Keeping Your Patients’ Data Secure — Best Practices to Minimize Risk

BY DEBRA BEAULIEU-VOLK
VITAL SIGNS STAFF WRITER

In today’s world, a person’s health information can be even more valuable to thieves than a credit card number, making medical identity theft one of the fastest-growing crimes in the United States. Meanwhile, the instances in which your practice stores and transmits protected health information (PHI) expand by the day. These vulnerabilities don’t just expose your patients to having their data stolen or misused, but also place your practice at risk for HIPAA audits — fines topping six figures and untold levels of reputational damage.

The first step toward preventing these leaks and their consequences is by achieving HIPAA compliance — for which the MMS offers a comprehensive online toolkit — a top priority, according to Kerry Ann Hayon, M.H.A., in-house consultant for the MMS’ Physician Practice Resource Center. “Practices do have a lot on their plate, but they need to focus on getting HIPAA compliance right — because that’s where they’re at risk now,” she said.

Ali Pabrai, cybersecurity expert and chief executive officer of the online security company eKlorf, agreed, noting that physician practices may be more vulnerable to audits than they realize. “Today it’s not a question of if, but when a practice experiences a breach,” he said. “The Office for Civil Rights (OCR) does look at breach notifications to see whether an organization is taking HIPAA seriously or not, and that could trigger a HIPAA audit.”

Mobile Device Security

Pabrai delivered a presentation on compliance and cybersecurity at MMS Headquarters last year, during which he highlighted the rapid proliferation of mobile device use in health care. As he predicted, the risks associated with PHI stored and accessed via laptops, tablets, thumb drives, smartphones, and other easily lost or stolen devices have only risen.

Experts agree that the most effective way to protect information flowing through or stored
Dear MMS Community,

I’m writing to share with you my plans to retire next year.

I’m planning on a retirement date of May 31, 2016, and I will work closely with the MMS until a successor is appointed. I’ve assured our leadership — and I want to assure you — that I will do everything possible to make certain we have a smooth transition for a new executive vice president. Our new MMS president, Dr. Dennis Dimitri, is appointing a search committee to begin the process.

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on these devices is with encryption, but barriers remain in applying the technology universally. “Physicians are very smart people, but there are physicians and practices that just don’t know what they don’t know,” said Leon Barzin, MMS’ director of health information technology.

DocbookMD

To help answer this need, the MMS partnered in 2015 with DocbookMD to provide members with free access to a HIPAA-secure messaging application for mobile devices. “It’s being used increasingly by our members to communicate among physicians and also with staff,” Barzin said. The platform guarantees no PHI, including text messages, X-rays, or other images, stay on the phone. “All of the information is stored off of the phone or device on servers that are encrypted, and it stays there for the legally mandated seven years. There’s no point at which somebody could break that information.”

“As there is no gray area when it comes to encryption — something either is or it isn’t,” added Pabrai. The checklist at right suggests 15 items that practices should encrypt.

The second item, cloud-based systems, is a common area of misunderstanding, as practices may think the cloud-service provider is responsible for security of the data. “But that’s not the case,” said Pabrai. “When there’s an OCR audit, the auditors look at it in a simple manner: ‘Who came into contact with that patient information?’” At the end of the day, it’s the entity that controls the supply chain of patient information, but that data is not typically being encrypted across all elements of computing ecosystems, he said.

Phishing Emails

Even if you encrypt all of your PHI that’s in motion and at rest, there’s the risk that personnel will be tricked into simply handing it over. One of the most common ways organizations inadvertently expose themselves to hackers is by responding to fraudulent “phishing emails.”

“There is no gray area when it comes to encryption — something either is or it isn’t,” added Pabrai. The checklist at right suggests 15 items that practices should encrypt.

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Preparing your Practice for ICD-10: IT System Considerations

BY KERRY ANN HAYON
PRACTICE SOLUTIONS AND RESEARCH DIRECTOR

This is the fourth in a series of Vital Signs articles intended to assist members in preparing their practices for the changes ICD-10 implementation will bring.

As we head into the summer months, we continue to focus efforts on encouraging physicians and their practices to prepare for the impending ICD-10 implementation deadline of October 1, 2015. Physician practices typically interact with many information technology systems and solutions daily, such as electronic health records, e-prescribing systems, billing systems, hospital systems, lab systems, and health plan systems. In all cases, these systems may contain ICD-based transactions. Knowing which systems your practice interacts with, and whether those systems will require upgrades or enhanced capability in order to efficiently function in the ICD-10 world is extremely important. Taking a moment to consider the following steps can help get you on the right path today.

Conduct an IT System Inventory
Engage your staff in a process to identify all of the IT systems that are in use both directly in the practice and those that you interact with but may be external to the practice. Consider all of the vendors, systems, and other entities that you may exchange ICD information with. This is an important step even for those that are not currently using electronic health records. An example is a third-party billing company that provides reports back to the physician or a web-based e-prescribing system.

Determine Which Systems Require Upgrades
Categorize the IT systems you interact with into ones that you directly own or license and those that you interact with through vendors. This step will help you identify which systems you will have to work to upgrade and those that you can work with the vendors to make sure the upgrades will occur.

Contact Your IT System Representatives
For the software and systems you own, reach out to the vendors and determine the steps necessary to upgrade the systems for ICD-10, including any associated cost. For systems you interact with, reach out to all vendors and make sure that the systems will be upgraded, what the timeline is and whether or not there will be any cost to your practice.

Create a Plan
Based on the outreach you’ve done, put together a strategic plan and timeline for the steps you need to take to make sure that your systems are ready in advance of October 1, 2015. As part of your plan, be sure to include a step to test transactions in advance of implementation so you are aware of any potential glitches and can already be working on a resolution.

Are You Having Problems Getting Paid?
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 the months of July and August. 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 below will be on hand to review claims with physicians and their office staff in order to facilitate claims processing. New this year, practices can schedule appointments online for an upcoming Individual Claims Consultation Day session.

To register or schedule your appointment today, visit: www.massmed.org/iccdays2015.

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Note: ✓ denotes plans that will be in attendance.

Quick Hit ICD-10 Checklist

- Speak with Vendors
- Educate Your Staff
- Conduct a Documentation Gap Analysis
- Review Internal Processes
- Create Your ICD-10 Conversion Plan
- Develop a Test Plan
- Create a Plan for Post Go-Live Monitoring

Monitor Transactions Post Implementation
Even with the best laid plans, glitches can happen. Be sure to monitor all systems and transactions on October 1 and beyond to make sure that everything is working as expected.

Group Enrollment for Legal Advisory Plan

A notification from the Board of Registration in Medicine of a complaint or investigation can be time-consuming, nerve-wracking, and costly. Hiring an attorney to respond can cost several thousand dollars, and if the initial response doesn’t resolve the issue, additional legal assistance to reach an acceptable outcome raises the cost — not to mention your stress level.

The Legal Advisory Plan (LAP) is low-cost legal insurance designed to effectively respond to Board issues. For a low annual fee you receive assistance to the point of formal proceedings. The Plan’s counsel, Adler, Cohen, Harvey, Wakeman and Guekguezian, LLP, are experienced with Board procedures and can assist physicians to avoid common mistakes.

LAP offers discounts to groups of five or more enrolled MMS physicians. For $60 to $65 per year, per physician, group members receive the same exclusive coverage and benefits.

Now is the time to enroll for this MMS member-only benefit from July 2015 to July 2016. Log in to www.massmed.org to view the details of the Plan, renew online, or print an enrollment form. You must be enrolled at the time you are made aware of a complaint or investigation in order to be covered.

For questions, please email lap@mms.org or call (781) 434-7311.

*LAP Group Pricing

5–19 physicians $65 each
20–30 physicians $60 each
30+ physicians $60 each, plus a FREE onsite seminar given by Plan counsel
The MMS offers these guidelines with the hope that they will be adopted by physician practices throughout the state. The will also be shared with the state Board of Registration in Medicine, so it will consider incorporating them into its prescribing guidelines for physicians.

### Opioid Epidemic

Continued from page 1

care, and those being treated for cancer. These patients have special circumstances that do not yield readily to guidelines. Their care must be based upon the long held medical principles of relief of suffering.

The MMS offers these guidelines with the hope that they will be adopted by physician practices throughout the state. They will also be shared with the state Board of Registration in Medicine, so it will consider incorporating them into its prescribing guidelines for physicians.

### Pain Management and Opioid Prescribing CME

**Free to All Prescribers**

Managing Pain without Overusing Opioids

- 3.00 CME Credits

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- 1.00 CME Credit

Managing Risk When Prescribing Narcotic Painkillers

- 1.00 CME Credit

Opioid Prescribing Series (6 modules)

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Principles of Palliative Care and Persistent Pain Management (2 Modules)

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NEW! The Opioid Epidemic: Policy and Public Health

Based on archived sessions from the 11th Annual Public Health Leadership Forum (video format)

- Module 1: We Don’t Have Time to Wait
- Module 2: Overdose Prevention in the Community and Medical Practice
- Module 3: Patients, Opioids, and the Law
- Module 4: Safe Opioid Prescribing for Chronic Pain
- Module 5: The Pain/Addiction Interface: Community and Physician Health Perspectives
- Module 6: Alternatives to Opioids

2.75 CME Credits

www.massmed.org/cme

These activities meet the criteria of the Massachusetts Board of Registration in Medicine for risk management credit, including credits in effective pain management and prescribing of controlled substances.

### Working to Prevent Substance Abuse in Our Communities

**One Physician’s Perspective**

BY MICHAEL GUIDI, D.O.

Substance abuse in the United States and in our local communities is growing at an alarming rate. We, as a medical society, have done our best this past year in trying to limit prescription writing of narcotics and we need to continue to do so.

But what are the solutions to limiting use of heroin, cocaine, methamphetamine, and synthetic marijuana? Do we continue to read the headlines — and the obituaries of young people — and hope and pray that our children and grandchildren do not fall victim to this epidemic?

I hope not.

Last year, the MMS House of Delegates adopted policy encouraging all primary care physicians to take a history of each patient’s illicit drug use, and support greater inclusion of behavioral health, including wrap-around services, within primary care settings, and advocate for payment for these services.

Here is what I am doing along those lines to create a wrap-around approach to primary care behavioral medicine:

- I take a proper history regarding the use of illicit and/or prescription drugs. I cannot emphasize enough the importance of physicians asking these questions directly to the patient and making eye contact while doing so.
- I incorporate behavioral health services in my office on a daily basis. This allows direct communication between the mental health specialist and me — something that has been missing for much too long.
- I helped establish a grassroots network in my community of those interested in reducing illicit drug use and substance abuse among those of all ages. Connecting with a network in your community is a way to share information and expertise and identify the resources and interventions that need to be developed. In my community, we are creating a network of substance abuse counselors, public health nurses, board members, public safety officials, probation officers, and school committee members.

Working with this network, I helped secure a grant from the MMS Foundation for Family Services of the Merrimack Valley to support a program for students ages 12 to 18 at risk for substance abuse in Lawrence. The $25,000 grant will support a mindfulness-based curriculum aiming to build emotional resilience and reduce substance abuse.

While this grant will help, we all need to do our part to fight against the ravages of substance abuse. So I urge all of you to please reach out to your family, friends, and neighbors and help create programs that will be successful in your communities.

Michael Guidi, D.O., is a family physician and member of the MMS Committee on Student Health and Sports Medicine.

### Public Education

An effective first step to reduce non-medical opioid use is through education. Therefore, in an effort to curb the supply of prescription opioids in the community, the MMS has agreed to partner with the Partnership for Drug-Free Kids and its Medicine Abuse Project to broadly disseminate information about the safe storage and proper disposal of opioid medications.

Most people are probably unaware that their medicine cabinets are attractive targets for those who would misuse opioids, and they could be an unwitting supplier. This education program will provide guidance on how to safely store and secure medications, and how to get rid of them when they are no longer needed.

This new SmartScripts MA campaign follows several meetings between MMS officers and state leaders, including Gov. Charlie Baker.

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SOLUTION THROUGH PHYSICIAN ACTION

MMS Opioid Therapy Guidelines

The Massachusetts Medical Society supports the position that physicians must use their best clinical judgment in the treatment of all patients. Guidelines exist in many areas to help physicians achieve the best possible outcomes for patients. We recognize that our initiative creates opioid prescribing guidelines that have general applicability and are most relevant in primary care. Specialty societies and specific practice settings may have more detailed recommendations for the care of patients. These prescribing guidelines have been shared with the Board of Registration in Medicine for consideration of incorporation into their prescribing guidelines for physicians. The guidelines will provide valuable guidance to physicians in their practices and as evidence of best practices and to the Board in its responses to patient complaints, accusations of substandard care, or accusations of inappropriate prescribing.

Deviation from prescribing guidelines is not a violation of standards of care per se. As MMS policy states the following: “Practice guidelines are not intended to be unique or exclusive indicators of appropriate care. Any physician should be able to demonstrate that the care rendered is safe and appropriate, even if it may vary from the guidelines in some respects.”

Elements

- The MMS supports the adoption and dissemination of specific guidelines related to the prescribing of opioids.
- Separate guidelines are needed for treatment of acute and chronic pain.
- Chronic pain guidelines apply to patients who receive opioids for a more than a 90-day period. This includes transferred patients with opioid treatment histories and existing patients who reach a 90-day period of treatment.

Guidelines do not apply to patients with cancer, patients in hospice or palliative care, and inpatients of hospitals and nursing homes.

- Work is ongoing with appropriate specialists and specialty societies to review opioid prescribing issues and guidelines to specialties and practice settings. Physicians should review existing guidelines for their individual specialties.

These guidelines were developed by the MMS Task Force on Opioid Therapy and Physician Communication, chaired by President-Elect James S. Gessner, M.D.

To read detailed guidelines on acute and chronic care situations, see www.massmed.org/opioid-guidelines.

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E-prescribing as a Tool to Enhance Flexibility

BY THOMAS SULLIVAN, M.D.
MMS PAST PRESIDENT

E-prescribing is one small way that physicians can help improve patient care and respond to the opioid crisis. “For example, by writing shorter duration pain management e-prescriptions, physicians can avoid having patients pick up multiple paper ones.”

An initial prescription could be provided for a three-day supply and a follow-up could be issued at the end of that period to cover ongoing pain management. Also, e-prescriptions go directly to pharmacies and have less likelihood of being altered or amended.

Many physicians are unsure about the rules for e-prescribing of federally controlled substances.

The Drug Enforcement Administration’s (DEA) 2012 (2010) Interim Final Rule dropped the federal prohibition on electronic prescribing and allowed physicians to e-prescribe Schedule II through Schedule V controlled substances, with some restrictions.

Before e-prescribing Schedule II drugs, the DEA requires that there be an independent third-party verification of the prescriber — so called “Identity Proofing” — and a two-factor authentication of each prescription.

It is possible to e-prescribe Schedule II–V electronically in Massachusetts, but the physician and the pharmacy must meet the DEA’s verification and authentication requirements. The software must also meet the requirements. Generally, systems are set up to be in compliance and as certified software. Many big system software programs are currently certified for use.

Once using a certified system, the prescriber must also use an approved second factor, such as a one-time password token, or the recently emerging biometric factors, such as a fingerprint for each prescription.

E-prescribing is still underused in Massachusetts, even though the Commonwealth had the first pilot project in the nation to test it out. This project ran with a DEA waiver from 2008 to 2011. Despite this fact, many pharmacies have no experience with e-prescriptions for controlled substances and do not provide this service for patients.

Dr. Sullivan is a past president of the MMS and is currently the chief strategic officer of DrFirst, a Maryland-based software company.

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Opioid Epidemic
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Health and Human Services Sec. Marylou Sudders, and Attorney General Maura Healey, as well as the MMS Public Health Leadership Forum on the topic of opioid addiction in April.

That forum brought together more than 200 physicians, health care professionals, and policy-makers to discuss the problem of opioids in Massachusetts, with keynote address by White House Drug Policy Director Michael Botticelli.

Moderated by John Burress, M.D., vice chair of the MMS Committee on Public Health, the program discussed policy and clinical challenges and opportunities in pain management and substance abuse prevention and treatment. The program highlighted the need for increased physician and patient education and addressed the challenges finding specialists in pain management and addiction treatment to whom to refer patients.

Opioids were also the focus of the Ethics Forum at the MMS Annual Meeting, which explored ethical considerations in pain management, including responsible prescribing, the complexity of pain as a clinical issue, and the ethical problems associated with under-
PHYSICIAN HEALTH MATTERS

Avoiding the CRASH: When Toughing it Out Stops Working

BY STEVE ADELMAN, M.D.
PHS DIRECTOR

The caped heroes in the accompanying illustration don’t need to shed their stethoscopes and white coats to reveal their true identities. We all know that doctors possess super-human skills. Armed with encyclopedic medical acumen, we relieve the suffering of thousands. We stay up late to finish our charts. We wake up early to go on rounds. Sometimes we skip meals in the course of our long and demanding days, doing whatever it takes to get the job done. It works until it stops working, and then … CRASH!

We physicians have been acculturated to tough things out — to endure hardship and overcome adversity in our efforts to master the science of medicine so that we can relieve human suffering and save lives. It starts in college, when we studied organic chemistry into the wee hours in order to be deemed worthy of being accepted to medical school. The basic science curriculum in medical school would overwhelm mere mortals, but with our noses to the grindstone we study 24/7 in order to move forward and gain entry to clinical rotations. Then we arrive on the wards, privates in a medical hierarchy populated by skilled house staff and storied attendings, the lieutenants, colonels, and generals in an elite, crackjack army. In order to move up through the ranks, we emulate them in every way: patients come first; medicine comes first; we’re doctors, after all, virtually invulnerable.

I have yet to meet a physician who has failed to buy into this culture of medical exceptionalism. Lesser human beings need not take the Hippocratic Oath and all that it entails.

But, alas, we physicians are human. Sooner or later, each of us hits personal and professional speed bumps: work-life balance problems that affect us as spouses and parents, stressful changes in the work environment, medical problems, emotional burdens, and the inevitable slowdown that occurs in the fourth quarter of any lengthy career.

Many successful physicians minimize the adversity in their lives and counter it with maladaptive coping strategies. Drink a little more alcohol at the end of a grueling work day and you’ll fall off to sleep more readily. Use that tramadol the patient left in your office to take the edge off of that annoying foot pain and you don’t need to waste half a day getting checked out by some other doctor. Avoid the dark hole of depression that seems to be eating away at you by telling yourself and others that you’re just fine, you’ll get through it. Although they never taught us these nifty tricks in medical school, many of us have mastered the art of self-serving rationalizations. “I’ll tough it out and then I’ll be okay.” It works until it stops working. CRASH!

Over the years, more than 2,500 Massachusetts physicians have found their way to Physician Health Services. It’s not surprising that most of these referrals occur just before things are about to come crashing down.

Individually and collectively, our inclination is to wait until it’s almost too late. A new and important trend at PHS is the growth of self-referrals. More and more Massachusetts physicians are picking up the phone and asking for help when their problems are milder and more manageable. That’s how it should be. We all know that a few ounces of prevention are worth tons of cure. That’s especially true for superheroes.

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.

Minimize Risk
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Boston-based Partners Healthcare, for example.

One reason phishing has become so problematic is that it’s become so sophisticated, Barzin said. “The branding has become so good that these emails really look like things you can’t ignore, and they come on a daily basis from what look like sources we wouldn’t think twice about interacting with.”

What’s more, the way many people quickly sort through emails, it’s all too easy for employees, managers, or physicians to realize a link is not good to click on just a second too late. For these reasons, Pabrai recommends IT-based safeguards. “Most people say it should start from policy and training, but I disagree. If you don’t have strong security controls deployed — antivirus software, antispyware, and the like — you have no chance. The capability to minimize the risk from phishing has to be automated and consolidated,” he said.

Once these systems are in place, however, a human being working for or with the practice must be actively managing them, Pabrai said. This person’s responsibilities must include making sure logs are reviewed, software updates are replied, regular training takes place, and the practice makes applicable updates to its policy documents.

Employee Vigilance

That said, it is still important to train employees to spot suspicious emails, and to never send PHI to an unconfirmed source.

Another best practice is to keep personal and work computers separate, added Hayon. “I tell people in practices that employees should not be surfing the Internet if they’re logged into your server, because that could open their network up to hacking.” To minimize this risk, many practices have set up a dedicated computer not connected to any PHI for employees to check personal email or browse the Internet during their break time, she added.
And the thing that truly baffles me — why are hardware and software companies churning out things like Google Chrome, the iPhone, Wikipedia, YouTube, Android phones, the iPad, Gmail, Facebook, and Twitter, but we still have EMR systems that look and act like Windows 95?

— Josh Herigon, M.D.

This popular quote sums up the frustration that many physicians observe after struggling with clinical documentation using the current crop of EHRs on the market. It also brings into focus why the MMS Committee on Information Technology brought together a panel of pioneers on the frontier of EHR development recently for an evening of open discussion about possible future directions for this controversial technology.

While the CMS Meaningful Use incentive program increased physician use of EHRs from single digits in 2008 to 70% in 2014, those using EHRs report that 60% are slowed down by the technology and 20% report that the quality of the record was worse after adoption of the system.

Faced with this ongoing challenge, on May 7 the Committee on Information Technology hosted the first in a series of events called Apps Invade Health Care: Why You Should Care. A panel of five physicians and technologists started the evening in Boston’s Longwood area with short overviews of their work and then opened the conversation to the audience for an extended examination of the future of Health Information Technology.

Dr. Ken Mandl from Children’s Hospital Boston pointed out that despite massive amounts of data becoming available in health care, almost none of it is used in clinical medicine.

"Doctors do not understand how data is used to inform the way we practice," he said.

The reason for this is that the innovative systems needed to bring the data into current clinical EHRs are monolithic, expensive, and difficult to integrate. The alternative he and his team are developing is called SMART (Substitutable Medical Apps, Reusable Technologies), a platform based on interoperable, substitutable modules that can easily be replaced as new, better clinical interfaces and functionality are developed.

Next in the lineup was Dr. Ricky Bloomfield from Duke Medicine. Dr. Bloomfield is a pioneer in bringing clinical data from wearable devices and Apple smartphones into their EPIC EHR. He began by showing the audience versions of Microsoft Word from 1983 to present and asking where modern EHR technology would fall, pointing out that the EHRs may not currently do exactly what physicians want them to do but will improve over time.

Next up was Dr. Adrian Gropper, an MMS CIT member and privacy advocate, who questioned proprietary, secret technology sold to large integrated academic systems and suggested an alternative: open-source, standards-based, patient-oriented technologies that employ technology to enhance the relationship between patient and physician.

Representing EPIC, a major EHR company, was Raghav Mani, one of the principal programmers on their portal software called MyChart. He pointed out the advantage of standards in interoperability and showed how EPIC has successfully implemented intelligent reports to clinicians feeding data from various patient wearable devices and apps.

Finally, Dr. Charles Safran discussed the big picture of informatics, pointing out that many apps focus on the "worried well" rather than the "truly sick" and distinguished between the "haves" and "have-nots" in smartphones and apps, concluding that the main benefits are in improving the efficiency of transitions-of-care.

Learn more about the presenters and view video of the event at www.massmed.org/apps2015.

If you would like to be notified of the next CIT event in the series, contact Director of Health Information Technology Leon Barzin at lbarzin@mms.org.
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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
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

ONLINE CME ACTIVITIES
Go to www.massmed.org/cme

Financial Management of Practice Case Studies (3 modules)
  • Module 1 — Revenue Cycles Case
  • Module 2 — Finance and Budgeting Case Study
  • Module 3 — Compensation Planning Case Study

Risk Management CME
Electronic Healths 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
  • Legal Advisor: Advance Directives

Pain Management
  • Principles of Palliative Care and Persistent Pain Management (2 modules)
  • Managing Pain Without Overusing Opioids
  • Opioid Prescribing Series (6 modules)
  • Legal Advisor: Identifying Drug Dependence
  • Managing Risk when Prescribing Narcotic Painkillers

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

Other Risk Management CME
  • 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)

Other CME
  • Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
  • Effective Chart Review for Quality Improvement

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.