program.

The American Academy of Pediatrics (AAP) opposes the legalization of recreational marijuana.
Practice, Managing Pain Without Overusing Opioids, Safe Opioid Prescribing for Chronic Pain, and Alternatives to Opioids. This has proven to be an effective tactic. According to a report by alternate health in July, the number of opioid prescriptions in the Commonwealth has declined by 25 percent, more than in any other state in the nation.

“The education of physicians and prescribers appears to be making a difference,” declared Dr. James S. Gessner, MMS president, to The Boston Globe on July 6. Medical education remains a MMS priority through the following initiatives:

- Prescribing guidelines for acute and chronic pain management created and issued in early 2015
- Offering CME courses related to opioids, management, and substance abuse and making these courses available free to all prescribers via the MMS website
- Partnering with the Department of Public Health (DPH) and deans of the medical schools to establish an innovative set of core competencies to be taught in all four medical schools in the Commonwealth
- Expanding the teaching of core competencies into medical residencies
- Assisting DPH in developing an improved prescription monitoring program — MassPAT — to promote best prescribing practices and prevent “doctor shopping” for medications
- Public information print and video campaigns directed to patients to encourage discussions with physicians and proper storage and disposal of prescription medications

National and Local Recognition
The MMS has been enlisted for its expertise and advocacy work on the national as well as local level. The U.S. Surgeon General in June invited representatives from the MMS to share lessons learned in its response to the public health crisis, and the MMS is one of a handful of state medical societies represented on the American Medical Association’s Task Force to Reduce Prescription Opioid Abuse. Locally, Gov. Charlie Baker has praised the MMS for its work with the medical schools’ core competencies. By focusing on prevention, education, treatment, and recovery, the MMS continues to provide a comprehensive plan of attack, including acknowledging that addiction is a disease and taking steps to erase the stigma that comes with it.

Much of the focus of the state legislature over the past year has been on prevention and prescribing. The governor’s legislative proposal led with a provision limiting the size of first-time prescriptions and increasing the mandated use of the prescription monitoring program. The Board of Registration in Medicine also addressed prescribing by adopt- ing the Medical Society’s prescribing guidelines into its own broader prescribing guidance.

The MMS has worked on both the state and federal levels to promote “partial filling” of opioid prescriptions, namely the ability to allow a patient to elect to receive a portion of the prescription but to be able to return to receive the remainder if the patient’s pain persists. In July, Congress passed federal legislation amending Drug Enforcement Agency regulations to allow states to pass bills allowing for “partial filling” — a tactic that reduces the amount of drugs that could potentially be misused.

From Prevention to Treatment
Now that the one-year mark has passed, what lies ahead? The MMS, through the guidance of its leadership and the Task Force on Opioid Therapy and Physician Communication, is redirecting its focus to implementation and treatment. The first area of focus of the MMS will be ensuring that the provisions of the law put in place are carried out in a fair and thoughtful manner. The governor’s opioid bill has dozens of provisions that will affect physicians. These provisions are being closely monitored by the MMS and include the prescribing limits and exceptions, and the emergency department substance use disorder evaluations. The MMS has been working closely with the DPH to ensure a seamless transition to the new MassPAT system. This includes supplementing communications to ensure all physicians understand the process to sign up for and use the new system.

The second area of focus is treatment. The Opioid Task Force is exploring various strategies to facilitate education and understanding of medically assisted treatments including buprenorphine, methadone, and naltrexol. The MMS has also advocated for the expansion of coverage of opioid alternatives — both pharmacologic and nonpharmacologic — to treat pain. This is of particular importance as physicians face continual pressure to reduce opioid prescribing.
Implementing Telemedicine into the Physician Practice

BY JILLIAN PEDROTTY
PPRC SPECIALIST

The physician-patient relationship has transformed over the last couple decades and the emergence of telemedicine technologies is a contributing factor. As defined by the Institute of Medicine, telemedicine is “the use of electronic information and communications technology to provide and support health care when distance separates participants.” Telemedicine comes in various forms — from inexpensive smartphones to more complex equipment.

Many practices that have engaged in telemedicine experience enhanced patient access and experience, reduced costs, and improved case management. As more physicians explore the use of electronic information and communications technology into their practice, the following strategies should be considered to ensure a smoother transition:

- **Conduct a Needs Assessment:** Since each practice is unique, there is no “one-size-fits-all” model for implementing telemedicine. Therefore, it is important to conduct a needs assessment and to identify areas in your practice where telemedicine would make sense and would improve operations.
- **Ensure Leadership Support:** Telemedicine is an extension of the traditional patient consults and represents an innovative shift in how health care services are delivered; it is extremely important to have a vision and support from the leaders of the organization. Without support from the top of the organization’s hierarchy, it will be difficult to obtain the necessary resources required for a successful implementation.
- **Research Vendors:** It is important to pick a vendor that provides the functionality needed to improve efficiency, not hinder it. Some vendors may not make sense for smaller practices and vice versa, so it is essential for stakeholders to have a full understanding of the specific functionality and niche a specific vendor fits into.
- **Develop an Implementation Plan:** The implementation plan should be detailed and address all the areas that require adjustment due to the organizational change and any anticipated barriers. It is important to remember that there is likely to be circumstances that arise which might offset your timeline, but don’t let that deter your progress and do your best to get back on track.
- **Monitor Performance:** Once the telemedicine program is implemented and initiated, the process shouldn’t stop there. There should be a process in place using tangible metrics that evaluate how the change has impacted the organization. A performance monitoring system will be able to help you monitor projects and determine if the outputs and services are being met.

Achieving an Optimal Co-payment Collection Rate

BY ALEXIS KLYM
PPRC SPECIALIST

All physician practices face challenges managing collection of co-payment fees. Success can be achieved by applying often overlooked strategies that increase co-payment collection rates. Reaching an optimal co-payment collection rate enables practices to reap benefits financially, freeing health care professionals to dedicate attention to the patient experience. Setting a 95 percent co-payment collection rate is a commendable target.

Consider the following strategies to boost collection rates:

- **Research:** Gather a team from the clinical viewpoint, the revenue cycle service, and the electronic medical record system to identify common collection barriers. Brainstorm solutions and pilot process improvement proposals at select clinics. Consider leveraging new technology or perhaps new administrative methods to proactively pursue late payers.
- **Educate:** After receiving feedback, develop educational materials for distribution. Create tip sheets to instruct administrators on how to correct reoccurring issues, such as how to manage the amount due once a patient has met his or her yearly out-of-pocket maximum for the year. Materials directed to patients should underscore the basics of co-payments, including when and why the amount of a co-payment may change.
- **Evaluate:** Track your practice’s performance on co-payment collection rates by analyzing metrics, such as the number of visits that require co-payments, the total co-payment amounts due, and the total co-payment amounts collected. Communicate performance measures to administrators on a monthly basis to reveal significant improvements and declines. Analyze non-collections and under-collections for trends and patterns and further investigate existing dilemmas.

For more information on enhancing the collection of co-pays, watch a webinar at www.massmed.org/copays.
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In a technical report published last year, the AAP wrote that “despite ongoing regulation of the tobacco and alcohol industries, youth remain common targets and ultimately consumers of these products.”

Another troubling issue is that the Massachusetts ballot question allows the sale of edibles, a point that the Supreme Judicial Court ruled in July that the ballot question must make clear after a citizens group challenged the ballot question as misleading, asserting that 45 percent of the marijuana products sold in Colorado are food and beverages.

In the year after recreational marijuana sales became legal in Colorado, calls to the area poison control center for marijuana exposure soared 70 percent. Many of these exposures are from marijuana edibles, namely, food products containing marijuana, such as brownies, chocolates, or candy.

“At the absolute rate of these exposures is low, the ingestions [of marijuana edibles] have the potential to be serious, even leading to hospitalization and necessitating critical care treatment,” said Alan Ehrlich, M.D., assistant professor of family medicine at UMass Medical School and the executive deputy editor for DynaMed.

Because of the significant delay between ingestion of marijuana contained within edibles and the onset of effects, users may not perceive the desired psychoactive effect quickly enough or may consume too much, Dr. Ehrlich noted. He referenced a tragic story of a 19-year-old college student who consumed a marijuana cookie containing six times the standard amount of THC, and, experiencing acute psychosis, jumped to his death from a hotel balcony in Colorado.

Dr. Ehrlich also noted that individuals with a personal or family history of psychosis may be at increased risk for developing schizophrenia if exposed to marijuana before brain development is complete in their early 20s.

“The acute problems are easy to pick up,” said Dr. Levy. “The biggest part of the story here is what happens with exposure over time, particularly during adolescence — the effects on the brain — cognitive decline and mental health problems. There’s good data on the chronic long-term problems. Kids who start using marijuana, we’ll see a problem with mood, anxiety, drops in IQ, poorer functional outcomes, lower likelihood of establishing a family, poorer school outcomes.”

Risk for Addiction

Studies have shown other neuro-psychiatric adverse effects, including cognitive effects and addiction. Marijuana is the third most common cause of drug dependence in the United States, after tobacco and alcohol. An estimated 9 percent of those who try marijuana will become addicted — 17 percent for those who start using as teenagers and as many as 25 to 50 percent in those who use marijuana daily.

Dr. Levy noted a “pretty clear link” that marijuana is a gateway drug to other substance use, including opioids. “Cannabinoid receptors and opioid receptors are on the same neurons. It appears that [marijuana use] ‘primes the pump,’ changing the cell in ways that make it more vulnerable to opioids.”

The MMS has advocated that the Drug Enforcement Agency (DEA) reschedule marijuana so that its health effects can be studied more rigorously. Marijuana is currently listed under the Controlled Substances Act as a Schedule I drug, defined by the DEA as “drugs with no currently accepted medical use and a high potential for abuse... with potentially severe psychological or physical dependence.”

The classification makes it extremely difficult to obtain the drug for research purposes.

Trend toward Liberalization

Since 2012, the national trend is tipping toward widespread liberalization of marijuana laws. Twenty-five states, including Massachusetts, have already voted in favor of medical marijuana. Four states — Colorado, Washington, Alaska, and Oregon — and the District of Columbia have legalized recreational marijuana. Four additional states — California, Nevada, Maine, and Arizona — will vote on referenda to legalize recreational marijuana this year.

Liberalization of marijuana laws has brought an increased risk of motor vehicle accidents, as marijuana can impair coordination, reaction time, and sensory perception. The AAA Foundation for Traffic Safety found the percentage of drivers involved in fatal crashes who recently used marijuana more than doubled in the year after legalization. In 2014, one in six drivers involved in fatal crashes in Washington state had recently used marijuana.

Proponents claim that legalizing marijuana in Massachusetts would make it safer by regulating it, and point to potential boons of increased tax revenue and jobs. The basis for these claims, however, is unclear, since the legislation allows for home cultivation of marijuana.

And, according to findings by the Massachusetts Legislature’s Special Senate Committee on Marijuana, the anticipated uptick in revenue may actually result in a shortfall. In a report released in March of this year highlighting the concerns and considerations of the ballot question, the senate committee stated that “revenues and fees that would be generated from legal sales may fall short of even covering the full public and social costs and should not be expected to provide a significant new funding source for other public needs.”

If passed, Massachusetts would impose a 3.75 percent tax on retail marijuana sales, and municipalities could impose an additional two percent tax. By contrast, Washington state imposes a 37 percent tax at point of sale and Colorado imposes a 15 percent excise tax on the first transfer or sale from the cultivator to the consumer.
Health Information Technology Continues to Evolve

BY LEON BARZIN
MMS HIT DIRECTOR

“Health Information Technology does indeed hold promise, but its priority should not be on data collection, but on how it can raise the level of patient care — a goal shared by each of us as physicians.”

— James S. Gessner, M.D.,
President, MMS, June 2016

The 2009 passage of the American Reinvestment and Recovery Act (ARRA) injected $35 billion into medicine to computerize hospitals and practices. This type of investment over a relatively short period often causes as many disruptions as it brings improvements. The advent of electronic health records (EHRs) is a prime example. Adoption of EHRs increased from single digits to over 90 percent in less than seven years, forcing serious disruptions in the workflow of many practices. Among myriad complaints is that technology has distanced the physician from the patient. Patients frequently remark that their doctors spend an inordinate amount of their appointment time staring into a screen laboriously typing on a keyboard and checking boxes.

Over the years, the MMS Committee on Information Technology (CIT) has developed resources to smooth this transition, including publishing the ARRA Advisor newsletter, the Guide to Information Technology, and hosting several live educational events. Currently, the CIT is focusing on further evolving technology to restore the physician-patient relationship and strengthening the autonomy of the physician in working with patients and their data.

In May the MMS House of Delegates approved a seven-point framework for how HIT should be integrated into practice. These included recommendations that technology should:

• Support the physician’s obligation to put the interests of the patient first
• Support the patient’s autonomy by providing access to that individual’s data
• Be safe, effective, and efficient
• Have no institutional or administrative barriers between physicians and their patients’ health data

• Promote the elimination of health care disparities
• Support the integrity and autonomy of physicians
• Give physicians direct control over choice and management of the information technology used in their practices

As HIT continues to evolve, the CIT intends to employ these principles to help all MMS members to better use technology and patient data to enhance physician-patient relationships and to strengthen their partnership toward better health.

Medical Library Expands Services

BY JOSH ROSENFELD
MMS COMMUNICATIONS ASSISTANT

Since opening its doors on the second floor of the MMS headquarters in 2000, the Boston Medical Library (BML) branch has offered MMS members access to articles as well as reference assistance through the Countway Library, a partnership between the BML and the Harvard Medical Library.

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retail establishment, and a 10 percent sales tax on marijuana on top of the state sales tax, and local tax on recreational sales.

One troubling aspect of the ballot question is that no revenue from the sale of recreational marijuana is earmarked for administration and enforcement, public health, prevention, education, treatment, or research. By contrast, California’s ballot question earmarks $100 million over 10 years for research, and $50 million over five years for local programs supporting mental health and substance use disorder treatment, system navigation services, job placement assistance and other services, as well as youth education, prevention, early intervention, and treatment services.

“We’re so incredibly underresourced in terms of helping kids with substance use disorders,” Dr. Levy said, noting there’s a push to do interventions in primary care, but then the next step up is rehabilitation. “That leaves an enormous gap, patients with marijuana addiction are all going to fall into this gap. As marijuana becomes more toxic and more concentrated, we can predict that we can see more kids with problems and families struggling with what to do.”

“This ballot question was written by and for the marijuana industry with no real consideration of public health consequences,” Dr. Gessner said, noting that MMS has developed resources and materials for physicians to help them answer patients’ questions about marijuana leading up to the vote.

“We want to make sure physicians and their patients are aware of the serious public health implications of this ballot question,” Dr. Gessner said.

Information on the health effects of marijuana, an analysis of the ballot question, a flyer for patients, links to the Report of the Special Senate Committee on Marijuana, and other resources are available on www.massmed.org/marijuana.

Climate Change and the Growing Risk of Nuclear War: A Health Care Perspective

SATURDAY, OCTOBER 15
TUFTS UNIVERSITY SCHOOL OF MEDICINE, SACKLER AUDITORIUM
9:00 AM–4:00 PM

Join fellow physicians at a one-day symposium examining the public health consequences of climate change and the ways in which climate change can increase the risk of conflict, including nuclear war.

For more information and to register, visit www.psr.org/chapters/boston/events/symposium.
PHYSICIAN HEALTH MATTERS

Risky Prescriptive Practices that Endanger Physician Careers and Patients

BY STEVEN ADELMAN, M.D.
PHS DIRECTOR

We have a serious opioid epidemic in the United States. In the Commonwealth, we are averaging three to four opioid-related deaths per day. All eyes are on the medical profession: advances like electronic health records and mandated prescription monitoring programs have increased the visibility of the prescriptive practices of all physicians. The new Massachusetts Prescription Awareness Tool (MassPAT) launched on August 22, and as of October, the system will have to be queried every time a physician writes a prescription for a Schedule II or III medication.

MassPAT is intended to help us combat the opioid epidemic. It is too soon to know how it will unfold. It won’t be a surprise if some individual physicians are identified as high-risk prescribers. Although the current focus is on “high-risk prescribing” of opioid medications, some general principles about prescribing may be considered across the board. What can you do to minimize potentially risky prescribing?

Review the Board of Registration in Medicine’s (BRM) prescribing guidelines, which incorporates the MMS’s opioid prescribing guidelines, last amended in October 2015. These guidelines state, “To be valid a prescription must be issued for a legitimate medical purpose, by a practitioner in the usual course of his or her professional practice. As with every aspect of medical care, prescription practices should be guided by medical knowledge, best practices, professional guidelines, and consensus standards.” The guidelines refer to Minimum Norms and Standards. Before prescribing, physicians should familiarize themselves with the MMS Practice Guide (www.massmed.org/opioidguide). Also, establish a proper diagnosis and treatment regimen and take and record a history and appropriate exam.

BRM regulations cite three red flags that may indicate inappropriate prescribing: (1) permitting a patient to name “the drug he desires”; (2) repeated refills over relatively short periods; and (3) failure to schedule appropriate follow-up.

Over the past four years a number of physicians deemed high-risk prescribers have come to Physician Health Services (PHS). This happens when issues involving the physician’s health and/or emotional well-being may be connected to the pattern of presumed problematic prescribing. A few of these physicians have referred themselves. Others have been referred by employers, health plans, attorneys representing them, and regulatory bodies. Some high-risk prescribers are prevailed upon by regulatory bodies to leave practice in a hurry. The abrupt departure of a physician typically takes an enormous toll on everybody.

Here are some additional pointers to optimize prescribing:

• Write prescriptions for legitimate patients only. (They are not you, your friends, your family, your colleagues, or your co-workers.) You are treating them and must document your prescriptions in their medical record. Documentation is crucial if you are ever called before a board or employer about prescribing.

• Practice careful, evidence-based medicine.

• Learn everything you can about managing pain without opioids, addiction, and drug-seeking behavior. Develop and utilize refusal skills.

• Know your limits, abide by them, and endeavor not to be an outlier or a maverick.

• When in doubt, ask for help. Don’t succumb to pressure to do something that doesn’t look right, doesn’t feel right, or doesn’t make sense.

• Utilize MassPAT as required, and whenever the clinical situation calls for more information.

If prescribing medication has become a source of personal stress or professional distress, please call us at (781) 434-7404. PHS is a private, confidential, and free resource, with experience assisting physicians who are struggling with the current challenges of medical practice.

MMS Delegation Attends AMA Annual Meeting

A delegation of MMS members — specialty, organized medical staff section (OMSS), medical students, residents, women physicians, international medical graduate and others — attended the American Medical Association Annual Meeting in Chicago on June 11-15. The delegation also mentored four MMS Ambassadors, who learned more about organized medicine at the national level. Delegation members serving on AMA Councils include Omar Maniya (student), Council on Long Range Planning and Development; Mario Motta, Council on Science and Public Health; Richard Pieters, Council on Medical Education; James Sabin, Council on Ethical and Judicial Affairs; Lynda Young, Council on Medical Service.

Five resolutions were accepted by the delegation and accepted by the New England Delegation and reviewed as business of the HOD: an assessment of the impact of high deductible health plans on patient health and the financial impact on medical practices; transfer of jurisdiction over required clinical skills examinations to accredited medical schools; appropriate labeling of sleep products for infants; support for detergent poisoning and child safety act; and promotion of milliliter-only liquid medication dosing. Additionally, the MMS delegation collaborated with other states in regards to the Maintenance of Certification policies at the AMA and offered an amendment that was accepted as policy.

2016 Interim Meeting of the MMS House of Delegates

FRIDAY AND SATURDAY, DECEMBER 2-3, 2016
MMS HEADQUARTERS AND THE WESTIN HOTEL, WALTHAM

• Online registration opens in late September.

• Resolutions must be submitted by October 18 at www.massmed.org/resolutions on the template.

• Deadline for hotel rooms is November 3. Please visit www.massmed.org/IM16reservations or call the Westin Hotel at (781) 290-5600.

• Other Interim Meeting events include a Town Hall Meeting with the Presidential Officers, the Annual Oration, the biannual Ethics Forum, and the 11th Annual Research Poster Symposium.
MMS Publishes Essential Facts for International Medical Graduates

International medical graduates (IMGs) struggle with immigration, linguistic, and cultural issues. Turning to the MMS, they seek guidance on how to cope with these and other challenges, including how to apply for limited or permanent medical licenses, admission to residency programs, and how to establish medical practices in the Commonwealth.

The MMS IMGs Executive Committee has published the third edition of an informational booklet with a resource directory of services available to IMGs, including:

- Immigration guidelines (specifically visa requirements)
- How to obtain a limited and/or permanent license (basic steps and contact information)
- How to obtain a residency
- How to cope with discrimination

Essential Facts for International Medical Graduates is free to MMS members.

For more information, visit www.massmed.org/imgessentialfacts or contact Erin Tally at (800) 322-2303, ext. 7413, or etally@mms.org.

Research Grant, Event for LGBT Health Care

Medical Student Research Grant on LGBT Matters Proposal Deadline is October 3, 2016

The MMS LGBT Research Grant program encourages cultural competency training early in medical education to advance the quality, access, and equity of health care services for LGBT patients in the Commonwealth. A yearly sum of $16,000 is allocated for awards of up to $4000 each to qualified medical students, residents, and/or fellows from Massachusetts institutions for use in curriculum development, or to produce research that addresses lesbian, gay, bisexual and transgender health disparities.

To learn more about the grant and to download an application form, visit www.massmed.org/lgbtgrant, or contact Erin Tally at etally@mms.org or (781) 434-7413.

Networking Event for LGBT Health Care Providers

Harvey Makadon, M.D., will receive the 2016 Lesbian, Gay, Bisexual, and Transgender Award recognizing his outstanding contributions to LGBT health on Thursday, November 3, 2016, at 7:00 p.m., at Club Café, 209 Columbus Avenue, Boston, MA. The event is sponsored by the MMS Committee on Lesbian, Gay, Bisexual, and Transgender Matters. A prix-fixe menu for $15 per person (includes taxes and tip, drinks extra) is available.

RSVP to Erin Tally at etally@mms.org or (781) 434-7413. For more about Dr. Makadon’s accomplishments, visit www.massmed.org/lgbt.

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.

William F. Brown, M.D., 92, Mashpee, MA; Boston University School of Medicine, 1947; died June 8, 2016.

Terry D. Ryan, M.D., 82, Niantic, CT; Tufts University School of Medicine, Boston; died May 21, 2016.

Clayton L. Thomas, M.D., 94, Santa Monica, CA; Medical College of Virginia, 1946; died February 6, 2016.

Steven A. Myers, M.D., 72, Raleigh, NC; University of Missouri School of Medicine, 1975; died April 16, 2016.

Louis W. Meeks, M.D., 78, Newton, MA; University of Michigan Medical School, 1963; died September 14, 2015.

Ronald B. Miller, M.D., 83, Irvine, CA; Columbia University College of Physicians and Surgeons, 1958; died March 9, 2016.

John MacIver, M.D., 92, North Chatham, MA; Columbia University College of Physicians and Surgeons, 1949; died June 8, 2016.

Linda J. Michaud, M.D., 64, Sandwich, MA; University of Washington School of Medicine, 1982; died Oct. 5, 2015.

Donald W. Foster, M.D., 64, Sherborn, MA; New York Medical College, 1988; died July 8, 2016.

www.massmed.org/memoriam
LIVE CME ACTIVITIES

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

Evolutionary Biology in Clinical Medicine Webinar
Monday, September 19, 2016

Building Leadership Skills: What’s in Your Toolbox?
Friday, September 30, 2016

ONLINE CME ACTIVITIES

Go to www.massmed.org/cme

Electronic Health Records Education (3 modules)
- Module 1 — EHR Best Practices, Checklists, and Pitfalls
- Module 2 — Making Meaningful Use Meaningful: Stage 1
- Module 3 — Making Meaningful Use Meaningful: Stage 2

End-of-Life Care
- End-of-Life Care (3 modules)
- The Importance of Discussing End-of-Life Care with Patients
- Advance Directives (Legal Advisor)
- Principles of Palliative Care and Persistent Pain Management (3 modules)

Pain Management and Opioid Prescribing
- Managing Pain Without Overusing Opioids
- The Opioid Epidemic: Policy and Public Health (6 modules)
- Principles of Palliative Care and Persistent Pain Management (2 modules)
- Opioid Prescribing Guidelines in Practice
- Opioid Prescribing Series: (6 modules)
- Identifying Potential Drug Dependence and Preventing Abuse (Legal Advisor)
- Managing Risk when Prescribing Narcotic Painkillers for Patients (Legal Advisor)

Medical Marijuana (4 modules)
- Module 1 — Medical Marijuana: An Evidence-Based Assessment of Efficacy and Harms
- Module 2 — Medical Marijuana in the Commonwealth: What a Physician Needs to Know
- Module 3 — Medical Marijuana in Oncology
- Module 4 — Dazed and Confused: Medical Marijuana and the Developing Adolescent Brain

Additional Risk Management CME Courses
- Initiating a Conversation with Patients on Gun Safety
- Bullies and Victims: Can You Tell the Difference?
- Understanding Clinical Documentation Requirements for ICD-10
- ICD-10: Beyond Implementation
- Prostate Cancer and Primary Care
- Cancer Screening Guidelines (3 modules)
- HIPAA 2.0: What's New in the New Rules?
- Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
- Effective Chart Review for Quality Improvement

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