

VITAL SIGNS



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Can the Doctor See You Now? Access to Primary Care Still a Statewide Problem

BY VICKI RITTERBAND

Despite the healthy supply of physicians in Massachusetts, some patients must still wait as long as four months for a first-time visit with a primary care physician.

A new MMS study shows that new patients seeking an appointment with an internist in the New Bedford area can expect to wait an average of 128 days. Typical waits for family physicians in Berkshire County can reach 102 days.

These numbers are much higher than those in other parts of Massachusetts, but the average wait times statewide for adult primary care are still too long,

said MMS President Ronald Dunlap, M.D.

"The fact that even in a high-supply state, we have a 50-day wait for internal medicine and a 39-day wait for family medicine is reflective of the depth of the problem," said Dr. Dunlap. "And the regional data shows significant variation in access and physician supply from county to county."

Now in its ninth year, the MMS's Patient Access to Care study asked 1,137 physician offices (e.g., internists, family physicians, OB/GYNs, gastroenterologists, cardiologists, pediatricians, and orthopedic surgeons) the following:

- How long do new patients wait for non-emergency appointments with a physician?
- Do they accept new patients?
- Do they accept Medicare and MassHealth?

Year after year, the headline for the wait times study has remained stubbornly consistent: primary care doctors are in short supply. And it's hardly just a Massachusetts story. Nationally, 16,000 primary care providers are needed to meet today's need and an estimated 52,000 primary care physicians by 2025, according to a 2013 report, *Primary Care Access*, authored by the U.S. Senate

Committee on Health, Education, Labor, and Pensions.

Primary Care Waits

Richard Dupee, M.D., an internist and geriatrician with Wellesley Hills PCMH, attributes the long waits for internists — the average jumped by six days since last year — to a couple of factors: first, state and federal health care reform continues to add new patients to the rolls of the insured. Second, with Medicaid rates rising to Medicare levels for certain primary care services this year, it's likely that some internists are accepting Medicaid patients for the first time, making their panels even larger, he said.

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Writing 'The Next Chapter' in Massachusetts Health Care Reform *A Vital Signs Interview with David Seltz, Executive Director of the Health Policy Commission*

BY ERICA NOONAN

The newly created Health Policy Commission faces a formidable task: to oversee and implement the ambitious spending limits set forth by Governor Deval Patrick in his 2012 payment reform law.

At the same time, the commission must navigate other uncharted health care waters, namely overseeing the certification of accountable care organizations, and a series of regional hospital improvement grants.

The commission has also broken new ground by electing to review certain large hospital mergers.

For the commission's executive director, David Seltz, taking over the top post six months ago was a chance to pursue a challenge he

called "the next chapter" in Massachusetts health care reform.

"Personally, I have a passion for this. I believe the ongoing health reform here in Massachusetts is worth defending and strengthening, and this coalition around this effort is so important to that," said Seltz, 32, a former health care advisor to Gov. Patrick and Massachusetts Senate President Therese Murray.

Seltz sat down with *Vital Signs* to discuss his first several months on the job, the challenges and time pressures his agency faces,

and how policymakers should best balance cost controls with economic growth.

The commission won't be able to change decades of entrenched practices overnight, Seltz said.

"This isn't going to be solved in one year," he said. "If we are too focused on the year-to-year [in terms of cost-containment] we are going to lose something in the

long term. It's not just about meeting the benchmark, but also what is driving it and what is happening underneath that."



"I believe the ongoing health reform here in Massachusetts is worth defending and strengthening"

— David Seltz

Because health care is a top Massachusetts industry and employer, Seltz said he must frequently address concerns from business groups and health care systems that overenthusiastic cost-cutting and patient protections will halt growth.

"We take the job of balance very seriously," he said. "The vibrancy of the health care industry is so connected to our innovation economy... We wanted to ensure that our actions regarding cost containment would not be a hindrance. Part of this is pushing towards shared goals, but recognizing that change can be destructive sometimes."

"You could imagine a scenario where we meet the benchmark

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PRESIDENT'S MESSAGE



Practice Integration and Alignment

We recently convened our first major MMS program designed to help physician practices navigate issues of clinical integration and alignment.

The two-hour program generated excellent dialogue on the issues and challenges unique to practicing medicine in Massachusetts.

What we call "the big shift" is already happening. The old fee-for-service system and fragmented delivery services are fast transitioning to physician integration and a patient-centered health management paradigm.

The need for new infrastructure has resulted in alignment and consolidation before alternative payment models are fully developed and implemented.

I have long believed that physician-led systems provide the best opportunities for physicians to control their environment and their practice of medicine.

As we look at successful models of clinical integration, we see that physician-led teams are also crucial to that effort.

If we are at the bottom of the governance tree, we will have to live with the results of decisions made by others. We cannot be passive in that regard.

Physicians must have the necessary internal leverage to implement principles needed to make ACOs and other integrated care models a success.

MMS can offer a unique service in the coming year by providing the resources and forums for physicians to share experiences and analyze system problems.

In the coming months we will host more forums in the western and southeast regions of the state to engage members in this crucial conversation about our future. I hope you will make time to join us.

Ronald W. Dunlap

— Ronald W. Dunlap, M.D.

Can the Doctor See You?

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Yet for every internist who accepts new patients, another internist does not: 55% turn away new patients. And Dr. Dupee, who has practiced for 39 years, attributes that partially to the greying of internal medicine.

"Many primary care practices have been around for a long time and the physicians are not interested in taking on new patients," said Dr. Dupee, who still accepts new patients. "They're maxed out. They want to go home at a decent hour." And for salaried internists working for hospital-owned practices, the incentive to squeeze in that new patient just isn't there, he said.

The PCP Pipeline

It's pretty much the same story — shortage-wise — when it comes to family physicians, according to the 2013 MMS survey. And judging by the lack of new family physicians in the Massachusetts pipeline, it's unlikely to get much better, according to Joseph Gravel, M.D., chief medical officer and residency program director at Greater Lawrence Family Health Center.

"We like to think in Massachusetts that we're progressive and leading the curve," said Dr. Gravel. "But the fact is 8.5% of residents are in family medicine nationally, but only 3.5% in Massachusetts. We shouldn't be so far below in terms of primary care physicians." Dr. Gravel attributed the paucity of family physicians largely to the dominance of tertiary medical centers in the state.

Other Specialties

While wait times for other specialties haven't changed much

since last year, the one exception — and bright spot — was gastroenterology, where average wait times fell by 11 days to the lowest level since the study began — 33 days (although in Franklin County, patients wait on average 213 days, the longest wait time for any specialty anywhere in the state). Douglas Pleskow, M.D., a gastroenterologist with Beth Israel Deaconess Medical Center, said his colleagues recognized that long waits have been a problem in the past. "The shorter waiting time

"The fact that even in a high-supply state, we have a 50-day wait for internal medicine and a 39-day wait for family medicine is reflective of the depth of the problem."

— Ronald Dunlap, M.D.

is the response by the GI community to the demands of our patients," said Dr. Pleskow. As is the case every year, orthopedic surgery had the shortest average wait time (22 days), followed by pediatrics (25 days) and cardiology (28 days).

Medicare and MassHealth Acceptance

The vast majority of Massachusetts physicians accept Medicare, and while internists are the least likely to, 85% still do. MassHealth is also commonly accepted, although a sizable number of

Where have all the PCPs gone?

30% of U.S. physicians are PCPs, while **70%** are specialists.

50 years ago, half of U.S. physicians practiced primary care. Today, fewer than one in three do.

The average primary care physician in the U.S. is **47**, and one in four is nearing retirement.

*From Primary Care Access (2013)
U.S. Senate Committee on Health,
Education, Labor, and Pensions*

family physicians and internist are saying no — 30% and 34% respectively.

"When you get just 60 cents on the dollar, why would you join?" asked Dr. Dupee, the Wellesley internist and geriatrician. "[For PCPs], many studies show that Medicaid fees just pay the overhead. Most practices that do accept Medicaid are downtown clinics that receive city or state help."

Dr. Dunlap believes that Massachusetts will have won the universal care battle when access is improved in even the most underserved areas of the state.

"That's the frontier that needs to be crossed," he said. "And those regional differences in access in turn affect quality." **VS**

The complete study can be found at massmed.org/patientaccess.

Letters to the editor should be 200 words or fewer, and all are subject to editing. Send to the MMS Department of Communications, 860 Winter Street, Waltham, MA 02451-1411; vitalsigns@mms.org; or fax to (781) 642-0976.

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YOUR PRACTICE

How to Run a Quality or Process Improvement Project

Financial incentives are being increasingly tied to improvements in quality and efficiency scores as the environment continues to shift toward alternative payment models. As a result, many practices are seeking new opportunities to improve quality and efficiency in the practice setting. Practices that want to improve in these areas may want to consider running a quality or process improvement project to help boost their scores. Here are some steps that may help you get started:

Pick an Area of Focus

The first step in running a quality and/or process improvement project is to pick an area of focus. Appointment wait times, post-appointment follow-up contact, and ease of accessing information are some potential areas for improvement that are correlated with patient experience scores, for example. Practices that want to engage in an improvement project should first determine which area they want to focus on.

Set SMART Goals

Once a topic has been determined, set a clearly defined SMART goal. A SMART goal is specific, measurable, attainable, relevant, and time-based. An example of a SMART goal for reducing wait times is: "Reduce mean wait time for primary care patients by 5 minutes from when they check in to when they are called into the exam room. This will be achieved within six months of project implementation." You may need to conduct an initial assessment of your practice in order to determine a goal that is attainable. In this example, you should know the current average wait time and what factors influence wait time in your practice.

Design a Process

Consider the steps necessary to achieve your SMART goal:

- **Conduct a baseline data analysis.** Measure the process, examine the current data, and

determine what the targeted improvement should be.

- **Analyze the process.** Determine how the current process is working and whether there are unnecessary steps that can be streamlined.
- **Determine the opportunity for improvement.** Consider the opportunities for process redesign or extra step elimination. Consider whether there are resources that are necessary to make things more efficient and whether or not workarounds have been created over time.
- **Create an action plan.** Outline the steps that you will take to improve the process and define who is responsible for undertaking the necessary actions.
- **Implement.** Move forward with redesigning the process within a targeted timeframe according to your action plan.
- **Monitor the process and review the data.** Make sure that the

implemented actions had the desired effect of improving the process.

- **Measure your progress and adjust accordingly.** Ask questions such as: What has worked? What has not worked? What should be done differently moving forward based on findings? Include your staff in every step of the decision-making process.
- **Continue to monitor the process post-implementation.** Don't miss additional opportunities to streamline even after changes have occurred.

A successful quality or process improvement project will likely have many positive benefits on your practice, from financial rewards to improved satisfaction of patients and staff.

If you would like more details about how to implement a quality and/or process improvement project, visit www.massmed.org/pprc or contact PPRC Consulting Services at (781) 434-7702 or pprc@mms.org. **VS**

— Georgia Feuer

MMS 2013 Public Opinion Poll Results: Affordability is Key Concern

Seventy-eight (78) percent of Massachusetts adults believe that affordability is the single most important health care issue facing the state, according to the 2013 MMS Public Opinion Poll, released last month.

Residents were more likely to cite affordability and cost-related issues than issues related to health care access by a three-to-one margin. Access-related issues are a distant second, mentioned by just 13% of residents. When asked an open-ended question about the single most important health care issue facing the state, the most common responses still focused on cost and affordability.

This year's poll, conducted in collaboration with Anderson Robbins Research, included

approximately 417 telephone interviews with randomly selected Massachusetts residents over 21 years of age. Region and gender quotas were established to ensure a representative sample.

Most Massachusetts residents polled, approximately 84%, said they were generally satisfied with the health care they received over the past year. This percentage includes 56% of residents who were "very satisfied" and 28% who were "somewhat satisfied" with the health care they received in the past 12 months.

While the survey findings were largely positive in terms of residents' feelings about health care quality, there were clear divisions with regard to socioeconomic status. Those with higher income

levels and more education were more likely to be satisfied with their health care and reported less difficulty in obtaining care than those with lower income and less education.

Approximately 90% of those with household income over \$100,000 were at least "somewhat satisfied" with their health care, compared to 76% of those with income under \$50,000. Similarly, satisfaction was 10 percentage points lower among those with just a high school education or less (76%) than among those with at least some college education (86%).

When those who say they were either "very satisfied" or "somewhat satisfied" were asked to explain why, they were most likely

to explain their satisfaction in terms of the quality of care they have received. More than 45% of those interviewed reported that their satisfaction was based on "quality of care/good doctors," while another 6% reported that they "like their doctor/have a good relationship with their doctor."

After quality-of-care explanations, residents explain their satisfaction in terms related to the ease of access to health care (27%) as well as positive experiences with health insurance (20%).

The full study is available on the Massachusetts Medical Society website at www.massmed.org/poll2013. **VS**

— Melissa Higdon

International Health Studies Grant Recipient Travels to India

Michael Matergia, M.D., received an International Health Studies Grant from the Massachusetts Medical Society and Alliance Charitable Foundation to help defray the costs of his trip to Darjeeling, West Bengal, India.

What started as a volunteer trip in 2007 to the eastern Himalayan region of Darjeeling, India, became a deep personal connection with the community for Michael Matergia. With the help of a grant from the MMS and Alliance Charitable Foundation, he returned to the area in the spring of 2013.

Under the supervision of local physicians, Matergia, then a fourth-year student at Harvard Medical School, learned how to manage malnutrition, diarrhea, acute respiratory illness, TB, and diabetes in a limited-resource setting.

While there, Matergia developed a system for screening children for mental health issues, to be implemented through the non-profit organization Broadleaf Health and Education

Alliance, founded by Matergia and his wife in 2011.

"Mental health is our generation's global challenge. Child mental health remains relatively neglected," says Matergia. "Epidemiologically, 10 to 20 percent of children across the globe have a diagnosable mental health



Photo by Dan Papa

A child in the Broadleaf Health and Education Alliance, founded by Michael Matergia, M.D., shows her work.

condition. In Darjeeling, zero percent of children are treated."

Schools hold students with mental health and developmental issues at a grade level where they are able to complete the work, until they age out of the school system. Matergia saw 12-year-olds held back in a first-grade classroom, with no opportunities for personal development.

Physical or corporal punishment is standard; children with ADHD are physically punished into submission, he said. Human resources are scarce in the Darjeeling area. With the exception of one psychiatrist, there are no professionals to provide mental health care.

Beginning in 2014, Broadleaf will hire and train fieldworkers from local communities to screen for mental illnesses and challenges that children are facing using a strength and difficulties questionnaire and counseling. They plan to then offer stable, community-

based support to the children, teachers, and their families.

Currently in seven primary schools in three communities, Matergia plans to expand the program to 30 schools and 1,000 students by 2017 and create a model that can be pursued on a larger scale.

Matergia, now a family medicine resident in Colorado, refers to Darjeeling as his "second home" and feels a "lifelong professional commitment" to finish the work he started there. Matergia thanked the MMS and the Foundation for their support.

"This experience has pushed me to develop as a clinician and grow as a future leader in global health," he said. **VS**

— Allison Healy

The application deadline for this year's International Health Studies grants is September 15. Visit www.mmsfoundation.org for more information and to apply.

AMA Recognizes Obesity as a Disease: MMS Members React

In June, the AMA voted to recognize obesity as a disease, a move that has received attention in both the popular and medical news media. *Vital Signs* interviewed three members of MMS's Committee on Nutrition and Physical Activity — Denise Rollinson, M.D., chair, Rick Buckley, M.D., vice chair, and Mitch Gitkind, M.D. — about the implications of the AMA classification.

VS: What is your opinion about the AMA's announcement?

Dr. Rollinson: To any physician caring for obese patients, it is clear that obesity is a disease, is associated with hypertension, hyperlipidemia, metabolic syndrome, sleep apnea, gallbladder disease, cancer, etc.

Dr. Buckley: There are so many related issues to obesity that it is long overdue in being labeled a disease.

Dr. Gitkind: And, let's keep in mind that this is the AMA joining other groups who have already classified obesity as a disease in the past, including CMS and other professional societies.

VS: Will the AMA's new position change the way obesity is viewed?

Dr. Buckley: The AMA's decision should raise awareness among physicians of the seriousness of the problem. I still feel some physicians don't pay sufficient attention to it. Part of that issue may be that it is so difficult of a problem to tackle. Making it a disease may remove some of the stigma that patients now feel.

Dr. Gitkind: The sense that obesity is a "lifestyle choice" as opposed to a public health emergency needs to go away.

Dr. Rollinson: By classifying obesity as a disease, hopefully we can finally help obese patients obtain coverage for medical treatment for obesity.

VS: Speaking of coverage, last December MMS adopted policy based on U.S. Preventive Services Task Force recommendations advocating that third-party payers cover multidisciplinary weight management teams for obese patients. Will the AMA decision help in this effort?

Dr. Buckley: It should allow the conversation with insurers to move forward on coverage of various to-be-named treatments, e.g., multidisciplinary programs, behavioral therapy, office visits specific to obesity, etc.

Dr. Rollinson: I would like to see obese patients (BMI 30) receive prevention before they end up with BMI 35 or 40, which is when they now "qualify" for treatment. While we need to treat patients with higher BMIs (surgically), it would be far better to prevent patients who are overweight from becoming obese and to be able to intervene sooner in patients with BMI of 30 from gaining weight to BMI of 35 or 40.

Dr. Gitkind: Assessments that lead to treatment plans always need to look at more than just weight and BMI. Whether surgery, pharmacologic treatments, lifestyle modifications, or combinations of one or more of these



Denise Rollinson, M.D.



Rick Buckley, M.D.



Mitch Gitkind, M.D.

modalities make sense depends on comprehensive assessments that take time and expertise. These just aren't happening enough right now.

My hope is that the AMA decision will put providers and health care systems on notice that we owe patients much more than advice to "eat less and exercise more," especially those in high-risk categories.

Moving beyond the argument that patients just "trying harder" will fix the problem, perhaps we can really answer our patients' needs — and our own professional obligations.

Overall, the AMA decision needs to create urgency amongst providers and payers that pushes us ahead in addressing the epidemic. **VS**

— Robyn Alie

David Seltz

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but see some trends that are very troubling. Part of our role is to identify those [trends] and put forth some policy recommendations to mitigate those,” Seltz said.

The commission, which includes its chair, veteran National Health Advisor and Brandeis University Professor Stuart Altman, Harvard University Health Economist David Cutler, and Carole Allen, M.D., who recently retired as director of pediatrics for Harvard Vanguard Medical Associates, are now grappling with the “difference between writing legislation and implementing legislation.”

The guiding values of the commission are transparency and a collaborative approach, he said.

“We weigh wanting to move quickly with wanting a deliberative process and making sure there is a voice for all the affected stakeholders,” he said. “Ultimately we are focused on the consumer impact of market changes.”

But that does not mean reinventing the health care wheel, he emphasized.

“We can’t pretend [the commission is] going to come in and solve all of these problems on our own; we need to ensure we are tapping into all the resources already here. These efforts around changing [the] health care system have been going on for quite awhile,” he said.

That means frequent “listening sessions” around the state far in advance of any regulatory changes.

Seltz said he is carefully considering issues raised this year by physicians, such as complaints that state regulations and data reporting requirements — sometimes to five or six state agencies per year — is a disincentive for some doctors to remain in private practice.

“The state has set out a vision for the health care industry to be more coordinated and share information, but the state should also be having that same goal,” he said.

Alignment should be a two-way street for physicians and state officials, Seltz said.

“Where appropriate, agencies should share information so we

MMS Legislative Priorities Included in FY 2014 State Budget

PMP and DA&O Programs See Important Changes

Governor Deval Patrick recently approved a \$34 billion state FY 2014 budget that made important improvements to the state Prescription Monitoring Program (PMP) and the Disclosure, Apology and Offer (DA&O) program. These issues have been major advocacy priorities for the MMS.

Under the revised PMP rules, physicians would have to check the program only when prescribing a Schedule II or III narcotic to a patient for the first time. As originally written, the law would have required physicians to use the PMP for every new patient, regardless of age, diagnosis, or intent to prescribe a scheduled medication.

The budget also specifies that payments made under the DA&O program will be exempt from inclusion in Board of Registration in Medicine physician profiles.

are not asking for another level of data or reporting that is unnecessary. We have definitely heard that message and are striving to minimize the administrative burden,” he said. “Quality indicators are one of those things where physicians have a lot of frustrations, and we have to ask ourselves, are we actually aligning in a way that will drive things in the right direction.” **VS**



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FEDERAL UPDATE

Important Update: New England’s New Medicare Carrier Practices Must Make Changes by Oct. 25, 2013

While Congress continues to work on a new Medicare physician payment formula, another Medicare issue of great importance to physicians is brewing.

On October 25, 2013, National Government Services (NGS) will officially take over as the new Medicare Administrative Contractor (MAC) for Medicare Parts A and B for all of New England.

In order to be paid, all physician offices *must* change their electronic data interchange by October 25, 2013. We recommend you contact your software vendor, clearinghouse or billing service for additional information.

Information for practices will be posted to the NGS transition website at NGSMedicare.com.

If you currently use the free NHIC software you *will need* to convert to the NGS free software program, which will be available on their website.

You *will also need to contact any third-party groups* who conduct your billing or related functions to see if they are aware of the change and what steps they are taking to make your office compliant.

Register for the NGS email updates program to receive important information about the transition and upcoming training opportunities. (From the [NGSMedicare](http://NGSMedicare.com) home page, click

“Part B” in the center column, under “Publications” in the left column, click “Email Updates.”)

Another useful resource is Medicare University (MU), an interactive online educational system designed to offer a broad spectrum of Medicare-related training options. Practices can access MU on the National Government Services website at NGSMedicare.com.

Closer to the transition date, NGS will encourage physicians to sign up for NGSConnex (NGSConnex.com), a free Web application developed and maintained by NGS to provide a wide array of self-service functions, including beneficiary eligibility information, claims status queries, initiation of

reopening/redetermination requests, provider/supplier demographic information, and financial data queries.

The MMS is working closely with NGS on a series of webinars and seminars for physicians and office staff to facilitate this transition. More information on the carrier changes will be made available in *Vital Signs This Week* and on the MMS website at www.massmed.org/NGS.

Please check the NGS and MMS websites regularly to make sure you have the information you need to make this Medicare payment transition in a timely fashion. **VS**

—Alex. Calcagno

PHYSICIAN HEALTH MATTERS

A Physician Runs for His Life

A growing body of research presided over by Erica Frank, M.D., M.P.H., at the School of Population and Public Health at the University of British Columbia indicates that the more health-conscious medical students and physicians are, the more attention they pay to prevention-related counseling and screening practices with their patients.

Put quite simply, healthy physicians inspire health in their patients. I'd like to share with you how this phenomenon has played out in my life — as a patient and as a psychiatrist.

About five years ago, I found myself with a BMI approaching 30. As my career had unfolded, I was getting less and less exercise. The stresses and strains of everyday life and medical practice were such that I wasn't sleeping as well as I had as a younger man. Along with my weight, my blood pressure was going up. But I didn't have the time or the motivation to do anything about these gradual changes.

A younger colleague in family medicine began sharing with me her experiences as a triathlete. Initially put off by all the talk of running, swimming, and biking, her vigor and excitement began to engender curiosity, with a dollop of "Type A" envy. If she could do it, why couldn't I? Then she lowered the boom:

"You're getting too heavy," she said. "You are developing hypertension. Before you know it, you'll have an MI and you'll be dead."

Her upsetting words jarred me out of complacency; there was an element of truth to them. I started running — running for my life.

I hated it at first. It wasn't fun. I huffed and I puffed, with barely enough stamina to make it around the block.

But after about six months I was hooked. I was getting up in the dark, strapping on my headlamp and reflective gear, and running 20-plus miles per week. My BMI and BP were dropping, and I was sleeping well again.

With each daily run I felt as though I was rebooting my nervous system and my psyche. I came to work feeling refreshed, and with a newfound sense of equanimity. I was getting more done.

Some patients, noticing my weight loss, wondered if I was okay. Many hung on my every word when I described my transformation. They checked in with me to see if I was still running. And

I began to "prescribe" exercise as a matter of course. It's a powerful antidepressant. It's a suitable substitute for people who give up smoking or drinking. It can help with the weight gain brought on by psychotropic medications. And, of course, the more you exercise, the better you will sleep.

So there we have it. It's what we learned in medical school: see one, do one, teach one. If you have yet to embrace the exercise bug, stop making excuses and begin taking charge of your health and well-being. As they say in AA, "bring the body and the mind will follow." You'll feel better, and you'll deliver better health care. Your patients, friends, and family will be grateful. **VS**

—Steve Adelman

Director, Physician Health Services

For more on this topic, and for the free video, *10 Minutes of Exercise You Can Do Anywhere*, please pay a visit to instituteoflifestylemedicine.org.



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Interim Meeting 2013: December 6–7

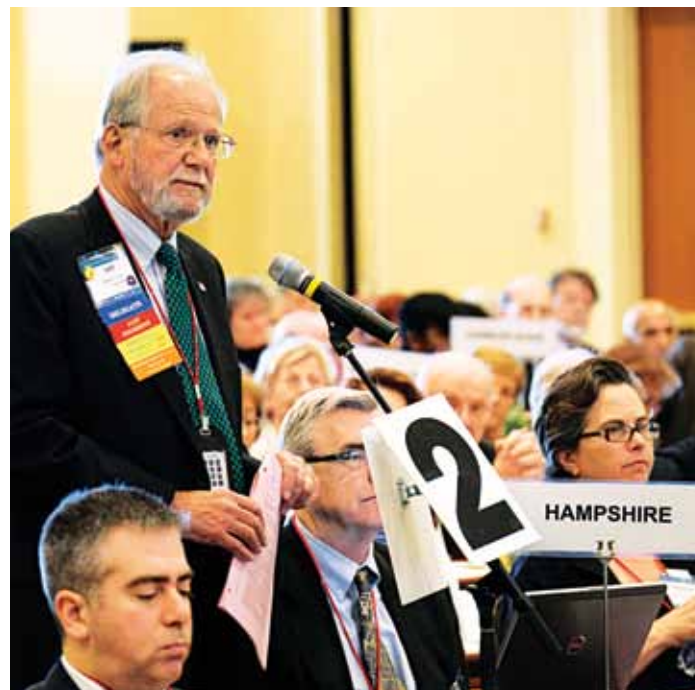
The 2013 Interim Meeting of the MMS House of Delegates will be held Friday and Saturday, December 6–7 at MMS headquarters and the Newton Marriott Hotel.

The deadline for submitting resolutions is Tuesday, October 22.

Members may submit resolutions via email to www.massmed.org/resolutions or resolutions@mms.org. For more information on submitting a resolution, please contact Annemarie Tucker at (800) 322-2303, ext. 7332.

The deadline for hotel reservations at the Newton Marriott Hotel is November 8. To make reservations, please visit www.massmed.org/IM13reservations or call the hotel directly at (617) 969-1000.

Online registration opens in late September.



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/memorial.

Arnold L. Abrams, M.D., 85; Lexington, MA; Boston University School of Medicine, 1952; died December 27, 2012.

James C. Alex, M.D., 50; Chestnut Hill, MA; Dartmouth Medical School, 1989; died May 29, 2013.

Ingrid Cardenas-Ramirez, M.D., 39; Weston, MA; University of Colombia, Bogotá, 1997; died February 20, 2013.

Charles D. Chipman, M.D., 85; Peabody, MA; Dalhousie University Faculty of Medicine, 1953; died June 13, 2013.

William R. Cranley, M.D., 70; Wakefield, MA; Boston University School of Medicine; died May 18, 2013.

Harland N. Hannon, M.D., 100; Hyannis, MA; Kansas City University of Physicians and Surgeons, 1939; died May 13, 2013.

Edward B. Jaffe, M.D., 67; Bolton, MA; University of Cincinnati College of Medicine, 1972; died June 23, 2013.

Julie G. Maher, M.D., 33; Framingham, MA; University of Massachusetts Medical School, 2004; died August 6, 2012.

John B. Parker, M.D., 84; Boston, MA; Medical College of Virginia, 1956; died April 14, 2012.

Laurence A. Simons, M.D., 83; Lynnfield, MA; University of London, 1962; died March 9, 2013.

John C. Wolfe, M.D., 70; Gloucester, MA; Cornell University Medical College, 1968; died May 8, 2013.

MMS Celebrates Women in Medicine Month

Studies have shown that positive mentoring relationships have been linked to higher career satisfaction and rates of promotion. In honor of Women in Medicine Month, the Committee on Women in Medicine will be hosting the program, *Competition, Collaboration, and Team Leadership* to increase women physician's influence as team members and gain insight into how women physicians can achieve greater inroads into leadership positions. Featured speakers include past MMS presidents, Dr. Lynda Young and Dr. Alice Coombs, along with Dr. Najmosama Nikrui and Dr. Cynthia Sacco, immediate past chair and vice chair of the Committee on Women in Medicine.

At this event, the Committee will present the Women Physician Leadership Award to Marianne E. Felice, M.D., in celebration of her multiple outstanding leadership accomplishments.



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The Committee offers lectures for women physicians three to four times per year. If you are interested in learning more about the Committee on Women in Medicine or would like to suggest a topic or speaker for a future lecture, please contact Erin Tally at (800) 322-2303, ext. 7413, or via email at etally@mms.org. **VS**

Women in Medicine: Competition, Collaboration, and Team Leadership

Thursday, September 26, 2013, 6:30 to 8:00 p.m.

A networking dinner precedes program at 5:45 p.m.

MMS headquarters, Waltham.

For more information or to register, visit www.massmed.org/WLF2013.

The Massachusetts Medical Society designates this live activity for a maximum of 1.5 AMA PRA Category 1 Credits™.



Link In with MMS

Connect with your peers by joining our members-only LinkedIn group at www.massmed.org/linkedin.

Special Membership Offers to Physician Group Practices

As health care evolves and the number of integrated physician practice entities increases, the MMS continues to expand its representation of physician groups. In order to fortify the Society's representation of group practice physicians at the State House and in Washington, D.C., we are extending special membership offers to group physician practices, with discounts up to 30 percent.

MMS membership offers incredible benefits, which include print, online, and mobile access to the *New England Journal of Medicine* (\$169 annual value). We also offer discounts of up to 50 percent on clinical, practical, and newly required continuing medical education, online access to your CME profile that documents all of your CME activities, and other mobile-friendly resources and services.

Visit www.massmed.org/About/Membership-Info/Group-Enrollment-Options for more information. For questions, please email info@massmed.org or call (800) 322-2303, ext. 7311. **VS**



ACROSS THE COMMONWEALTH

District News and Events

Charles River — Fall Family Outing. Sun., Sept. 22, 11:30 a.m. Location: Fenway Park, Boston. Boston Red Sox game. **Executive Committee Meeting.** Wed., Sept. 25, 5:30 p.m. Location: MMS headquarters. **Delegates Meeting.** Wed., Sept. 25, 6:30 p.m. Location: MMS headquarters. For more information, contact Northeast Regional Office.

Essex South — Fall Clambake. Sat., Sept. 7, 1:00 p.m. Location: Wingaersheek Beach, Gloucester. For more information, contact Northeast Regional Office.

Middlesex — Membership Jazz Brunch with Balloon Artist. Sun., Sept. 29, 11:00 a.m. to 1:00 p.m. Location: MMS headquarters. For more information, contact Northeast Regional Office.

Middlesex North — Fall Family Outing. Thurs., Sept. 12, 5:30 p.m. Location: Kimball Farm, Westford. For more information, contact Northeast Regional Office.

Norfolk South — Executive Committee Meeting. Tues., Sept. 10, 6:30 p.m. Location: Abby Park Restaurant, Milton. For more information, contact Southeast Regional Office.

Plymouth — Executive Committee Meeting. Wed., Sept. 18, 6:00 p.m. Location: Southeast Regional Office, Lakeville. For more information, contact Southeast Regional Office.

Suffolk — Students, Residents, and Young Physicians Reception. Thurs., Sept. 26, 7:00 to 9:00 p.m. Location: Clerys, Dartmouth Street, Boston. For more information, contact Northeast Regional Office.

Worcester — 22nd Annual Women in Medicine Breakfast. Fri., Sept. 20, 7:30 a.m. Location: Beechwood Hotel, Worcester. Speaker: Alex. Calcagno, MMS federal and community relations director. For more information, contact Joyce Cariglia at (508) 753-1579 or wdms@massmed.org.

Worcester North — Legislative Breakfast. Fri., Sept. 27, 7:30 to 9:00 a.m. Location: Sheraton Four Points, Leominster. For more information, contact West Central Regional Office.

Statewide News and Events

Art, History, Humanism, and Culture Member Interest Network — Herb Workshop. Sat., Sept. 28, 10 a.m. to noon. Location: MMS headquarters. For more information, contact West Central Regional office.

If you have news for Across the Commonwealth, contact Michele Jussaume, Northeast Regional Office, at (800) 944-5562 or mjussaume@mms.org; Sheila Kozlowski, Southeast Regional Office, at (800) 322-3301 or skozlowski@mms.org; or Cathy Salas, West Central Regional Office, at (800) 522-3112 or csalas@mms.org.

MMS International Health Studies Grantee Tackles Childhood Health in Rural India



Photos by Dan Papa

Schoolchildren in Darjeeling, India, participate in a health program founded by IHSF recipient Michael Matergia, M.D.

Inset: Dr. Matergia confers with a local teacher during a school visit. See full story on Page 4.

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MMS SPONSORED AND JOINTLY SPONSORED CME ACTIVITIES

LIVE CME ACTIVITIES

Go to www.massmed.org/calendar. Unless otherwise noted, event location is MMS headquarters, Waltham.

Women's Leadership Forum: Women in Medicine — Competition, Collaboration, and Team Leadership

Thurs., Sept. 26, 2013, 5:45 to 8:00 p.m.

Principles of Palliative Care and Persistent Pain Management:

Tools to Integrate into Your Practice

Fri., Sept. 27, 2013, 8:00 a.m. to 4:30 p.m.

Caring for the Caregivers IX:

How Do We Reduce Physician Stress and Burnout?

Thurs., Oct. 3, 2013, 8:00 a.m. to 4:00 p.m.

CME Accreditation Orientation

Tues., Oct. 15, 2013, 8:30 to 11:45 a.m.

Managing Workplace Conflict

Thurs., Oct. 17, 2013, 8:00 a.m. to 4:00 p.m. and Fri., Oct. 18, 2013, 8:00 a.m. to 3:00 p.m.

ONLINE CME ACTIVITIES

Go to www.massmed.org/cme.

Risk Management CME

End-Of-Life Care

- End-of-Life Care: Ethics, Communication and Conflict Resolution, and Advance Care Planning
- The Importance of Discussing End-of-Life Care with Patients*
- Legal Advisor: Advance Directives*

Pain Management

- Legal Advisor: Identifying Potential Drug Dependence and Preventing Abuse*
- Managing Risk When Prescribing Narcotic Painkillers for Patients*
- Opioid Prescribing, Risk Management of Opioid Therapy and the Opioid Abuse Epidemic (6 Modules)

Legal Risk Management CME

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- Legal Duties and Options when a Patient Raises Suicide
- Legal Advisor: Boundary Violations
- Legal Duties and Options when a Patient Raises Suicide

Other Risk Management CME

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- Avoiding Failure to Diagnose
- Getting It on Record and Getting It Right
- Medical Mistakes: Learn to Steer Clear of the Common Ones
- The Changing Nature of Informed Consent
- Dealing with the Changing Dynamic of Medical Staff
- Data Analytics Module 1: Population Health Management
- Data Analytics Module 2: How the ACO and You Can Succeed
- Data Analytics Module 3: Improving the Health of Your Patients
- Social Networking 101 for Physicians

*Also available in print. Call (800) 322-2303, ext. 7306.

TO REGISTER FOR ANY OF THESE ACTIVITIES,
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CME CREDIT: These activities have been approved for
AMA PRA Category 1 Credit™.

For additional information, contact the Department of
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