Moving Forward on Mental Health Parity
Prior Authorization Requirements Removed; Some Physicians Feel More Reforms Needed

BY ERICA NOONAN

The state’s health care payment reform law, passed in August, contained important provisions that will require payers across Massachusetts to demonstrate compliance with federal mental health parity laws.

The new provisions are determined to reduce many long-standing barriers to timely and consistent mental health care, such as quantitative limits on care, and requires insurers to treat behavioral health patients no differently from medical-surgical patients.

Mass Health will no longer require prior authorization permission before treating a patient for behavioral health issues. Private insurers will be required to submit annual reports to the Mass. Attorney General’s office certifying compliance. The law also requires insurers to increase transparency in how mental health reimbursement decisions are made and establishes a special task force to make recommendations on how to integrate behavioral health services in new payment and delivery systems.

Mental health patients frequently wait in the emergency department for hours — sometimes days — for treatment authorizations and admissions, while hospitals engage in a lengthy permission-seeking process to treat and get reimbursed for the care, said Mark Pearlmutter, M.D., F.A.C.E.P, chair and vice president of emergency services at Steward Health.

A medical-surgical emergency room patient is generally admitted to a facility within 4 hours. For a mental health patient the average is closer to 18 hours, he said. A mental health patient who must be transferred will typically wait close to 24 hours, said Dr. Pearlmutter.

Outpatient psychiatric care is similarly hard to obtain in a timely manner. “If one of my peers refers out, say for a GI issue, he can expect a specialist

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New PHS Director Plans to Bring Prevention Focus
Steven Adelman, M.D., Takes Top Post; Luis Sanchez, M.D., Retires

BY VICKI RITTERBAND

As a child, Steven Adelman, M.D., was mystified by his mother’s years-long battle to quit smoking. “How could this intelligent, health-conscious woman struggle with this chronic addiction? This captured my interest in a deeply emotional way,” Dr. Adelman recalled.

Dr. Adelman, 58, went on to become a psychiatrist and an expert in addiction at a time when scientists were just beginning to understand the interplay between biology and addiction and before the term “addiction medicine” had even been coined.

Three decades later, the former director of Behavioral Health and Addiction Medicine at Harvard Vanguard Medical Associates is set to become the new director of Physician Health Services (PHS), one of the most influential programs of its type in the country. PHS, a nonprofit corporation founded by the Massachusetts Medical Society, provides confidential consultation and support to physicians, residents, and medical students facing behavioral or physical health concerns.

“I thought if Dr. [Luis] Sanchez ever retired, this is a job I’d be very interested in,” said Dr. Adelman, who worked closely with PHS while at Harvard Vanguard. “This job fits with everything I’ve been doing for the past 20–30 years.”

Dr. Adelman, who officially assumes his new duties March 18, believes that the services provided by the 20-year-old nonprofit are needed more than ever now, as medicine has become an increasingly high-stress profession.

“If I would put it up there with the military, law enforcement, and air traffic control,” he said. “The pace is grueling and a lot [more] is being dictated down to doctors as ever before. The result is an unprecedented number of doctors experiencing burnout.”

An Emphasis on Prevention
Dr. Adelman said he would like to see PHS intensify its work in the area of prevention. “PHS will always focus on providing assistance to struggling physicians, but I’d like to see us place an even greater emphasis on physician health and wellness, self-care, work-life balance, resilience, and stress management,” he said. “The presumption is that physicians who take better care of themselves and support one another throughout their careers will manage the vicissitudes of medical practice more effectively.”

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Mental Health Parity
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to see a patient within one to three days. But try doing the same thing for a patient they think may be depressed."

Payers have long protected the criteria used for approving mental health treatment as proprietary information, so physicians and hospitals have no way to know what care will be reimbursed and what will be rejected.

“We need transparency with behavioral health vendors. We need them to show us the criteria they are using, so we are all working off the same piece of music,” said Dr. Pearlmutter.

The inclusion of mental health parity in Chapter 224 reforms came after years of advocacy by the MMS, MA ACEP, the Massachusetts Association of Behavioral Health Systems, MPS, and the Mass. Hospital Association.

However, there are some aspects of mental health care where more reforms are still needed, said Paul Summergrad, M.D., chair of psychiatry at Tufts University School of Medicine and Tufts Medical Center.

Unlike any other medical-surgical emergency, a psychologically ill patient’s admission to the hospital is not determined by the treating physician in the facility, but requires prior insurance approval for admission in the ER. For MassHealth beneficiaries, the plan for admission must first be approved by an emergency screening team of non-physicians who see patients in the ER prior to admission. Approval by the insurer, said Dr. Summergrad, also a past president of the Massachusetts Psychiatric Society.

“It is the one situation in clinical medicine where an emergency department or psychiatric physician can say that someone needs to be hospitalized, but it depends on non-physician review,” he said.

The screening team and the physician almost always agree on the diagnosis and the treatment, but the process takes many hours. MassHealth will also not reimburse psychiatrists or any hospital mental health provider for emergency consultation — which may have contributed to the reduction in mental health staffing in hospital ERs.

“It’s the one place where physicians do not get to make clinical judgments and the state, as policy, actually restricts their judgments. Can you imagine if you told the average person that a doctor was not allowed to make the clinical decision about their heart attack?” said Dr. Summergrad. “Shouldn’t the most trained person be making the care decision about brain disorders, especially at a time when we are worried about access to high quality psychiatric care and safety?”

Still, outside of these ER issues things do seem to be improving, he said. There will be better access and coverage for behavioral health situations as the insurers comply with parity. “Parity is moving things in the right direction,” he said.

David Matteodo, executive director of the MABHS, the trade association representing 49 Massachusetts in-patient psychiatric and substance abuse facilities, said his group was eager to see the state parity regulations finalized, something that was supposed to happen early this year.

“My hope is that we won’t see the constant micromanagement from the carve-out [fourth-party] firms and we’ll have behavioral health managed comparable to medical-surgical,” he said.

The transparency requirement for reimbursement criteria is vital to achieving parity, he said.

“I am very interested in how these companies will interpret them. I think the provider community is in a much stronger position going forward because we provide the services. The oversight services and the insurers will have some tough questions to answer,” said Matteodo.

One looming development that may help ensure parity between medical-surgical patients and mental health patients, predicted Dr. Pearlmutter, will be the coming shift among many systems to accountable care organization and medical home payment models.

The uncounted dollars currently spent on extra emergency department boarding, security, nursing staff time, and overtime while patients languish in behavioral health insurance limbo will finally be quantified.

Right now, those expenses stay in the emergency room “silos,” reducing costs for the mental health providers because patients often stabilize and even improve slightly while under emergency care, he said.

“We have a ways to go [in pursuit of mental health parity], but I am optimistic,” said Dr. Pearlmutter.

VIK
Making the ICD-10 Transition

The Centers for Medicare and Medicaid Services (CMS) recently extended the ICD-10 deadline to allow health care organizations more time to complete their conversions. By the new deadline (currently slated for October 1, 2014), all entities covered by HIPAA should be successfully conducting health care transactions using ICD-10 codes.

ICD-10 planning takes time and significant resources. As such, it is important for practices to start planning immediately in order to avoid potential problems in the future. According to CMS, planning for ICD-10 implementation should incorporate six phases: planning, communication and awareness, assessment, operational implementation, testing, and transition.

• **Planning.** The planning phase includes establishing a project management structure and governance to support the ICD-10 undertaking. Staff should meet to discuss what the transition plan will look like, given the changes that will be required. Assigning different responsibilities to members of your staff will ensure that everyone is involved in the project.

• **Communication and Awareness.** This phase includes creating a communication plan and assessing needs of the organization. Once needs have been established, then a roles-based training plan can be designed for both administrative and clinical staff. The impact of ICD-10 should be communicated throughout the process.

• **Assessment.** Once a project plan has been created and clearly communicated, the practice should assess the many business, policy, and technological impacts. It is important to contact your practice management and billing software vendors to determine whether they are on target to meet the transition deadline (depending on where they are in the process, you may need to develop new vendor relationships). Also, review payer contracts and service-level agreements to identify potential impacts of ICD-10. A thorough risk assessment and gap analysis will help minimize potential risks after conversion.

• **Operational Implementation.** The operational implementation phase puts the project plan into action. One example of a business modification might be creating “superbills” of frequently used ICD-9 code sets and identifying how they translate to ICD-10. Training of staff should be initiated during this stage as well.

• **Testing.** This phase involves internal and external testing. Internal systems will need to be tested to ensure that ICD-10 transactions are processing correctly. Collaborating with payers and clearinghouses early will allow ample time to identify potential problem areas.

• **Transition.** Successful transition depends on collaboration among all parties involved. Preparing and establishing the “go live” environment is key during the transition phase. Ideally, the practice should be submitting clean claims to payers prior to the October 1, 2014, deadline. Supporting and communicating with staff, continually monitoring the process, and performing regular audits will ensure a smooth transition to ICD-10.

For more information on ICD-10, please visit www.massmed.org/icd10.

— Talia Goldsmith

HIPAA Update: Important Information for September 2013 Compliance Deadline

In recent months there has been a lot of news focusing on fines levied for data breaches of private health information (PHI) as a result of lack of compliance with HIPAA. Fines have been imposed on large academic medical centers and small physician practices across the country and here in Massachusetts. Recently, four pathology groups and a medical billing company agreed to $140,000 in fines for violations related to improper disposal of medical record information. Reviewing internal practice policies and HIPAA compliance is extremely important, especially in light of the *Final Rule* published January 25, 2013, by the U.S. Department of Health and Human Services, which outlined changes to HIPAA.

Many changes have taken place since HIPAA was first enacted. As such, the recent update addresses a number of regulations that have been introduced since 1996, including the Health Information Technology for Economic and Clinical Health Act (HITECH), final regulations for breach notification requirements, and privacy protections required under the Genetic Information Nondiscrimination Act. The latest update is meant to protect patient privacy in the digital age and is scheduled to take effect March 26 with the expectation that entities will be fully compliant by September 23, 2013.

Changes outlined in the final rule require the attention of practices in three key areas:

• **Review of vendor relationships to ensure HIPAA compliance.** The *Final Rule* defines a business associate as anyone who “creates, receives, maintains, or transmits” PHI for a covered entity. Practices must be sure that vendors are actually living and breathing HIPAA compliance. Practices should also review and update existing business associate agreements to ensure compliance with the requirements of the *Final Rule* and engage in business associate agreements with vendors who meet the newly defined definition of a business associate.

• **Know what qualifies as a “breach.”** The definition of “breach” has been expanded and does not require there to be a significant risk of financial, reputational, or other harm to an individual. The definition now relates to the impermissible acquisition, access, use, or disclosure of the PHI itself. This means that PHI data without information that could directly identify a patient could still be considered a breach if it were not handled properly. The new definition allows for protection of the data itself.

• **Review and update “Notice of Privacy Practices.”** The new rule requires changes to the existing Notice of Privacy Practices provided to patients. These documents are now required to include:

  • A description of the types, uses, and disclosures of PHI that require patient authorization
  • The ability for a patient to opt out of having PHI disclosed for payment if the PHI relates to health care paid in full and out-of-pocket by the patient
  • Language that indicates the patient has the right to opt out of fundraising communications
  • Language that indicates the practice is required by law to notify individuals of a breach of PHI in the event a breach occurs

This summary of recent changes to HIPAA law is provided for educational purposes. If you have questions regarding how it applies to you, please contact the Physician Practice Resource Center at (781) 434-7702.

— Kerry-Ann Hayon
Tobacco Cessation Medications, Counseling Covered by Commonwealth Care

All FDA-approved smoking-cessation medications and counseling support are now covered by Commonwealth Care. Evidence-based studies have shown that a combination of behavioral counseling and pharmacotherapy gives smokers the greatest chance of success in quitting. Similar to MassHealth’s tobacco cessation benefit, Commonwealth Care’s benefit includes:

- Two 90-day treatment regimens per year with FDA-approved medication, including nicotine-replacement therapies (patch, gum, and lozenge), bupropion, and Chantix (varenicline).

- Up to 16 face-to-face counseling sessions per 12-month cycle. These 16 sessions can include any combination of two 45-minute intake/assessment sessions per year and 14 sessions of individual or group counseling. For information about the benefit and counseling reimbursement rates, contact the individual Commonwealth Care plans. Commonwealth Care plans vary slightly in their prior authorization requirements and benefit limits.

Information about MassHealth’s tobacco cessation benefit is available through MassHealth Provider Services at (800) 841-2900, and on the MassHealth website at mass.gov/masshealth.

Register Now for Mass. Adult Immunization Conference

Influenza surprised us again this year and pertussis remains a threat in Massachusetts and across the nation. Learn the latest information about vaccine-preventable diseases from experts at the CDC and in Massachusetts at this year’s Massachusetts Adult Immunization Conference at the DCU Center in Worcester on Tuesday, May 21, 2013.

The annual conference attracts more than 300 professionals from physician’s offices, hospitals, community health centers, long-term care facilities, local public health organizations, pharmacies, and college health centers, as well as medical, nursing, and pharmacy students. The conference, which offers CME and CEU credits, is organized by the Mass. Department of Public Health, the Mass. Adult Immunization Coalition, and JSI Research and Training Institute, Inc. Carolyn Bridges, M.D., associate director of adult immunizations at the CDC’s National Center for Immunization and Respiratory Diseases, will keynote the program. Workshop offerings include presentations on vaccinations, epidemiology, surveillance of vaccine-preventable diseases, the Massachusetts vaccine registry, travel vaccines, and other topics.

For more information or to register, contact shoshanna_fine@jsi.com or at (617) 482-9458.

MMS Leadership Forum to Examine Mental Health in Massachusetts

April 3 in Waltham

Recent events have drawn considerable attention to the state of mental health care in America, highlighting a fragmented and overwhelmed system plagued by problems with access to affordable, equitable, and effective screening, treatment, and follow-up care for those who need it. The problem is longstanding and widespread. According to the National Institute of Mental Health, 1 in 4 American adults experience a diagnosable mental disorder in a given year, and about 1 in 17 suffer from a serious mental illness, such as major depression, schizophrenia, bipolar disorder, OCD, panic disorder, or PTSD. Untreated mental illness can have a profound effect on the individual: unnecessary disability, unemployment, substance abuse, homelessness, incarceration, and suicide. Mental disorders affect family members, the health care system, the criminal justice system, and the economy. Mental illness is the greatest cause of disability in North America and Europe, and increasingly the world, according to the National Alliance on Mental Illness (NAMI), which estimates the annual economic cost of mental illness due to lost productivity at $100 billion.

A 2009 NAMI report on services for adults with serious mental illness gave the United States a grade of “D” for its treatment of mental health, based on the services available through the mental health system. Massachusetts received a grade of “B”, showing improvement from 2006. Five other states — Connecticut, Maine, Maryland, New York, and Oklahoma — also received “B” grades. However, the report notes a “critical limitation” of these states’ data: states do not know the number of seriously mentally ill patients not receiving services, or the effectiveness of the services that are provided.

In April, the MMS will host a public health leadership forum to examine mental health care in Massachusetts and its impact on patients, physicians, and the health care system. The forum will address what the health care system, policymakers, and MMS can do to ensure that children and adults in Massachusetts receive timely, effective, and affordable treatment.

— Robyn Alie

Public Health Leadership Forum: Mental Health

April 3, 2013
1:00 to 5:00 p.m.
MMS Headquarters, Waltham

Presenters: Kathryn Power, regional administrator, Substance Abuse and Mental Health Services Administration Mark Pearlmutter, M.D., F.A.C.E.P., chair and vice president of emergency network services, Steward Health Care Peter Metz, M.D., clinical professor of psychiatry and pediatrics, UMass Medical School Ken Duckworth, M.D., medical director, National Alliance on Mental Illness Richard Frank, Ph.D., professor of economics, Harvard Medical School Program, case presentation, and panel discussion moderated by Harold Cox, associate dean, Public Health Practice, BU School of Public Health.

For more information or to register, call (781) 434-7373 or email phforum@mms.org.

Massachusetts Adult Immunization Conference

Tuesday, May 21, 2013
DCU Center, Worcester
GOVERNMENT AFFAIRS

STATE UPDATE

On Beacon Hill in 2013: Payment Reform, Cost Containment
MMS Submits 10 Bills to Mass. Legislature

The MMS has submitted 10 bills to the Massachusetts Legislature for consideration during its 2013–14 session. Two bills in particular seek to clarify important peer review and medical liability provisions in the state’s new payment reform law.

• An Act Relative to Medical Peer Review
  Sponsor: Representative Michael Costello (D-Newburyport)
  HD.1422
  This bill would help ensure high standards of care by updating existing peer review statutes and corresponding confidentiality protections. Under current law, only certain peer review programs are afforded confidentiality. This legislation would expand that definition to include accountable care organizations (ACOs) and other entities with legitimate interests in reviewing the quality of care provided to patients of the Commonwealth.

• An Act to Clarify the Reporting of Medical Liability Claims
  Sponsor: Representative Steven Walsh (D-Lynn); Senator James Eldridge (D-Acton)
  HD.1306; SD.1002
  Chapter 224 established the statutory framework for encouraging the disclosure of unanticipated medical injuries and the subsequent apology and financial compensation if warranted, so-called Disclosure, Apology and Offer programs (DA&O). Current state law requires professional liability insurers and physicians to report all medical malpractice awards if a payment is awarded to a complaining party. This reporting requirement was enacted prior to the adoption of DA&O program language. This legislation would clarify the existing statutes so that payments made under a DA&O program where the unanticipated injury is not the result of substandard care would be exempt from reporting.

For more information on MMS legislative initiatives and priorities, visit www.massmed.org/2013-14-Legislation.

— Ronna Wallace

FEDERAL UPDATE

MMS Partners with AMA on Stemming Onerous Regulations
Back-dating of Penalty Programs Are of Concern

The AMA, along with specialty and state medical societies, has encouraged the Centers for Medicare and Medicaid Services (CMS) to address serious concerns about an onslaught of overlapping regulations that affect physicians. Programs with overlapping timelines include the penalties under the electronic prescribing program, physician quality reporting system and electronic health record incentive programs, the value-based modifier, as well as the transition to ICD-10.

The physician community is especially concerned about the back-dating of penalty programs, such as performance in 2013 determining penalties for 2015, and the lack of alignment in the requirements for the various programs. The MMS has joined with the AMA on these issues. The list of total activities is extensive but includes e-prescribing, CMS Audits, ICD-10 implementation, comparative effectiveness research, and ACOs. In addition to the regulatory challenges at the federal level, a number of national organizations have developed model policy and regulations to be used by state regulators. Groups such as the National Association of Insurance Commissioners (NAIC), the National Governors Association, and the National Conference of State Legislators all engage in this type of organizational advocacy, which can have a strong effect on local regulations and, subsequently, the practice of medicine in Massachusetts. For example, the AMA worked closely with the NAIC to develop model regulations around strict medical loss ratios for health plans.

Legislators all engage in this type of organizational advocacy, which can have a strong effect on local regulations and, subsequently, the practice of medicine in Massachusetts. For example, the AMA worked closely with the NAIC to develop model regulations around strict medical loss ratios for health plans.

The AMA’s Advocacy Resource Center (ARC) works closely with states, including Massachusetts, in identifying, developing, and advocating issues that are important to physicians and their patients. More often than not, the AMA is the sole voice on behalf of physicians and their patients before these organizations. The MMS strongly values this relationship with the ARC and the work it does with states. In the coming year they will be focusing in on ACA implementation, including Medicaid expansion and reimbursement levels, scope of practice, prescription drug abuse, and medical liability reform.

— Charles Alagero, Esq.

Charles Alagero is the MMS representative to the ARC’s Executive Board and welcomes member input on advocacy issues. For more information, contact him at calagero@mms.org.
PHS Director Plans to Bring Prevention Focus
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Medical training equips physicians with the skills and knowledge to deliver superb care, but not the “personal tools they need at the front lines,” said Dr. Adelman. “How do you stay calm under fire, deal with the next set of complex requirements foisted on you by various third parties, while adroitly juggling your work with your personal life?”

Dr. Adelman envisions PHS developing some of these tools for physicians—including innovative materials and experiences that promote physician wellness. Some of these might have commercial possibilities, providing revenue to support the mission of PHS. One example might be a smartphone app that prompts physicians at daily intervals to assess their level of stress and suggests activities (such as a quick breathing exercise) to defuse tension. Dr. Adelman dreams of piloting the tools in Massachusetts, then offering them more widely.

“I think that the successful, mission-driven non-profit that is PHS has the potential to develop and hopefully to market a new set of innovative functions around prevention,” he said. “I’d like to leverage the expertise of PHS in ways that help us grow, so we can do even more good.”

Dr. Adelman says he is taking over PHS at a time when the program is widely known and respected, thanks in large part to Dr. Sanchez’s leadership. “He’s done it with a lot of grace and a great deal of clinical sophistication. He’s also built a great team. PHS radiates a sense of mission and I think Dr. Sanchez epitomizes that mission.”

Board-certified in psychiatry and addiction psychiatry, Dr. Adelman completed his internship, residency, and chief residency at McLean Hospital. He is a clinical associate professor of psychiatry at the University of Massachusetts School of Medicine and a graduate of Harvard College and the University of Pennsylvania School of Medicine.

Luis Sanchez, M.D., Looks Back
It’s at the annual dinner for monitored doctors that Luis Sanchez, M.D., 70, sees the work of PHS in all its glory. “It’s great to see these physicians with their spouses,” said Dr. Sanchez, who recently retired from PHS after nearly 15 years at its helm. “They are so different from when we first met them. They have completely [turned] their lives around.”

Dr. Sanchez said that in the years he led the organization, PHS had broadened its mission to address the changing needs of its physician clients. “Programs like ours originally focused on alcohol and drugs,” he said. “Over the years, we’ve expanded to other areas such as stress and interpersonal conflicts within medical settings.” More and more, physicians are arriving at PHS without a definitive diagnosis, like substance use or depression. “We’re getting increasing numbers of referrals for physicians saying, ‘I’m stressed. Practicing medicine is no fun anymore,’ ” said Dr. Sanchez. “They’re feeling overwhelmed and out of balance.”

Under Dr. Sanchez’s leadership, PHS stepped up its efforts in prevention, sponsoring a yearly conference on caring for the caregivers and a course on workplace conflict — work that Dr. Adelman plans to expand.

Dr. Sanchez says he is leaving PHS in very able hands. “PHS has done well, has a terrific team, and helps a lot of people,” he said. “This is a good time to move on and turn over the reins to someone who is younger, has fresh ideas, and might move PHS in a different direction. I’ve known Steve Adelman for many years and he is the perfect person to keep the mission moving forward.”

While he plans to continue practicing psychiatry, Dr. Sanchez looks forward to having more time to indulge in his wide-ranging hobbies, including gardening, refinishing furniture, and playing the guitar.
Women’s Lecture Series Celebrates 10th Anniversary

For more than 30 years, the Committee on Women in Medicine has worked to raise the profile and status of women physicians through innovative programming and networking opportunities. As a result of these efforts, the committee introduced the Women’s Lecture Series in 2003 to recognize and celebrate the growing number of women physicians and to specifically address areas of interest to them. Since that time, 34 programs have been featured, ranging from personal and professional topics to the latest trends in women’s health. Annual events include the women’s leadership forum and the women’s cardiac health conference.

This series of programs has been increasingly popular, attracting new members as well as increasing participation among women members who want to contribute more to the Massachusetts Medical Society. To date, nearly 2,000 people have attended these programs, with an average of 60 people at each program. Through the wide range of topics covered, the goal is to benefit women physicians in their professional lives as well as their personal lives.

To learn more about the Committee on Women in Medicine or to suggest a topic or speaker for a future lecture, contact Erin Tally at etally@mms.org.

ACROSS THE COMMONWEALTH

District News and Events

Barnstable — Executive Committee Meeting. Tues., March 5, 6:00 p.m. Location: Coonamessett Inn, Falmouth. For more information, contact the Southeast Regional Office.

Charles River — Executive Committee Meeting. Tues., March 19, 5:30 p.m. Location: MMS headquarters, Waltham. Delegates meeting immediately following. For more information, contact the Northeast Regional Office.

Essex South — District Meeting. Thurs., March 7, 6:00 p.m. Location: Peabody Marriott, Peabody. Speaker: Anya Wallack. Topic: Vermont Health Care Reform: Controlling Cost and Improving Quality. For more information, contact Northeast Regional Office.

Hampden — Legislative Breakfast. Fri., March 22, 7:30 to 9:00 a.m. Location: Monte Carlo Restaurant, West Springfield. High School Doctor for a Day Program. Thurs., April 11, Breakfast 7:30 to 8:30 a.m. Debriefing dinner 5:00 to 6:50 p.m. Location: Baystate Health Education Center, Holyoke. For more information, contact the Hampden District Office at (413) 736-0661 or hdms@massmed.org.

Norfolk South — District Meeting. Thurs., March 14, 6:00 p.m. Location: Neighborhood Club of Quincy, Quincy. Speaker: Ronald W. Dunlap, M.D., MMS president-elect. For more information, contact the Southeast Regional Office.

Plymouth — Mid-Winter District Meeting. Thurs., Feb. 28, 6:00 p.m. Location: Atlantica Restaurant, Cohasset. Presentation: Samuel Forman, M.D., author. For more information, contact the Southeast Regional Office.

Suffolk — Annual Meeting. Thurs., March 14, 6:00 p.m. Location: Harvard Faculty Club, Cambridge. Speaker: Donald Berwick, M.D., former president and CEO, Institute for Healthcare Improvement and former CMS administrator. For more information, contact the Northeast Regional Office.

Worcester — 7th Annual Louis A. Cotelle Medical Education Conference. Mon., April 1, 5:30 p.m. Location: Beechwood Hotel, Worcester. Speaker: David Hemenway, Ph.D., professor of health policy, Harvard School of Public Health. Women in Medicine Leadership Forum. Wed., Mar. 20, 5:30 p.m. Location: Beechwood Hotel, Worcester. Speaker: Michele Cyr, M.D., associate dean for Academic Affairs, Division of Biology and Medicine, professor of medicine, Brown University. Topic: You Can’t Run in Your Pumps and Other Lessons over a Thirty-Plus Year Career in Medicine. For more information, contact Joyce Cariglia at (508) 753-1579 or wdms@massmed.org.

Worcester North — Annual Meeting. Tues., March 12, 6:00 p.m. Location: Pay Club, Fitchburg. Guest Speaker: Richard V. Aghababian, M.D., MMS president. Topic: Payment Reform: What Physicians Need to Know. For more information, contact the West Central Regional Office.

Statewide News and Events

Art, History, Humanism, and Culture Member Interest Network — Creative Writing Workshop. Sat., March 16, 9:00 a.m. to noon. Location: MMS headquarters, Waltham. For more information, contact the West Central Regional Office.

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

IN MEMORIAM

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

Richard A. Bradlon, M.D., 89; Venice, FL; Johns Hopkins University School of Medicine, 1946; died April 15, 2011.

Edwin L. Carter, M.D., 83; Dedham, MA; Harvard Medical School, 1953; died November 15, 2012.

Patrick J. Donegan, M.D., 78; Buzzards Bay, MA; National University of Ireland, 1956; died November 24, 2011.

Jonathan B. Greenberg, M.D., 84; Eastham, MA; University of Zurich, Switzerland, 1956; died November 15, 2012.

Elizabeth A. Gregory, M.D., 95; Kennett Square, PA; Boston University School of Medicine, 1942; died October 30, 2012.

Varant Hagopian, M.D., 84; Wayland, MA; Tufts University School of Medicine, 1954; died January 3, 2013.

Robert H. Hamlin, M.D., 89; Medina, OH; Northwestern University Medical School, 1947; died June 1, 2012.

Ruby Jackson, M.D., 96; Wayland, MA; McGill University Faculty of Medicine, 1950; died March 28, 2012.


George W. Mitchell Jr., M.D., 95; San Antonio, TX; Johns Hopkins School of Medicine, 1942; died October 20, 2012.

Robb H. Rutledge, M.D., 83; Fort Worth, TX; Harvard Medical School, 1949; died December 25, 2009.

Virender K. Saini, M.D., 86; Cambridge, MA; King Edward Medical College, Pakistan, 1948; died April 26, 2011.

Richard H. Saunders Jr., M.D., 93; Middlebury, VT; University of Rochester School of Medicine, 1943; died August 12, 2012.

John Shillito Jr., M.D., 89; Chapel Hill, NC; Harvard Medical School, 1952; died March 16, 2012.

Edward D. Thomas, M.D., 92; Bellevue, WA; Harvard Medical School, 1946; died October 19, 2012.

INSIDE MMS

.Linked In with MMS

Connect with your peers by joining our members-only LinkedIn group at www.massmed.org/linkedin.
Speakers Shweta Motiwala, M.D., (left) and Najmosama Nikrui, M.D., chair, MMS Committee on Women in Medicine (right), at the recent 8th Annual Women's Cardiac Health Conference. The event was moderated by Malissa Wood, M.D., co-director of the Corrigan Women's Heart Health Program at Massachusetts General Hospital Heart Center. Speakers also included Loryn Feinberg, M.D., director of the Women's Cardiovascular Health Program at Beth Israel Deaconess Medical Center; James A. Feldman, M.D., M.P.H., attending physician, emergency medicine at Boston Medical Center; and Dr. Elizabeth Pegg Frates, M.D., director of Medical Student Education at the Institute of Lifestyle Medicine at Harvard Medical School.