Protect Your Practice from HIPAA Breaches

BY VICKI RITTERBAND
VITAL SIGNS STAFF WRITER

For the past several years, the physicians at Family Medicine Associates have been concerned about the security of their patients’ private health information. Last fall, they hired a security expert to do a vulnerability assessment. One recommendation was that they encrypt all of their providers’ laptops, an expensive proposition. But they finally hit the bullet six months ago and did it. “Our greatest concern was having a laptop go out of the office and someone accessing patient records,” said Hugh Taylor, M.D., 1 of 11 physicians at the three-site practice. “We’re feeling better about that now.”

Dr. Taylor’s practice was right to be concerned. In 2013, stolen laptops or other mobile devices accounted for 35 percent of the data breaches reported to the U.S. Secretary of Health and Human Services. And health care is one of the top targets of cybercriminals. Almost 44 percent of breaches identified by the Identity Theft Resource Center in 2013 were in the medical/health care industry.

In 2012, stolen laptops or other mobile devices accounted for 94 percent of breaches reported at least one data breach in the past two years; 45 percent reported they had experienced more than five incidents.

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When it comes to cybersecurity, health care is playing catch-up with other industries; as a result, patients’ medical and insurance records are particularly vulnerable to criminals. And because electronic private health information, or ePHI, is so rich in identity information, it is highly valued on the black market. Health insurance credentials—which include information such as a patient’s name, date of birth, contract, and group number—fetch $20 each, compared to $1 to $2 for a U.S. credit card number, according to security service provider Dell SecureWorks. Thieves use private health information for everything from fraudulently billing insurers to obtaining prescription drugs or treatment.

HIPAA brought the privacy and security of medical records to the fore, requiring that providers safeguard both. The Health Information Technology for Economic and Clinical Health Act (HITECH) came along in 2009, with the purpose of stimulating electronic health records adoption, and broadened the scope of privacy and security protections under HIPAA. It also put teeth into the enforcement of HIPAA by creating penalties for violations, making healthcare organizations’ “business partners” equally liable and requiring that providers notify patients when a breach occurs. And if all this wasn’t enough motivation to shore up a practice’s cybersecurity, the Center for Medicare and Medicaid Service’s “Meaningful Use” incentives emphasize this continued on page 2

MMS Elects New Leaders; Adopts Policies on Youth Substance Abuse and HIV/AIDS at Annual Meeting

Richard S. Pieters, M.D., Elected MMS President

BY ERICA NOONAN
VITAL SIGNS EDITOR

The MMS elected new leaders for the coming year and adopted policies on youth substance abuse and mental health, HIV/AIDS, and guardianship of patients at its recent annual meeting of its House of Delegates.

MMS delegates adopted a policy that encourages all primary care physicians to perform in-office physical examinations annually on all adolescents and young adults. This will emphasize an accurate history regarding the use of all drugs, including prescription and nonprescription drugs. The policy also calls for greater inclusion of behavioral health in primary care, for in-school coordinators to assist students and their families with access to mental health counseling, and for disseminating information on mental health, addiction medicine, and substance abuse treatment.

Physician-delegates also approved an updated policy on HIV/AIDS that addressed several areas, including public health, medical care of patients, HIV/AIDS education, and HIV-related health care disparities. Other resolutions approved included a measure to propose legislation to expedite the decision-making process for patients unable to make medical decisions for themselves. Delegates also approved a strategic plan for the MMS focusing on three key areas: physician advocacy, education, and outreach; patient care advocacy, including minimizing barriers to care; and the preservation of professionalism to ensure patient-centered, physician-led care and an optimal educational and training environment for the next generation of physicians.

Duxbury resident Richard S. Pieters, M.D., was elected MMS president for the coming year. Dr. Pieters is a radiation oncologist at the University of Massachusetts Memorial Medical Center, with a practice in Fitchburg; he is also a clinical associate professor at the University of Massachusetts Medical School. Worcester resident Dennis M. Dimitri, M.D., was elected president-elect. Dr. Dimitri is vice chair of the Department of Family Medicine and Community Health at UMass Memorial Medical Center and is a past president of the Massachusetts Academy of Family Physicians. James Gessner, M.D., an anesthesiologist from Chestnut Hill, was elected vice president.

Read full coverage of the 2014 MMS Annual Meeting at www.massmed.org.
Moving Forward Together

Thank you so much for the honor of serving as your president.

We all know these are not easy times for practicing physicians. Health care reform seems to bring physicians an endless series of challenges.

I find it helps to remember there is a constant to guide our decisions and our actions: the doctor-patient relationship. Our patients have always wanted and needed us to be there for them.

A recent AMA study found that 75 percent of patients want to be seen by a doctor, even if there is a long wait. Even in this age of abundant Internet health information, patients continue to highly value their doctor's clinical expertise and advice.

In the days ahead, the MMS will continue to direct its energies to ensure the sanctity of the doctor-patient relationship and the viability of all physician practices, both large and small. We will continue to be outspoken advocates for patient-centered, physician-led care at the state and national level.

During my presidential year, I also plan to focus attention on the value of our medical professionalism. This is not only the essence of our calling as physicians, but our best defense as we face new challenges.

The best way to achieve high-quality health care is for physicians to promote a culture of commitment to lifelong learning, duty to patients, honor, and respect.

I look forward to working with you, and with your help, we will have a great year together.

Thank you.

— Richard S. Pieters, M.D.

HIPAA
continued from page 1

aspect of Electronic Health Record adoption as well.

Breaches are Expensive
MMS’s Director of Health Information Technology Leon Barzin worries about the vulnerability of smaller practices to cybercrime. “They may not have advanced security installed or haven’t implemented the most secure measures for protecting ePHI,” he said. “If one of these breaches occurs, it causes a lot of harm, and not just in terms of fines and penalties but in remediation as well. That’s when the costs start to add up. It’s not hard to get into hundreds of thousands of dollars to remediate.” Remediation expenses can include investigating the breach, notifying patients, new security software and hardware, and training.

When a physician’s personal laptop with patient information was stolen from a Beth Israel Deaconess Medical Center office in May 2012, the hospital spent $300,000 on encrypting staff’s personal devices alone. The financial impact of data breaches for health care organizations in the Ponemon study ranged from less than $10,000 to more than $1 million over a two-year period. In May 2014, New York-Presbyterian Hospital and Columbia University agreed to pay $4.8 million in HIPAA fines — the largest HIPAA penalty ever — for inadverently allowing 6,800 patients’ records to be accessible on the Internet.

Encryption Is Key
Encrypting all transmissions of electronic private health information — including texts and emails — is one of the most important ways to protect patient data, according to Ali Pabrai, a presenter at MMS’s recent conference, Electronic Health Records Next Chapter: Best Practices, Checklists, and Guidelines. Encryption is the conversion of data into a form that cannot be understood unless the reader has a key or password to unscramble the information. Even if a practice has a security breach, the information is protected. “Unfortunately, application vendors in the health care industry have been lethargic about embedding encryption capabilities,” said Pabrai.

Barzin believes that practices that haven’t yet adequately addressed ePHI safety might consider hiring a data security consultant, as Dr. Taylor’s office did. “And to better understand what’s required to comply with the HIPAA privacy and security rules, he recommends physicians check out the Department of Health and Human Services’ (HHS) CME-eligible online educational programs at hhs.gov.

Among other actions, the HHS suggests that practices designate a security or compliance officer, conduct security risk analyses at least annually, develop and document security strategies, and train staff (see below for additional security suggestions).

As more and more practices and other health care entities begin linking electronically to each other, cybersecurity concerns will grow, according to Barzin. “Any time you connect a computer to a network, you have a vulnerability,” said Barzin. “When you have a lot of people without security expertise connecting up and transferring data to other entities, there’s bound to be areas where information is diverted. The problem of security will get worse.”

Securing Your Practice’s Private Health Information

The U.S. Department of Health and Human Service’s Office of Civil Rights, which is responsible for enforcing privacy and security rules, suggests that practices implement the following steps to stay on the right side of HIPAA:

- Designate a privacy and security official whose responsibilities include developing, documenting and maintaining privacy and security practices, and making sure staff understand their responsibilities.
- Disseminate privacy and security policies among staff and continue communicating how your practice is integrating privacy and security measures into its operations.
- Develop an action plan to manage risk and minimize the vulnerability of ePHI. Risk management should address the security settings of the Electronic Health Record (EHR), IT network, hard drives, and other devices where ePHI may be stored. There are industry best practices for these settings.
- Communicate with patients. Create policies and procedures for communicating with patients about your privacy and security plan and especially ones that address what to do if your practice experiences a security breach.
- Make sure business associates have provided you with written agreements outlining their privacy and security measures before your practice shares protected health information with them. Business associates include billing companies, EHR vendors, and storage companies.

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A Framework for Patient-Centered Medical Homes

BY KERRY ANN HAYON
PPRC MANAGER

Whether practices have gone through the National Committee for Quality Assurance’s (NCQA) rigorous process or have unofficially structured themselves as a medical home, the patient-centered medical home (PCMH) movement here in Massachusetts continues to expand. The PCMH elements outlined in Chapter 224 of the Massachusetts Executive Office of Health and Human Services are to have all primary care practices in the state become patient-centered medical homes by 2015.

The PCMH movement has been focused on primary care practices, specialty practices are increasingly adopting the concept of the medical home model as well. In order to accommodate this growing demand, the NCQA recently rolled out a patient-centered specialty practice designation.

In talking with physicians and practice managers, I often encourage them to start by considering the following high-level framework:

- **Do You Have Access to Data?** The ability to drill-down and access patient-level, disease-specific data and to identify what your practice considers complex and high-risk patients is an important component of the medical home model.

- **What Are Your Processes?** Often practices have processes, but they may not be clearly outlined, documented, or well communicated. Having your staff trained on reliable, consistent processes in place is key.

- **How Do You Communicate?** Communication can be considered a core framework component of the PCMH model. It is extremely important to have communication among practice staff, between care providers both in the practice and externally, with patients, and with other support services and other health care institutions. Consistent communication on essential patient information with key stakeholders in a timely and consistent manner is critical.

- **Do You Engage Your Patients?** Engaging patients is not just a buzzword in a PCMH model; it is a crucial element. Identifying how to engage your patients and mechanisms that work for your particular patient base will be required.

- **Is Your Practice Accessible?** Appointment availability during office hours and the ability to reach a care provider during off hours is extremely important. Providing same day appointments for patients who require them is a must-pass element in the NCQA’s criteria. You may want to start with reviewing your data, determining where you currently stand, and working on necessary improvements in access.

While it is important to note that implementing a medical home model calls for attention to numerous requirements with a considerable level of detail, reflecting upon where your practice stands in relation to this high-level framework is a great first step in considering what elements you may already have in place and what elements may need to be implemented.

Massachusetts Health Policy Commission Will Certify Patient-Centered Medical Homes

BY MELISSA HAFNER
MMS HEALTH POLICY MANAGER

This spring the Massachusetts Health Policy Commission (HPC) proposed a new program to certify patient-centered medical homes, or PCMHs. The program, as currently envisioned, would offer two levels of certification — advanced and advanced plus — and spreads criteria across six domains, including care coordination, enhanced access and communication, integrated clinical care management, population health management, data systems/performance measurement, and resource stewardship.

Because some practices in the state are already recognized as PCMHs by the National Committee for Quality Assurance (NCQA), and others are in the process of applying for recognition, the announcement of the new certification program raised questions among the physician community. At a March 18 listening session held by the HPC, stakeholders generally expressed support for PCMH certification, and many supported the idea of adding criteria to the existing list of 45 or making some higher-level criteria required for the basic level of certification.

In response to the proposed PCMH certification program, the MMS submitted official comments requesting a flexible approach to the implementation of this program. Because the NCQA already has a robust PCMH recognition program that covers most of the same criteria, the MMS asked the Commission to consider “deeming” practices that already hold this designation. The HPC is in the process of developing a “fast track” for third-party certified practices. The MMS also asked the HPC to consider size, specialty, and location when certifying practices, and to take into account a practice’s progress toward certification when determining enhanced payments. Because enhanced payments are an important incentive for PCMH creation, an all-or-nothing approach could discourage certain practices from applying.

The commission continues to revise the proposed PCMH program based on stakeholder feedback, and it plans to release a new version during the summer with an additional comment period to follow. Keep an eye on the MMS website at www.massmed.org for further updates on this important issue.

Are You Having Problems Getting Paid?

MMS Regional Offices to Host In-Person Claims Review Sessions with Massachusetts Payers

The MMS Regional Offices are happy to announce that the annual Individual Claims Consultation Days will be taking place during July, August, and September. These in-person troubleshooting sessions are designed to allow MMS member physicians and their practice staff to schedule 30-minute appointments with health plans in order to focus on adjudication of troublesome claims.

Representatives from the health plans listed in the table will be on hand to review claims with physicians and their office staff in order to facilitate claims processing between 9 a.m. and 4 p.m. Also, practices can now schedule appointments online for an upcoming Individual Claims Consultation Day session. To schedule your appointment today, please visit www.massmed.org/iccdays2014.

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Note: √ denotes plans that will be in attendance.
Reducing Health Care Disparities in Massachusetts

BY KOMAL KARNIK
MMS PUBLIC HEALTH STAFF

Massachusetts is a pioneer in universal health coverage, has one of the highest insured rates in the country, and faces lower than national average rates of racial and ethnic disparities in key health areas.

However, access to primary care physicians in certain parts of the state is still a problem, said MMS President Ronald Dunlap, M.D., at the 2014 MMS Public Health Leadership Forum.

Dr. Dunlap pointed out the inverse relationship between the number of MassHealth patients and the number of providers in those areas; as a result of this relationship, disadvantaged communities have shortages of PCPs.

An MMS survey of providers conducted in February and March 2014 indicated that providers who accept Medicaid face numerous challenges, including administrative burden, poor reimbursement, and lack of referrals to subspecialists under the payment model.

Focus on Effective Interventions

“We need to focus our efforts on interventions that bridge communities and health systems to achieve equity in health outcomes,” said John Ayanian, M.D., M.P.P., director of the Institute for Healthcare Policy and Innovation at the University of Michigan. At the April 8 forum, he highlighted three policy approaches that have the potential to create equity in the health care system: expansion in insurance coverage, coordination of care, and performance measures.

Another panelist, Joel Weissman, Ph.D., discussed what he called the “seven terrors of the Fire Swamp,” the potential pitfalls in using pay-for-performance measures to reduce disparities. He recommended policy solutions including collecting race, ethnicity, and language data to stratify quality performance measures; targeting improvement to underlying factors such as language and access barriers; rewarding provider improvement, as well as threshold attainment; and requiring transparency in disparities measurement.

Patient, Community Engagement Key

All of the speakers on the expert panel stressed the importance of community engagement in addressing the social determinants of health outcomes, including access to care. While most physicians agree patients’ social needs are as important to address as their medical conditions, they are typically not confident in their capacity to address these problems, according to Sonia Sarkar, chief of staff to the CEO at Health Leads, a Boston-based organization which facilitates physicians’ referring patients to student advocates who are trained to help patients access resources such as transportation and food.

Technology is also a key element in patient engagement and could help reduce barriers such as a lack of reliable access to PCPs. “We are not pushing the boundaries of what patients can do,” said John Moore, M.D., Ph.D., who urged the adoption of the conceptual framework of the “patient as apprentice.” Technology is redesigning the system so the patient and physician can make shared decisions in managing chronic diseases. In Dr. Moore’s recently published study, 100 percent of patients in the experimental group (who monitored their own health with “health coaches”) achieved their blood pressure goals in three months at a cost of $70 per patient per year, compared to the typical cost of care of $250.

To learn more about health care disparities and MMS’s educational activities on the topic, visit www.massmed.org/disparities.

MMS Hosts Reality Medicine Program

Eduardo Hariton, medical student representative to the Committee on Diversity in Medicine (standing), and Joyce Sackey, M.D. (left), talk with medical students about challenges and strategies for success in medical school at Reality Medicine, an educational and networking program for students, residents, and new physicians hosted by the MMS Committee on Diversity in Medicine on April 10.

The program aims to reduce health care disparities and increase diversity in the medical workforce by educating students and young physicians about health care disparities, and by supporting students and young physicians who will be caring for minority and underserved patients. For more information, visit www.massmed.org/Reality_Medicine.
STATE UPDATE

MMS Expresses Concerns Over Nurse Staffing Ballot Question

BY RONNA WALLACE
MMS LEGISLATIVE CONSULTANT

After a thorough review by the Committee on Legislation of presentations from the Massachusetts Nurses Association (MNA) and the Massachusetts Hospital Association (MHA), the MMS has taken a position relative to a pair of ballot initiatives relative to health care facilities in the Commonwealth.

These ballot initiatives are a new strategy to go directly to the voters to achieve through the ballot process state laws which the legislature has rejected in the past.

House Initiative Petition No. 3843, the Patient Safety Act, would designate specific maximum nurse staffing ratios of registered nurses to patients in hospitals and certain other health care facilities. For example, in intensive care, each registered nurse could have no more than one patient. Ratios are specified in 13 subsections of the proposed law, addressing virtually every hospital setting and patient type.

Thus, the ballot initiative, if passed, will mandate the maximum number of patients that may be assigned to a given registered nurse in a variety of specified health care facilities, with ratios depending upon the type of unit and care delivered. The teeth in the initiative comes from the state Health Policy Commission (HPC), which would certify a patient acuity system that each facility would have to develop, and require the HPC to report violations of patient assignment limits to the Massachusetts Attorney General, with possibility for civil penalties of $25,000 per day for such violations. HPC oversight would come in addition to the Department of Public Health’s oversight of patient safety and quality and existing hospital licensing requirements.

In considering our position on this ballot initiative it was noted that the MMS has always advocated for the safety of all patients in Massachusetts health care facilities. The MMS also recognizes that there are significant changes in the manner in which such facilities are staffed, and the tasks that staffs are required to do both in terms of direct, hands-on patient care and indirectly when complying with ever increasing documentation regulations. The Society appreciates that efforts to accurately quantify nurse/patient ratios attempt to do so in the non-patient-contact responsibilities could be reduced by either absolute reduction or transfer to non-nursing personnel, giving the nurses more time to spend with their patients. We also recommend that the MNA and MHA work together to evaluate more completely the aspects of nursing/patient ratios which impact patient safety. An attempt to come to agreement on a way to achieve maximal patient safety without the negative impact of simply mandating fixed ratios serves everyone’s best interests.

The MMS is more than happy to work with the MHA to develop a plan which would achieve through the ballot process the goals of mandating increasing nurse/patient ratios in this setting will of necessity require cutting costs in other health care disciplines.

Mandating increasing nurse/patient ratios in this setting will of necessity require cutting costs in other health care disciplines.

face of marked variation not only between hospitals (by nature of their specialty and sub-specialty patient populations) but even among nursing units within one institution. It seems logical to consider all of the factors which impact patient safety for a given unit when arriving at staffing recommendations, and to be careful not to limit the ability of those managing the nursing unit to make changes in order to maximally utilize available resources when an unanticipated need arises.

Mandate Will Force Cuts, Threaten Patient Safety

It also is clear that in the current environment, no additional funds will be diverted to health care for increasing nurse/patient ratios; in fact the fiscal policy of the state and the country is to decrease the cost of health care wherever possible. Mandating increasing nurse/patient ratios in this setting will of necessity require cutting costs in other health care disciplines. Reductions in numbers of hospitalists, physical therapists, respiratory therapists, pharmacists, transport staff, housekeepers, and dietary staff, to name a few, will invariably decrease the quality of the care offered and possibly prolong hospital length of stay in addition to giving rise to new concerns about a decline in immediate patient safety.

The MMS is advocating that the utilization of our nursing colleagues be reviewed to determine how much of their current impact patient safety. An attempt to come to agreement on a way to achieve maximal patient safety without the negative impact of simply mandating fixed ratios serves everyone’s best interests. The MMS is more than happy to contribute to this working group in any way to support such worthy goals.

California Assembly Bill 394, implemented Jan. 1, 2004, is the only law in the nation that defines mandatory nurse staffing ratios in health care settings.

Laws such as California’s measure have not been shown to improve patient safety. However, as common sense and experience support, the literature tends to indicate that “those hospitals that are most effective in ensuring patient safety generally find it optimal to employ more nurses per patient.” This conclusion highlights an important distinction: improved nurse staffing, in combination with other elements of the hospital, may contribute to improved patient safety; however, laws mandating patient nursing ratios have not had a significant effect alone on improving patient safety, and the effects of such laws have been difficult to distinguish given the number of confounding factors that contribute to patient outcomes in health care settings.

Nursing Community Mixed on Staffing Levels

The nursing community does not unanimously favor mandated nurse staffing levels. Although the MNA supports mandated nurse staffing ratios, the American Nurses Association (ANA) advocates for a more flexible approach. The ANA’s position accounts for patient numbers and the variable intensity of care required; the level of education, training, and experience of the nurses providing care; and care provided by other health care personnel, among other factors. The Organization of Nurse Leaders of Massachusetts and Rhode Island opposes the approach as well.

A second ballot initiative, also opposed by the MMS, would require greater financial disclosure by Massachusetts hospitals and limit the pay of top hospital executives. The proposal would require hospitals to detail all funds in offshore accounts, often used by self-insured hospital systems for medical malpractice coverage, and cap hospital chief executive salaries at 100 times that of their lowest-paid workers. Both ballot initiatives are being aggressively supported by the MNA, and equally opposed by the MHA.

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Would you like to receive this monthly newsletter via email instead of U.S. mail?

Send an email to vitalsigns@mms.org with your preferred email as well as the address currently listed on your VS mailing label.

The MMS will begin emailing Vital Signs to you as a downloadable PDF in September.

WWW.MASSMED.ORG

GOVERNMENT AFFAIRS
Almost every doctor I’ve met is well aware that the practice of medicine can be all-consuming. We begin to appreciate this as medical students, and the mounting demands of our medical careers become increasingly apparent during residency and fellowship training, despite well-intentioned duty hour requirements. Once we complete our specialty training, the stresses and strains of everyday practice take hold. Patient care in the office and the hospital is more than a full-time job — even for doctors who work part-time! Evenings and weekends are spent catching up on documentation, while staying up-to-date with the latest developments in our specialty. As we mature in the profession, our practices grow, and many of our sick and aging patients require more from us. We are running an uphill marathon, one that spans decades. WhatWorks4Me.org is a new health care community blog that showcases what we are doing right. We believe that in order to thrive in the practice of medicine, each and every one of us needs to thrive outside of the practice of medicine. Our passions, our pastimes, and our own homegrown coping strategies keep us fresh, vital, and engaged. Without activities that sustain and enhance our bodies, minds, and spirits, we run the risk of chronic occupational stress and burnout. At WhatWorks4Me.org we have started showcasing the success stories of individual physicians. What are you doing to combat emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment — also known as the hallmarks of physician burnout? Many doctors tell me that they simply don’t have the time to pursue a passion outside of medicine. Extreme time bankruptcy of this sort is an indicator that, sooner or later, something is going to give. Will patient care suffer? Will your health decline? Will the stress of it all lead you to question your career choice and dread each successive day of work? We simply cannot afford to put ourselves last. Carpe diem!

It’s time to recommit yourself to working out, or to dust off that hobby that you’ve been meaning to take off the shelf. Of course, many “Type A” physicians will fantasize about competing in the Iron Man Triathlon as the next step, or perhaps writing the great American novel. Don’t stress yourself by setting impossible goals. Start low and go slow. Dr. Leo Marvin, the psychiatrist played by Richard Dreyfuss in What About Bob?, had it right when he focused on “baby steps” as the essence of behavior change. You might want to take a look at a well-regarded book on this topic: One Small Step Can Change Your Life: The Kaizen Way (2004) by Robert Maurer, Ph.D. Dr. Maurer of the late best-selling author and Physician Health Services pioneer Michael Palmer, M.D., about how his father tended to an aquarium full of fish for a meditative escape.

Please check out WhatWorks4Me.org to see what other physicians are doing to pace themselves and to reignite passion for their work. And please use the site to send along your own account of what works for you.

Enroll in the Legal Advisory Plan Today

Join the ranks of your colleagues who have enrolled in the Legal Advisory Plan, an exclusive benefit for MMS members. They know the benefit of having a legal ally if an unexpected notice of an investigation or a complaint filed against them is sent from the Board of Registration in Medicine. For $70 a year, a small fraction of the cost of hiring an attorney, you can receive expert advice and legal services from the plan’s counsel (Adler, Cohen, Harvey, Wakeman and Guekguezian, LLP) on BRM matters. Many times an attorney’s well-crafted response to the board will resolve an issue.

Additional benefits include the following:

- A free quarterly newsletter, The Legal Advisor
- 25% discount on all The Legal Advisor online CME courses
- Discount pricing for groups of five or more MMS member physicians

Information and enrollment materials were sent to all members in May. You may renew or sign up by using the application contained in the packet, or via the online application at www.massmed.org/lap.

Enroll today for coverage between July 2014 and July 2015. You must be enrolled at the time you are made aware of a complaint or investigation in order to be covered. For questions, contact Carolyn Maher at (781) 434-7311 or lap@massmed.org.
DocbookMD App Gives MMS Members Free Access to Secure Messaging

MMS members are entitled to a free HIPAA-secure messaging application for their mobile devices (Android, iPhone, iPad, and iPod touch). Designed by and for physicians, DocbookMD provides a secure network for members to share patient information and collaborate with other MMS physicians and their own care teams.

The application sends HIPAA-secure text messages and images such as X-rays and EKGs. Users can also search for MMS members and local pharmacies through its directories. “One of its best features is that unlike some other messaging systems, it’s cross-institutional,” said MMS’s Director of Health Information Technology Leon Barzin.

All messages are sent and stored using high-grade encryption, and data is saved on DocbookMD’s secure servers — not on the user’s device — for 10 years.

For more information and to sign up for this free benefit, visit [www.massmed.org/docbookmd](http://www.massmed.org/docbookmd). For questions, please email info@massmed.org or call (800) 322-2303, ext. 7311.

IN MEMORIAM

The following deaths of MMS members were recently reported to the Society. We also note member deaths on the MMS website, at [www.massmed.org/memoriam](http://www.massmed.org/memoriam).

John P. Chandler, M.D., 92; Worcester, MA; University of Pennsylvania School of Medicine, 1944; died January 27, 2014.

Kenneth C. Edelin, M.D., 74; Sarasota, FL; Meharry Medical College School of Medicine, 1967; died December 30, 2013.

Edgardo A. Garcia-Trias, M.D., 89; Nashua, NH; Duke University School of Medicine, 1960; died March 3, 2014.

Nasir A. Khan, M.D., 72; Newton, MA; University of London Faculty of Medicine, 1962; died April 9, 2014.

Rosemarie Maddi, M.D., 63; Pittsburg, PA; George Washington School of Medicine, 1975; died October 21, 2013.

Suzy S. Silverstein, M.D., 54; Florence, MA; New York University School of Medicine, 1983; died April 27, 2014.

Vinod K. Tripathi, M.D., 82; Chelmsford, MA; University of Lucknow Medical College, India, 1957; died April 21, 2014.

Francis A. White, M.D., 90; Worcester, MA; Georgetown University School of Medicine, 1950; died April 29, 2014.

Congratulations to the MMS Community Clinicians of the Year

Barnstable ............................................ Michael R. Barnett, M.D.
Berkshire .............................................. Richard D. Perera, M.D.
Bristol North ........................................ Joseph F. Nates, M.D.
Bristol South ......................................... Harvey A. Reback, M.D.
Charles River ........................................ Nasir A. Khan, M.D.
Essex North ......................................... Saira Naseer-Ghiasuddin, M.D.
Essex South .......................................... Gregory A. Bazylewicz, M.D.
Franklin .............................................. Jeffrey M. Hayer, M.D.
Hampden ............................................. Francis D. Murray, M.D.
Hampshire .......................................... Robert M. Abrams, M.D.
Middlesex .......................................... Arlan F. Fuller Jr., M.D.
Middlesex Central ............................... Toby Nathan, M.D.
Middlesex North ................................ Lincoln N. Pinsky, M.D.
Middlesex West ................................... James F.X. Kenealy, M.D.
Norfolk .............................................. Barbara A. Rockett, M.D.
Norfolk South ..................................... Melody J. Eckardt, M.D.
Plymouth ............................................. Peter D. Rappo, M.D.
Suffolk .............................................. Judith A. Linden, M.D.
Worcester .......................................... Annie Abraham, M.D.
Worcester North .................................. Francis X. Zambetti, M.D.
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   > MMS Hosts Reality Medicine Program
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   > Ballot Question
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   > Save the Date: A Tribute to Michael Palmer,
     M.D., Oct. 19
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MMS AND JOINTLY PROVIDED CME ACTIVITIES

LIVE CME ACTIVITIES
Unless otherwise noted, event location is MMS headquarters, Waltham.

2014 Women’s Leadership Forum: Advancing Your Career for Women Physicians
Wed., September 17, 2014, 5:30 to 8:00 p.m.

New Trends in Women’s Health: What Every Provider Should Know
Fri., November 14, 2014, 8:00 a.m. to 5:00 p.m.

ONLINE CME ACTIVITIES
Risk Management CME

End-of-Life Care
- End-of-Life Care (3 modules)
- The Importance of Discussing End-of-Life Care with Patients
- Legal Advisor: Advance Directives

Pain Management
- Principles of Palliative Care and Persistent Pain Management (5 modules)
- Opioid Prescribing, Risk Management of Opioid Therapy, and the Opioid Abuse Epidemic (6 Modules)
- Legal Advisor: Identifying Potential Drug Dependence and Preventing Abuse
- Managing Risk When Prescribing Narcotic Painkillers for Patients

Other Risk Management Topics
- Preventing Falls in Older Patients: A Provider Toolkit
- Guide to Accountable Care Organizations: What Physicians Need to Know
- HIPAA 2.0: What’s New in the New Rules?
- Cancer Screening Guidelines (3 modules)
- Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
- Effective Chart Review for Quality Improvement

Additional CME
- Physician Employment Options in the Health Care Environment
- Contracting with an ACO
- Finance 101 for Physicians and Practice Administrators
- A Roadmap to Bring an End to HIV and STDs in Massachusetts (3 modules)
- Using Data Wisely
- Just a Spoonful of Medicine Helps the Sugar Go Down: Improving the 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

CME CREDIT: These activities have been approved for AMA PRA Category 1 Credit™.

FOR ADDITIONAL INFORMATION AND REGISTRATION DETAILS GO TO WWW.MASSMED.ORG/CMECENTERN, OR CALL (800) 843-6356.