The Quadruple Aim: Enhancing Patient Experience, Improving Health, Reducing Costs, Plus Improving Staff Morale

BY VICKI RITTERBAND
VITAL SIGNS STAFF WRITER

At hospitals like the Cleveland Clinic, when caregivers are having a trying day, they can call a “Code Lavender.” A team of nurses is dispatched, bearing massages, energy treatments, healthful snacks, and a lavender armband, to remind the person to breathe and relax. It’s a temporary fix to a problem that’s a growing threat to the health care system: caregiver burnout.

Lots of research points to the fact that physicians today are unhappier than they’ve ever been. Some 54 percent of physicians surveyed for a 2014 study published in the Mayo Clinic Proceedings reported suffering from burnout. That was a noticeable jump from just three years earlier, when 46 percent of respondents reported being burned out. And that unhappiness has serious implications for patient care.

Increased rates of physician burnout and depression “lead to our loss of empathy for those who entrust their care to us,” said outgoing MMS president Dennis Dimitri, M.D., in introducing the annual meeting’s educational program, Sustaining Joy in the Practice of Medicine: Compassion, Innovation, and Transformation. But there’s hope, according to the session’s three speakers, who each offered ideas about how to put the joy back into medicine.

HOD Approves Effort to Improve Medical Student Licensing Exam

Delegates Also Seek to Increase Participation in HIE

The MMS will seek to improve the clinical skills assessment exam required for licensure of medical school graduates and increase access to electronic records on the Massachusetts Health Information Highway (Mass HIway), thanks to a pair of resolutions the House of Delegates (HOD) passed at May’s annual meeting.

The United States Medical Licensing Examination Step 2 Clinical Skills exam, required of graduates of U.S. osteopathic and allopathic medical schools for licensure, has been criticized as redundant, costly, and inconvenient. Most importantly, critics charge that it truly measures clinical skills. Massachusetts medical students argue that as a graduation requirement, their schools require them to pass multiple clinical exams that are as rigorous, and in some cases more so, than the national exam.

In response, the HOD voted to urge the Massachusetts Board of Registration in Medicine to eliminate the test as a prerequisite to licensure. The resolve also requires the MMS to advocate for the National Board of Medical Examiners and the American Association of Medical Schools to work jointly on a better

continued on page 7
A Full Agenda in the Coming Year
I am honored to be serving as MMS president and look forward to a year of challenges, successes, and a lot of learning.

In truth, no issues belong to a single presidential year anymore. Our medical society will continue to take a leadership role confronting the opioid crisis that has claimed so many lives here in Massachusetts and across the nation. Our well-received education programs on opioid prescribing and pain management will be updated and expanded as needed and will remain free to all prescribers. We will also continue to advocate for more resources for patients with substance abuse disorders and mandatory insurance coverage for these services.

The economics of health care — how much it costs and how physicians are paid — are top of mind for me as I begin my tenure as president. Pharmaceutical prices and price transparency are receiving much-needed attention and will be high on our agenda this year. And we’re very much in sync with the public’s concerns. Last year’s poll by the Kaiser Family Foundation found that 72 percent of Americans believe that drug prices are unreasonable. We will also continue to follow the evolution of new payment models for Medicare and MassHealth and lend our voice to those issues as necessary (see related story on p. 5).

I’d like to look inward as well and examine our governance structure to ensure we encourage participation by our younger members. As in any organization as established as ours, these members are our lifeblood and our future. It promises to be an exciting year, and I look forward to working with many of you.

Quadruple Aim

- Additional nurses or medical assistants who take on much of the administrative burden and lower level clinical tasks: In some offices, physicians have two or three nurses assigned to them. Nurses can do all of the immunizations, schedule cancer screenings, conduct and document diabetic foot exams and hypertension visits, etc.

- Design changes to the environment: These include printers in every exam room so staff don’t have to leave patients, semi-circular desks that allow physicians to face patients, and radio frequency identification technology that enables physicians to sign onto computers with a wave of an identification card.

A Culture of Healing
M. Bridget Duffy, M.D., chief medical officer of Vocera Communications, cited her father, a retired periodontist, as one of her role models. At the end of the day, she said, he would call all the patients he performed surgery on that day to check up on them. “We invade people’s bodies, we crack their ribs, but we don’t call them to see how they’re doing,” said Dr. Duffy, who previously served as chief experience officer of the Cleveland Clinic, the first senior position of its kind in the country. “The best parts of our job are the human moments and relationships we have with patients.”

Dr. Duffy spoke about creating a culture of healing, in which patients are treated as people, not as medical cases. Now, in some operating rooms, it’s standard procedure for members of the surgical team to introduce themselves to the patient and explain what their roles are. She also pointed out the fear informed consent can provoke in a patient about to undergo a procedure, quoting a patient who asked, “Why, right before you put me to sleep do you tell me I can bleed, get an infection, and even die? Why not give us informed hope?” Dr. Duffy said that as a complement to informed consent, some health care organizations have instituted an informed hope process during which a caregiver — often a nurse anesthetist — asks patients about their health care goals, their fears and concerns, and the support they need to feel more comfortable with the procedure.

Another hospital, seeking to make the admissions process less stressful for patients, has instituted what it calls a “sacred moment on admission,” when patients are asked similar questions to the pre-surgery ones.

An important part of creating a culture of healing is ensuring that each member of the staff — no matter how ostensibly removed from direct patient care —

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CMS’s Slavitt Talks MACRA
“The role of payment models and incentives is simply to reinforce what the clinician believes to be the right way to deliver care. If incentives are done well and done right, clinicians will get reinforcement financially; and the payment system gives them the opportunity and the dollars to invest and reinvest in the kinds of things that they believe are right for their practice and for their patients. We have to make sure it is clear that we know it is the clinical and cultural leadership that improves quality, not public policy.”

— CMS Acting Administrator Andrew Slavitt during a recent interview with the MMS about the Medicare Access and Summary CHIP Reauthorization Act of 2015 (MACRA)

To read the entire interview, visit www.massmed.org/blog.
Advance Care Planning in Your Office

BY RYAN MARLING
PPRC SPECIALIST

As of January 1, the Centers for Medicare and Medicaid Services (CMS) began reimbursing physicians for consulting with patients and their families about advance care planning (ACP). An ACP visit is a face-to-face conversation between a physician and patient about future care treatment. This conversation compels the patient's decision-making capabilities. The conversation may include discussion of advance directives.

These appointments can help enhance patient-centered care—care that is respectful of and responsive to individual patient preferences, needs, and values. ACP appointments are intended to ensure that patient values guide all clinical decisions when patients' conditions prevent them from participating in decision making.

Keep in mind that Massachusetts law allows people 18 years of age or older to name health care proxies, but does not officially recognize living wills. During an ACP visit, encourage patients to discuss their end-of-life wishes with whomever they appoint as agents in their health care proxy document.

Other steps physicians can take include the following:

• Encourage patients to make at least four copies of the completed and signed health care proxy form and send one copy to you.
• Urge patients to notify you in writing of any changes they make to their health care proxy form or if the form is revoked.
• Have Medical Orders for Life-Sustaining Treatment (MOLST)—intended for patients who are clinically viewed as being in their last year of life—and health care proxy forms available. Proxy forms can be found at www.massmed.org/proxy and MOLST forms at molst-ma.org.

A brochure to share with patients and further information on advanced care planning is available at www.massmed.org/advancecareplanning.

Ensuring Revenue Collection in an Evolving Reimbursement Climate

BY JILLIAN PEDROTTY
PPRC SPECIALIST

The evolving health care environment has changed the way physicians are reimbursed. While insurers continue to pilot new products, there has been an increase in popularity of those with low monthly premiums that place more financial responsibility on the patient, in the form of higher co-payments or deductibles. The decline in provider reimbursement and increase in high deductible plans makes it more important than ever to have policies and procedures in place that help ensure the patient’s contribution is collected at the time of service.

For nonurgent office visits, consider incorporating the following suggestions:

Educate your staff: Each staff member should be knowledgeable about the practice’s collection policies and the importance of collecting co-payments at the time of service. This should be a team effort and all employees should be able to explain the policies to patients and be proactive about collecting payments.

Communicate your financial policy: When scheduling an appointment, inform patients of their financial responsibility, if possible. One way to do this is by mentioning any outstanding balances. Patients are more likely to be prepared if they have advanced knowledge of owed balances or expected co-payments or deductibles and associated practice policies for collection.

Verify health insurance eligibility and benefits: Checking eligibility and other patient information prior to visits is extremely important and will help to ensure there are no surprises when patients arrive.

Estimate patient responsibility: Staff should verify any co-payments and make sure they are collected when patients check in. When possible, estimating patients’ share after insurance will help your staff communicate financial expectations, which can ease the collection process.

Quadraple Aim

understands his or her importance to the care process, according to Dr. Duffy. She described a hospital where the housekeepers have business cards and are taught to view their role as preventing infection and making patients more comfortable. “There are many ways to make everyone on a team feel the purpose of their job and that’s what brings joy back to medicine,” she said.

Dr. Duffy stressed that these types of changes are much more likely to be embraced if they are promoted by physicians, not by the administration. “I often go and find the biggest curmudgeons — the biggest obstacles — in the organization and engage them to lead the work on well-being, resiliency, and patient experience,” she explained.

Understanding the Patient Experience

Jeffrey Cain, M.D., chief of family medicine at Children’s Hospital Colorado and a double below-knee amputee, talked about the hard-won insights he gained when he became a patient in his own hospital, following a plane crash that left him severely injured.

His experience as a patient profoundly changed him as a doctor, he said. He became more present for patients, sitting at the edge of their beds as he chatted. At first, his new habit was due simply to the fact it hurt to stand for too long, but later it transformed into something else. “Sitting next to them connected me with my patients in a way that reminded me why I went into medicine in the first place,” said Dr. Cain. “When we take off the white coat and really connect with our patients, we open the door for healing to begin.”

HOD Passes HIT Principles That Put Patients First

Electronic Medical Records have been the bane of some physicians’ practices, but a boost to others. In Massachusetts, adoption of health information technology (HIT) has been widespread, while acceptance has been another story.

At May’s annual meeting, the MMS House of Delegates unanimously approved a new set of principles governing HIT as it applies to physician practice. The principles were authored by the Committee on Information Technology (CIT) and state that health information technology available to physicians should accomplish the following:

• Support the physician’s obligation to put the interests of the patient first
• Support patient autonomy by providing patients access to their own 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

Guided by these principles, the MMS will continue to work on the issue of health information technology, with a focus on how its tools can improve patient care and physician practices. Members may read more about the MMS’s renewed effort on HIT in “The President’s Podium” by MMS President James S. Gessner, M.D., at blog.massmed.org.
State Releases Oral Health Practice Guidelines for Pregnancy and Early Childhood

BY HUGH SILK, M.D.
PROFESSOR OF FAMILY MEDICINE AND COMMUNITY HEALTH, UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL

The Massachusetts Department of Public Health has released its Massachusetts Oral Health Practice Guidelines for Pregnancy and Early Childhood. The guidelines provide oral health care recommendations and resources for health care professionals caring for pregnant women and young children. The guidelines are available at www.mass.gov/dph/oralhealthguidelines.

They answer questions about screening, prevention, referrals, and the safety of dental interventions and treatment for patients. They also provide resources to help physicians address oral health more effectively.

Dental caries is the number one chronic disease for children, affecting more than 40 percent of youngsters; unfortunately, more than half of the cases go untreated. Good oral health for young children begins with good oral health for the mother during pregnancy.

Hormonal and other physiological changes during pregnancy put women at risk for oral conditions such as enamel erosion, dental caries, periodontitis, gingivitis, loose teeth, and pregnancy oral tumors. If a child is born to a mother with active caries, the decay-causing bacteria can be passed to the baby, once teeth begin to erupt. Proper oral health care during pregnancy can reduce these bacteria.

While the American College of Obstetrics and Gynecology emphasizes that dental treatment is safe and desirable during pregnancy, only 50 percent of pregnant women receive a dental cleaning, according to the Massachusetts Pregnancy Risk Assessment Monitoring System. Often women are misinformed about the safety of dental care during pregnancy; for example, they may believe that x-rays are dangerous for the fetus.

Oral health is an important part of overall health, and health care providers can play a critical role in educating patients and collaborating with other professionals to improve oral health care.

MMS and Alliance Charitable Foundation Awards 15 Grants

BY JENNY LEONARD
PUBLIC HEALTH INTERN

In April, the MMS and Alliance Charitable Foundation issued 15 grants totaling more than $213,000 to organizations that focus on improving and supporting health in Massachusetts.

The grants are as follows:

- **Amherst Survival Center:** $22,000 to support the Free Health Clinic, which provides high quality medical care on a walk-in basis.
- **Boston Health Care for the Homeless Program:** $25,000 to expand the hours and services at its clinic located at the Southampton Street Shelter to ensure that patients can access consistent, high-quality health care for urgent and preventive health needs.
- **Boys and Girls Clubs of MetroWest:** $7,500 to support the Framingham Clubhouse Triple Play program, which promotes eating right, keeping fit, and forming positive relations for club members.
- **BU School of Medicine — Bridging the Gaps in Care:** $5,000 to support medical students’ and their physician mentors’ provision of preventative screenings, health education, and social supports to low-income, medically underserved residents of subsidized elderly housing in Boston.
- **Harvard Medical School’s Family Van:** $20,000 to further efforts to develop multisector collaborations to address the medical and social factors preventing clients from taking care of themselves and their families.
- **Father Bill’s and MainSpring:** $10,000 to support the MainSpring Outreach Project, a collaborative community-based project to engage at-risk Brockton homeless men and women, many with complex issues including mental health and substance abuse, who are living outside, and link them with services, including early detection, health promotion, and medical care.
- **Gavin Foundation:** $12,000 to support the Enrollment Assistance Support and Information (EASI) project at the South Boston District Court and its expansion to the Dorchester Municipal Court. The EASI project helps clients and their families through the barriers of starting substance abuse treatment.
- **Health Care Without Walls:** $20,000 to support year one of the Bridges to Moms pilot program, which seeks to improve health outcomes and maternal bonding among homeless pregnant and postpartum women receiving care at Brigham and Women’s Hospital.
- **Latino Health Insurance Program:** $12,500 to support the Lung and Heart Improvement Project, for hypertension screening, individualized cardiac risk assessment, smoking cessation, and culturally competent health education and behavioral health improvement strategies for uninsured and underinsured low-income Latinos in the MetroWest area.
- **MetroWest Free Medical Program:** $10,000 to support a pilot medical-legal partnership to screen for and address the socioeconomic needs of patients and optimize their eligibility and utilization of public benefits and community resources to improve health.
- **RESPOND Inc.:** $11,505 to support the Teen Dating Violence Program, providing students in middle and high school access to the knowledge, skills, and resources needed to advocate for safer relationships and seek help when necessary.
- **Rosie’s Place:** $10,000 to support the Community Health Outreach Worker Program, which provides medical/health support for poor women who are unable to access adequate medical care because of developmental delays, chronic mental illness, and/or substance abuse.
- **The Sharewood Project:** $10,000 to support student-run free health care clinic in Malden, which provides urgent care services to medically underserved individuals and families.
- **Sociedad Latina:** $12,500 to support the Health Educators in Action (HEIA) project, a collaborative outreach effort to increase cancer awareness and screening, individualized cancer risk assessment, smoking cessation, and culturally competent health education and behavioral health improvement strategies for uninsured and underinsured low-income Latinos between the ages of 14 and 24.
- **VIM Berkshires:** $25,000 to support the Non-Opioid Pain Management Program, which uses acupuncture, therapeutic massage, behavioral health therapy, and nutrition counseling to address chronic and episodic pain and prevent the use of opioids.
Proposed MACRA Rule Outlines New Ways Physicians Will Be Paid

BY LEON BARZIN, MMS HIT DIRECTOR, AND ALEX CALCAGNO, MMS DIRECTOR OF FEDERAL AND COMMUNITY RELATIONS

On April 27, the Centers for Medicare and Medicaid Services (CMS) released its much-anticipated notice of proposed rulemaking (NPRM), containing draft regulations to implement the Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act, or MACRA. Comments about the draft rules are due to CMS by June 27. Final regulations will likely be issued in the fall.

As this issue of Vital Signs went to press, MMS staff was still analyzing the 962-page document. The MMS’s detailed analyses, comments, and recommendations will be available at www.massmed.org as they are completed. The CMS has invited physician comments about the proposal and is hosting nearly 40 listening sessions in the next two months. The agency has responded to physicians’ concerns in several areas; for example, the draft rules seek to streamline the cumbersome reporting process and eliminate the pass-fail approach to scoring. Areas of the regulations that will continue to be debated include the impact on small physician practices, the definition of risk, and the specifics of the Advancing Care Information program — the new version of Meaningful Use (MU). CMS Administrator Andrew Slavitt has publicly acknowledged the need to address the proposal’s limitations and is reaching out to physician groups to suggest specific changes.

The NPRM outlines details of how physicians and other eligible Medicare providers will be paid, beginning in 2019, under the new Quality Payment Program, which includes two payment tracks defined by the MACRA law. The first, building on a fee-for-service approach, is called Merit-Based Incentive Payment System, or MIPS. Medicare reimbursement for physicians under the MIPS will be based on their composite scores in the following four performance categories:

1. Quality: 50 percent of the score in year one
2. Advancing Care Information: 25 percent of the score in year one
3. Clinical Practice Improvement: 15 percent of the score in year one
4. Cost or Resources Use: 10 percent of the score in year one

According to Slavitt, the Advancing Care Information program improves on its MU predecessor: the proposal allows physicians to choose the measures that best reflect their practices’ use of technology, reduces the number of measures from 18 to 11, and moves away from the pass-fail system, to name a few differences. As required by the MACRA law, the CMS is also working on developing a more accurate risk adjustment tool that factors in the impact of patients’ socioeconomic status on quality.

Although the new payment methodology will not be employed until 2019, the CMS proposes to use 2017 data for the MIPS score, which medical organizations oppose because it leaves insufficient time for providers to prepare. Under the MIPS, physicians can receive up to 4 percent in bonuses or penalties in 2019. Both will increase in subsequent years.

The second payment track is called Alternative Payment Models (APM) and pertains to organizations that assume risk as defined by the rule. There are several proposed APM models, including Advanced APMs, whose users must meet certain quality measurements, use certified electronic health records, and assume nominal risk. The proposal includes a very complicated definition of risk, which states that total risk must exceed 4 percent, marginal risk must be more than 30 percent, and the minimum loss ratio must be no more than 4 percent. Other models outlined in the proposal include MIPS APMs, APMs which do not meet the Advanced Payment requirements, and Physician Focused Payment Models. The current proposed rule presents a narrow definition of groups that would qualify as APMs — another key focus of the MMS and other medical organizations’ comments.

It is important to underscore that this proposal is a draft. The MMS, AMA, and other state and national stakeholders will be working diligently over the next several months with the CMS and Congress to develop the final regulations.

New PMP Slated to Launch at the End of the Month

BY BRENDAN ABEL

MMS ASSISTANT COUNSEL

The Department of Public Health’s (DPH) new Prescription Monitoring Program (PMP), “MassPAT” (Massachusetts Prescription Awareness Tool), is scheduled to be launched in late June, providing no technical problems emerge.

The state’s current PMP system, often touted as an important tool to ensure proper opioid prescribing, has been plagued by inefficient design and outdated functionality. Last year, Governor Charlie Baker pledged $6 million to procure a new prescription monitoring program, and the DPH finalized a contract this year with Appriss to use its prescription monitoring product that is currently utilized by several other states.

New Name, New Functionality

MassPAT will have increased functionality, including enhanced searching and a streamlined login process. The new system will no longer require physicians to access the site through the state’s “Virtual Gateway” website, thus eliminating one step in the login process. The Appriss support team will be available 24/7 to assist users.

MassPAT will have more up-to-date data as well. Recently, pharmacies have been able to upload data every 24 hours rather than every seven days as they did in the past, and the new system will process the data almost immediately. The system is projected to contain the past 12 months of prescribing data from Massachusetts Veterans Administration system and provide immediate access to Rhode Island, Connecticut, and New York prescribing data.

Prescription data from other states, including Vermont and Maine, are expected to come online in the near future. The state is discussing shared prescribing data with New Hampshire as well. Once the initial implementation of the system is complete this summer, the DPH and the vendor will shift their focus to integrating the prescription monitoring system with Electronic Medical Records (EMRs), something that has been successfully done in other states. Physicians should begin asking their EMR vendors about integration with MassPAT.

New Account Process

Physicians are currently required to query the PMP prior to prescribing to a patient for the first time a Schedule II or III narcotic or a benzodiazepine. In October, the system will have to be queried every time a Schedule II or III narcotic is prescribed. Any prescriber who writes prescriptions for either of these drug categories is required to create a new account for the system. The old PMP will no longer be active once MassPAT is launched.

The DPH will send information to physicians with instructions about creating an account for the new website. Creating accounts will no longer require the submission of paper forms. This also applies to delegates who will be able to create an account online and access the program once a licensed prescriber verifies their account. Please note that you will need your state medical license number, your DEA number, and your Massachusetts Controlled Substances Registration number. More information is available at the DPH website and at www.massmed.org/MassPAT.
Changing the Culture of “Presenteeism”

BY STEVE ADELMAN, M.D.
PHS DIRECTOR

“Dr. Gasket,” an ER physician in a small community hospital, blows up at the demanding family of a somatizing patient who appears to be exceedingly interested in receiving a prescription for oxycodone to alleviate an acute exacerbation of nonspecific musculoskeletal pain. Other patients and staff witness the outburst, which included finger-wagging, profanity, and shouting. After a minute, the doctor retreats to a private office to calm down. But the damage is done. Reports of her unprofessional behavior find their way to the CEO of the hospital, and the patient’s family files a complaint with the Board of Registration in Medicine. One thing leads to another and the physician is placed on administrative leave. It’s rather easy for me to make up this story, because I hear stories like this more often than you might imagine.

Why did Dr. Gasket behave this way? She came to work despite the fact that she experienced an exacerbation of her asthma over the weekend. She started coughing and wheezing more on Monday, but soldiered on, because that’s what we do. She was using more and more rescue doses of albuterol to no avail. One of her colleagues took pity on her, so she took a sick day on Tuesday, hoping that the prednisone left over from her previous exacerbation would kick in. She got up on Wednesday morning feeling a touch better, but she wasn’t sure she’d be able to handle her entire shift. None of her colleagues could cover. So she reported for duty at 8:00 a.m., hoping for the best.

Working While Sick
She just wasn’t herself. She had slept poorly the night before. During a busy shift, she attempted to take it easy as much as possible, but her discomfort never disappeared. Her angry outburst at the end of the shift was an unintended, unexpected, and unfortunate consequence of her decision to work while ill.

This decision was a byproduct of what JAMA has recently dubbed our “working while sick culture.” A perverse culture of “suck it up and soldier on” is alive and well in the medical profession. It is aided and abetted by institutions and systems that are not structured nor funded in a way that accommodates the reality that physicians are human, and that human beings are not able to show up and function in top form 100 percent of the time.

Last year, Julie Szymczak, Ph.D., and colleagues reported on a study of 536 clinicians in a pediatric hospital. They found that 83 percent reported that they continued to work while ill (JAMA Pediatr. 2015; 169(9): 815–821). An earlier study entitled “Presenteeism Among Resident Physicians” (JAMA 2010; 304(11): 1166–1168) found that 58 percent of residents reported for duty while ill on at least one occasion. These norms are abnormal. Patients don’t want to be treated by ill physicians, and physicians who attempt to practice medicine while ill are prone to errors in judgment that may jeopardize the care of the patient and the career of the physician, as in the case of Dr. Gasket.

Creating Float Pools
What can we do to change this perverse culture of presenteeism? Mark Linzer, M.D., estimates that when we are “adequately” staffed we are actually under-staffed by 10 percent (Am J Med. 2002; 113: 443–48). He advocates for the creation of “float pools” that increase the reserve of the system by 10 percent, and he asserts that this may be a cost-effective intervention. If we consider how the loss of Dr. Gasket places stress and strain on the department and the institution, it makes intuitive sense that float pools would promote better patient care, encourage improved physician health, prevent burnout, reduce turnover, and ultimately pay for themselves.
standardized clinical skills exam to be administered at every U.S. medical school.

**Sharing e-Records**

Delegates also voted in favor of a resolution to have the MMS work with the Massachusetts Executive Office of Health and Human Services and the Massachusetts eHealth Institute to change the process for gaining consent from patients to have their records shared across the electronic health information exchange. Currently, patients must opt-in to participate. The resolution asks that instead, the default be that records are shared unless patients opt-out. Lowering the barrier to participation, the change would allow physicians to exchange more health records via the MassHiway.

The HOD also adopted these policies:

- **Jail Diversion Program**: Delegates voted to support the statewide implementation of jail diversion programs for those with substance use disorder and to advocate for more government funding for treatment programs.

- **Intellectual/Development Disability**: Members adopted a resolution to provide continuing medical education opportunities addressing the medical care of this population.

- **Preventing Weight Stigma and Discrimination**: The MMS expanded its policy on obesity, resolving to develop and promote educational information to physicians and medical students about weight stigma and to advocate for legislation and practices to prevent stigma and discrimination.

- **Human Trafficking**: Delegates called for the integration of human trafficking education into medical school curricula and the schools of other health professions, the promotion of continuing education and training on the subject, and increased research on human trafficking.

- **Advertising by Pharmaceutical Companies**: Physicians voted to advocate that all direct-to-consumer advertising spending by pharmaceutical companies be reported publicly, to urge such costs not be passed on to patients, and to request that all relevant government agencies require reporting of direct-to-consumer advertising costs.

Final votes on all resolutions may be viewed at [www.massmed.org/hod](http://www.massmed.org/hod).

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**ACROSS THE COMMONWEALTH**

**District News and Events**

**NORTHEAST REGION**

If you have Northeast District news to contribute, please contact Michele Jussaume or Linda Howard, Northeast Regional Office at (800) 944-5562 or mjussaume@mms.org or lhoward@mms.org.

**SOUTHEAST REGION**

Plymouth — Executive Committee Meeting. Wed., Aug. 17, 6:00 p.m. Location: MMS Southeast Regional Office, Lakeville.

For more information, or if you have Southeast District news to contribute, please contact Sheila Kozlowski, Southeast Regional Office at (800) 322-3301 or skozlowski@mms.org.

**WEST CENTRAL REGION**

Hampshire — Legislative Breakfast. Fri., June 10, 7:30–9:00 a.m. Location: Cooley Dickinson Hospital, Conference Room B, Northampton.

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

**Statewide News and Events**

**Arts, Humanism, History, and Culture Member Interest Network — Herb Workshop.** Sat., July 16, 9:00–11:00 a.m. Location: MMS Headquarters, Waltham. Preserving the Tastes of Summer — How to Capture the Essence of Herbs to Infuse Your Life Year Round.

**River Ecology Cruise/Merrimack River Tour.** Sat., Aug. 13, 11:00 a.m.—1:00 p.m. Location: Joppa Flats, Newburyport. You will be introduced to the ecology, maritime history, and breathtaking beauty of the Merrimack River and estuary.

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

1 > The Quadruple Aim of Improving Health Care
   > HOD Pushes for Increased HIE Participation and Better Licensing Exam
2 > President’s Message: Full Agenda
   > Physician Well-Being Poll
3 > Advance Care Planning
   > Ensuring Revenue Collection
   > HOD Passes HIT Principles
4 > Firearms Safety
   > Oral Health Practice Guidelines
   > MMS and MMSA Grants
5 > Proposed MACRA Rule
   > New PMP Launch
6 > Changing the Culture of “Presenteeism”
   > In Memoriam
7 > Midlife Women’s Health
   > Across the Commonwealth

MMS AND JOINTLY PROVIDED CME ACTIVITIES

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

Women’s Leadership Forum
Building Leadership Skills: What’s in Your Toolbox?
Fri., September 16, 2016

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

Risk Management 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 Series (3 modules)
• The Importance of Discussing End-of-Life Care with Patients

Additional Risk Management CME Courses
• Initiating a Conversation with Patients on Gun Safety
• Bullys and Victims: Can You Tell the Difference?
• Intimate Partner Violence: The Clinician’s Guide to Identification, Assessment, Intervention, and Prevention
• 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
• Preventing Overuse of Antipsychotic Drugs in Nursing Home Care
• Finance 101 for Physicians and Practice Administrators

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.