ONE YEAR LATER ➤

Boston Marathon Caregivers Reflect: Looking Back and Moving Forward

BY VICKI RITTERBAND
VITAL SIGNS STAFF WRITER

For emergency medicine physician Christina Hennon, M.D., healing has come through yoga, raising money for The One Fund, and processing her emotions with other marathon medical volunteers.

Boston Athletic Association (BAA) co-medical director Aaron Baggish, M.D., is restored by physical activity and the support of his family.

For emergency physician Liz Mitchell, M.D., solace arrived through writing a song that captured the duality of the day — the horror versus the strength and courage that met it head-on.

As the one-year anniversary of the Boston Marathon approaches, Vital Signs spoke with physicians and others who cared for bombing victims about how they’re faring, whether they’ll return to the April 21 race as medical volunteers, and what they learned from the tragedy.

“I think there’s a huge range in how people are doing,” said Dr. Baggish. “Many, many people are moving on and feeling confident about returning to the marathon without residual trauma. For others, they are still struggling. The BAA has been very proactive in giving people the out if they have any concerns about volunteering this year. It’s not a sign of weakness and it will have no impact on our welcoming them to volunteer in the future.”

A ‘Cowboy-Up’ Culture

The stereotype of the physician, especially those with specialties in emergency medicine and surgery — disproportionately represented among the people who treated marathon victims — is one of “seen-it-all” equanimity. For several of the physicians interviewed for this story, including Carlo Rosen, M.D., who cared for six marathon victims in the Emergency Department at Beth Israel Deaconess Medical Center, there is a lot of truth to the cliché.

“I’m a hardened criminal, so to speak. I’m older. I’ve been in a number of mass casualty situations before. I’m pretty experienced in taking care of trauma patients with blunt and penetrating trauma,” said Dr. Rosen, who is also BIDMC’s residency director in emergency medicine. “The event definitely had a bigger impact on our junior physicians. They’re a group that hasn’t seen these types of events and hasn’t taken care of many patients like this.”

The downside of what psychiatrist Steven Adelman, M.D., terms the “cowboy-up” culture is that the approach can backfire.

Schwartz Center Rounds for Marathon Caregivers

The Schwartz Center for Compassionate Healthcare is sponsoring a series of confidential, facilitated sessions bringing together caregivers who treated Boston Marathon victims. At the free sessions, which are open to hospital staff, first responders, and medical tent volunteers, participants will discuss how they are coping and what feelings are triggered by the 2014 Boston Marathon.

Upcoming Sessions:
Thursday, April 3, 8 to 9:30 a.m., Inn at Longwood Avenue, 342 Longwood Ave., Boston
Wednesday, April 9, 6 to 7:30 p.m., Boston Park Plaza Hotel, Terrace Room, 50 Park Plaza at Arlington Street, Boston

To register, email schwartzcenter@partners.org with your name, email address, organizational affiliation, and date of the session(s) you’d like to attend.

ONE YEAR LATER ➤

Preparedness Key to Response

Paul Biddinger, M.D.: “We’re Continuing to Ask, ‘What If?’”

BY ROBYN ALIE
MMS PUBLIC HEALTH MANAGER

Boston was praised for its medical response to the April 2013 marathon bombings, which resulted in three fatalities at the scene and 264 injuries. That response was the result of years of training in preparedness for natural and man-made disasters.

“We’ve worked very hard to be as prepared as we can be,” said Paul Biddinger, M.D., chair of the MMS Committee on Preparedness and chief of the Division of Emergency Preparedness at Massachusetts General Hospital, attributing a lot of the good outcomes in Boston to preparedness efforts. “No one who made it to the hospital died.”

Those efforts included meeting with professionals from Israel, London, and Madrid, which had experienced similar events, to...
Lessons Learned from Tragedy

It is hard to believe that a year has passed since the horrific bombings that rocked the 2013 Boston Marathon. The emergency response by the city’s caregivers was admirable, yet many physicians are still haunted by the feeling that they somehow did not do enough. They are still wondering if their skills will be tested by another crisis situation in the future.

We are proud to share the stories of some of the Boston Marathon physician caregivers in this issue of Vital Signs. Paul Biddinger, M.D., chair of the MMS Committee on Preparedness, reflects on the city’s preparedness and the role of its physicians. He says: “Everybody can be necessary, and sometimes you’re necessary in an unexpected way.”

Jeff Kalish, M.D., describes in vivid detail how the bombings were a “life-altering and career-altering event” for him and many other physicians. He details how caregivers came together across all levels of the system to give the best possible care for victims.

We also have a first-person account from John Herman, M.D., detailing how his institution supported caregivers in the aftermath of the attacks, and continues to do so today. We hope all caregivers who responded to the bombings will consider attending one of the special sessions planned for this month at the Schwartz Center for Compassionate Healthcare.

As a medical community we have much to be proud of. There are many more lessons to learn about how to be even better prepared for the next time we are called to action.

— Ronald W. Dunlap, M.D.

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Tips to Transform Your Practice into a Patient-Centered Medical Home

BY TALIA GOLDSMITH
PPRC SPECIALIST

If you are a primary care provider and are not familiar with the term "patient-centered medical home," or PCMH, now is the time to start learning.

The PCMH is the up-and-coming model of care that promotes and supports comprehensive, coordinated, patient-centered care delivery. The Massachusetts Executive Office of Health and Human Services has set the goal for all primary care practices in Massachusetts to become patient-centered medical homes by the year 2015.

The PCMH model emphasizes care coordination and communication between patients and their providers. Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care. Massachusetts has not yet established clear guidelines for primary care practices to follow; however, many local health care organizations and physician practices have already embraced this model by becoming recognized as patient-centered medical homes through the National Committee for Quality Assurance, or NCQA, recognition program.

The NCQA program looks at various aspects of patient care delivery (including access, care coordination, patient education, disease management, and patient satisfaction), and if a practice can demonstrate that it meets the required elements of the joint principles for at least 75 percent of its patients, it can be eligible for PCMH recognition by NCQA.

Transforming your practice into a patient-centered medical home can take some time and resources depending on what processes you may or may not have in place. Here are some practical tips to help you practice start implementing the PCMH model:

Look at your current processes. It is important to identify your current processes around patient scheduling, referrals, follow-up, and other areas that impact patient care and access. Does your office offer late night or weekend appointments? Is someone available for medical emergencies 24/7 (this can be through a relationship you have with other covering physicians and/or clinics)?

Identify gaps and implement a plan to address them. You should prioritize based on those areas that will ultimately have the most impact and are fairly simple to implement. For instance, what are you doing around scheduling to ensure that physician schedules leave room for same-day appointments? Are you currently providing patient education materials? How is the practice following up on lab? Referrals? Creating a plan around the different processes is important. Other questions to consider may include:

• What is your practice doing to enhance communication and engage patients in their care?
• Is your practice currently using community resources?
• Do you offer patient education programs to increase patients’ knowledge of how to best access care and participate in treatment decisions?

Track and assess your progress over time. You may need to make some adjustments along the way as you try different approaches. For example, you may implement a referral tracking system to manage and keep track of where you send your patients, only to find out that some patients who happen to have a language barrier are not showing up to their scheduled appointments. To address this issue you may need to have your staff personally contact those specific patients to confirm appointments.

For more information on implementing the PCMH model, please contact our certified PCMH Content Experts, Talia Goldsmith and Kerry Ann Hayon, at pprc@mms.org or (781) 434-7702.

Improve Outcomes with Shared Decision Making

BY LEIF BRIERLEY
MMS HEALTH POLICY ANALYST

As accountable care delivery models, patient-centered medical home models, and other emerging models of care delivery increase in prevalence, there is a need for increased involvement of patients in the decision-making process.

Experts agree that patient engagement through shared decision making can improve health outcomes while also achieving cost savings.

Patient engagement through shared decision making involves patients taking an active role in improving and maintaining their health. Physicians can engage their patients by discussing with them their care preferences, needs, and values. As a result, the care paradigm becomes more patient centered, and allows patients to be active and engaged participants in their care. For example, diabetic patients might discuss various treatment options with their physician taking into consideration specific options that fit their lifestyle, their dietary needs, and their cultural background.

Many studies have shown that this method is beneficial from both an outcomes and cost savings perspective. Patients who are more engaged in their care tend to display improved preventive behaviors, such as having regular check-ups, screenings, and immunizations.

Additionally, chronically ill patients, whose health costs are often highest, are more likely to adhere to treatment plans when they are more engaged in making decisions about their care. Highly engaged patients also have a lower probability of having an emergency department visit, and tend to have lower rates of hospitalizations. In fact, a recent Health Affairs article found that less engaged patients have significantly higher health costs than those who are more engaged in their care.

The following tips will help you achieve shared decision making and patient engagement in your practice:

• Speak with your staff and make sure that everyone is on board with the practices’ established patient engagement and shared decision-making framework. Educating your staff on the importance of this will help you work toward a shared goal of providing optimal patient care.
• When seeing patients, lay out the options for care and explain the pros and cons of each option. Ask patients what their concerns are and discuss with them their preferences and/or any barriers that may exist.
• Do you offer patient education programs to increase patients’ knowledge of how to best access care and participate in treatment decisions?
• Stop and ask patients simple follow-up questions, such as if they have any other health concerns. Evidence has shown this can greatly increase patient satisfaction and participation in care, as it leaves the patient feeling valued for their input.
• Provide patients with information about alternatives and understand how, and to what degree, the patient prefers to be involved in decisions. Use education tools and information technology to your advantage. If you have a patient portal, this is a great way to engage patients and encourage active participation.
ensure Boston’s plans were appropriate, Dr. Biddinger said, and working with local, state, and federal agencies.

In the two years prior to the event, hospitals in the Metro Boston Homeland Security Region had conducted exercises and evaluations of mass casualty response plans of Boston hospitals, community health centers, and emergency medical services.

And, just four months prior to the marathon, the region’s hospitals had conducted an annual 24-hour full-scale exercise of emergency personnel response to various scenarios involving more than 600 emergency responders from 50 agencies.

Dr. Biddinger, who has been involved in preparedness and response efforts to emergencies locally and around the world, was working at Heartbreak Hill during last year’s Boston Marathon. When he heard about the bombings at the finish line, he went immediately to MGH and took charge of the emergency department response.

Dr. Biddinger acknowledged luck played a role in preventing more casualties. The explosions occurred outdoors, equidistant from the city’s trauma centers, and during a shift change so that emergency departments and operating rooms had double staff.

Dr. Biddinger noted that departments beyond the ED were a very important part of MGH’s response. Some of the internal medicine physicians took over the care of the patients already in the ED when the bombs went off and transported some patients to other areas of the hospital, enabling the ED to treat the incoming blast victims.

“We’re not patting ourselves on the back... we’re continuing to ask, ‘What if?’ and looking at any challenges we experienced that day.”

Dr. Biddinger

Communicating with hospital employees in the moment is difficult but important, Dr. Biddinger learned during the event. “They want to know what’s going on, if they’re needed, what the threats are. By pushing information out quickly, we can limit crowding in the ED of physicians and others.”

“People want to contribute; they just want to know how they can best help,” he added. “If they feel confident that they’ll be called quickly, they’re less likely to self-resign.”

Hospitals and local and state health authorities are trying to improve communication of accurate information across the system so that families can find where their loved ones are, said Dr. Biddinger.

Psychosocial Support Important

Biddinger commended the city and the hospitals for the psychosocial support they provided for medical responders.

“The most important lesson is that everyone is different and a one-size-fits-all strategy definitely doesn’t work,” he said, noting that a variety of approaches over time are necessary. Some people need one-on-one support, some want to share their experiences with others, some want no support, and some don’t realize they’ve been affected until weeks later, he said.

Anniversary Approaching

As the anniversary of the event approaches, some of those affected may have a significant amount of difficulty. “They may seem de- spondent, fearful, angry,” he said, recommending that physicians be vigilant, so they recognize if a patient, colleague or employee is having difficulty, and refer them to support.

“These events can happen anywhere at any time,” said Biddinger.

Dr. Biddinger recommends that all physicians associated with a hospital should know what the hospital emergency plan is, what his or her role is, and be prepared to help. Community physicians can join their local medical reserve corps, he said. “Everybody can be necessary, and sometimes you’re necessary in an unexpected way.”

Can Health IT Reduce Health Care Disparities?

BY KOMAL KARNIK

MMS PUBLIC HEALTH STAFF

Health and health care disparities with respect to race, ethnicity, and socioeconomic status continue to be a serious problem at the national and state levels. A 2013 study by the Office of the National Coordinator suggests health information technology has a role in addressing systems that will improve care for populations facing health disparities.

“For example, technological improvements in data collection and analysis could pinpoint disparities and assist providers in giving culturally appropriate care.”

— Ronald Dunlap, M.D.

For example, technological improvements in data collection and analysis could pinpoint disparities and assist providers in giving culturally appropriate care.

“There are new tools to reach a larger number of patients,” said Massachusetts Medical Society President Ronald Dunlap, M.D. “Given the smaller number of providers, these tools may allow us to get very good outcomes, at lower cost, and really put the patients in charge of their care.”

Technology systems, such as blood pressure monitoring applications on smartphones, could have positive effects on patient engagement, which could in turn help reduce health care disparities, he said.

Leaders in health care, public health, and policy will discuss health IT, as well as policy, practice, and systems changes to reduce health care disparities at the Public Health Leadership Forum on April 4. The Forum is sponsored by MMS and the national Commission to End Health Care Disparities. To learn more, visit www.massmed.org/disparities.
Meaningful Use and Massachusetts Medical Licenses

BY WILLIAM J. RYDER, ESQ.
MMS LEGISLATIVE COUNSEL

There is a great deal of concern among physicians regarding a provision of the state’s 2012 health reform law linking federal meaningful use to physician licensure in Massachusetts. The brief section requires physicians to be proficient in the use of health information technology as a condition of obtaining or renewing a medical license, after January 1, 2015.

The issue dates back to 2008 when an EMR proficiency requirement for 2015 was included in another piece of legislation. The Board of Registration in Medicine passed regulations interpreting the law to apply to licenses issued or renewed after January 1, 2015. In seeking language repealing this requirement or eliminating references to federal standards, the MMS worked with the Mass e-Health Institute, a quasi-public state agency that receives federal funding to assist in adoption of EHRs and meaningful use. The MMS met with MeHI several times and helped develop statistics and approaches to adapting to the new statutory requirement.

Of the approximately 40,000 physicians with Massachusetts licenses, about 15,000 have attained meaningful use certification. The vast majority of the remaining 25,000 are not eligible for a variety of reasons. For example, there are nearly 5,000 residents and interns with limited licenses. First-year residents and interns have no history on which to claim meaningful use. Other categories lack firm numbers but would include researchers, volunteer physicians, academics, and those not treating a certain threshold of Medicaid or Medicare patients.

The MMS does not favor a process to “certify” physicians as meeting the meaningful use requirement. The MMS feels that an individual certification process beyond a CME course is not warranted. Physicians do not need an additional state-mandated process and presumed cost relating to EMRs, particularly as Massachusetts is a leading state in the adoption of EMRs and in achieving meaningful use.

The Board has started the process to hold a public hearing on proposed regulations to comply with the legislative requirement. In a recent public session, the Board voted to take a view of the statute that would allow compliance in a number of ways, including meaningful use certification, working in a MU-certified hospital, using the MA HIWay information exchange, or taking a three-hour training program. Additional exemptions would be made for those not actively seeing patients, volunteers, and limited licensees. The Board intends certification to be one-time event and not subject to every renewal.

The MMS is still seeking legislative repeal of the 2012 requirement and supported alternative language that will allow physicians to meet the requirements for proficiency in EMRs in a manner consistent with the proposed regulations. We have won support in the House but not the Senate.

Look to Vital Signs This Week and our Legislative Update e-newsletter for news on the status of the legislation and the dates of the Board hearings on regulations. We hope that physicians will actively support the Board of Registration’s proposed regulations in public testimony.

Protection and Disclosure of Mental Health Medical Records

BY LIZ ROVER BAILEY, ESQ.
MMS ASSOCIATE COUNSEL

We thought it would be helpful to address a topic that a few members have inquired about over the past year: the protection and disclosure of mental health records. A medical record contains information that enables the health care provider to deliver the proper diagnosis and treatment to the patient. In other words, any information upon which a health care provider would rely in diagnosing or treating the patient, including electronically transmitted information, is considered to be part of the patient’s medical record.

Generally, Massachusetts’ law does not authorize physicians to disclose a patient’s protected health information based on a subpoena or request letter alone. You can disclose a patient’s medical record or personal health information to a litigant or attorney (including the patient’s own attorney) only pursuant to a judicial or administrative order or if you have the patient’s written authorization on a HIPAA-compliant authorization form.

The same limitations on disclosure apply to mental health medical records as apply to all medical records, except that psychotherapy notes receive higher protection in some instances. Thus, the following mental health records are treated as ordinary medical records: medical prescription and monitoring; counseling session start and stop times, the modalities and frequencies of treatment furnished; results of clinical tests; any summary of diagnosis, functional status, treatment plan, symptoms prognosis, or progress to date. However, HIPAA applies special protections to “psychotherapy notes,” which are defined as notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session, and that are separated from the rest of the individual’s medical record. This means that unless psychotherapy notes are separately maintained, the same rules apply to them as apply to any medical records.

Except in limited circumstances (such as an internal training program, legal defense, disclosure to the patient, required regulatory disclosures, or as required by other laws), HIPAA requires a separate patient authorization for the disclosure of psychotherapy notes. In the absence of such written authorization, the provider may rely on a valid court order.

The “Law and Ethics” column is provided for educational purposes and should not be construed as legal advice. Readers with specific legal questions should consult with a private attorney.
Electronic Health Records: The Next Chapter
BEST PRACTICES, CHECKLISTS, AND GUIDELINES

Wednesday, April 30, 2014
MMS Headquarters
Waltham, MA

Caring for the Marathon Caregivers

This month, my colleague and friend John Herman, an MGH psychiatrist who directs Partners’ Employee Assistance Program, shares memorable reflections with us on the impact of the Boston Marathon bombing on the staff of his institution. Impressively, MGH provided a safety net for a small number of distressed individuals, while setting a positive tone that helped most involved staff members to pull themselves together and do their jobs. I continue to ponder his observation that none of the 30 staff members assisted by the MGH EAP were physicians.

— Steve Adelman, M.D., Director, Physician Health Services

BY JOHN B. HERMAN, M.D.

Monday April 15, 2013, 2:54 p.m.
A text message from an ever-vigilant friend:
“I heard something happened at the marathon… something about an explosion… did you?”
Another Internet prank?
Within seconds the chorus of emergency pagers vibrated:
“Explosions heard at Marathon finish line.”

Minutes later the hospital began receiving victims at an unprecedented pace. Focusing only on their clear and present duties, the emergency room staff was shielded from the bombing’s unknowns, uncertainties, and speculations. Those would come later.

In the hours and days following the bombing, attention turned to addressing the emotional and psychological impact of the bombing on victims, their families, and our own staff. For staff, there was a sense of deep relief and satisfaction that their years of careful preparation had produced a well-choreographed response.

Debriefings Effective
To encourage thoughtful personal reflection, Employee Assistance Program staff and trauma psychiatry specialist Naomi Simon, M.D., director of the MGH Center for Anxiety and Traumatic Stress Disorders led highly effective debriefings for the clinical units most closely involved with the care of bombing victims.

To help staff distinguish normal and expected anxiety from more pathologic conditions, Dr. Simon said it best: “If you are not a bit freaked out by this experience, your brain isn’t working.”

Nevertheless, we anticipated that a small fraction of staff responders would eventually develop the need for skilled clinical intervention. We created a triage process, which successfully prevented an indiscriminate flood of referrals from saturating the limited availability of specialists we knew would be called upon to treat victims, finish-line witnesses, and first responders in the coming weeks.

Consistent with this estimate, only one or two of the 21 employees requesting help from the EAP for bombing-related issues required further evaluation.

Since the bombing, our department’s outpatient Post-traumatic Stress Disorder group has evaluated around 30 patients. None of these were physician responders.

Schwartz Center Rounds
Responding to the needs of marathon bombing caregivers, The Schwartz Center for Compassionate Healthcare sponsored a series of citywide special Schwartz Center Rounds exclusively for hospital staff, first responders, and medical tent volunteers. Held last fall, these sessions were quite moving in both their content and in the pervasive sense of shared achievement for jobs well done.

Encouraged by the success of those sessions, the Schwartz Center has planned psychiatric first aid for caregivers for mid-April. (See details on these sessions on page 1.)

In the days following that Monday’s bombing and Friday’s citywide shutdown, the “where were you when?” stories were widely and excitedly shared by the citizens of Boston and particularly among hospital staff who were directly involved in the clinical care of victims. By week two the frequency and intensity of these reflections began to fall. Steadily, healthily, routine life in Boston resumed.

Dr. Herman is the Associate Chief of Psychiatry at Massachusetts General hospital and medical director for the Partners Healthcare Employee Assistance Program.
District News and Events

NORTHEAST REGION

Charles River — Annual Meeting. Tues., Apr. 8, 6:00 p.m. Location: The Boston College Connors Center, Dedham. Entertainment: The Bostonians, Boston College’s first and original a cappella group.

Essex North — Annual Meeting. Wed., Apr. 9, 6:00 p.m. Location: DiBurro’s Function Facility, Haverhill. Topic: “Medical Marijuana.”

Essex South — Annual Meeting. Wed., Apr. 23, 6:00 p.m. Location: Peabody Marriott, Peabody. Guest Speaker: Richard Pieters, M.D., MMS president-elect.


Middlesex Central — Executive Committee Meeting. Thurs., Apr. 17, 7:45 a.m. Location: Emerson Hospital, Concord. Annual Meeting: Tues., Apr. 29, 11:45 a.m. Location: Emerson Hospital, Concord. Delegates Meeting, Thurs., May 1, 7:45 a.m. Location: Emerson Hospital, Concord. Resolution Review.


Suffolk — Annual Meeting. Thurs., Apr. 3, 6:00 p.m. Location: The Downtown Harvard Club of Boston, Boston. Speaker: James O’Connell, M.D., president and founder of Boston Health Care for the Homeless. Topic: “Lessons from the Streets: Successes and Failures in Caring for Boston’s Rough Sleepers.” For more information on these events, or 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

Bristol North/Plymouth — Joint Spring Annual Meeting. Tues., Apr. 1, 6:00 p.m. Location: Boston Tavern, Middleboro. Speaker: Dr. Ronald Dunlap, M.D., MMS president.

Bristol South — Spring Annual Meeting. Wed., Apr. 9, 6:00 p.m. Location: Venus de Milo, Swansea. Speaker: Samuel Forman, M.D., author. 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

Hampden — High School Doctor for a Day Program. Wed., Apr. 16, 7:30 a.m. Breakfast, 5:00 p.m. Debriefing. Location: Baystate Conference Ctr., Holyoke.

Worcester — Annual Meeting. Wed., Apr. 16, 5:30 p.m. Location: Beechwood Hotel. Meeting includes presentation of the 2014 Community Clinician of the Year Award.

Worcester North — Annual Meeting. Wed., Apr. 2, 6:00 p.m. Location: Fay Club, Fitchburg. Speaker: Dr. Ronald Dunlap, M.D., MMS president. 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, History, Humanism, and Culture Member Interest Network — Creative Writing Workshop. Sat., Apr. 12, 9:00 a.m. to noon. Location: MMS headquarters, Waltham. Bird Banding. Sun., Apr. 27, 9:00 a.m. to noon. Location: Joppa Flats, Newburyport. 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.

2014 Senior Volunteer Physician of the Year Award

BY CAROLYN MAHER
MMS MEMBER BENEFIT COORDINATOR
The MMS Committee on Senior Volunteer Physicians has chosen Leo L. Stolbach, M.D., of Dedham, as the 2014 Senior Volunteer of the Year. Dr. Stolbach, a graduate of the University of Rochester School of Medicine and Dentistry, began his career as a practicing medical oncologist in 1964 at Lemuil Shattuck Hospital in Jamaica Plain. He retired from clinical practice in 1998.

During his career in medicine he has also been associated with each of the four medical schools in Massachusetts. He currently holds the rank of senior affiliate in medicine in the Department of Medicine at the University of Massachusetts Medical School.

For nearly 20 years, Dr. Stolbach has taught “Caring for the Seriously Ill,” a preclinical medical student course. The course explores all aspects of end-of-life care and is made possible solely by voluntary faculty participation, commitment, and generosity. Winter and spring, since the program began, Dr. Stolbach has faithfully shown up to teach.

Dr. Stolbach’s contributions to the course include precepting discussion groups, providing patients for student interviews, and sharing his wisdom and experience in class discussions. His dedication, gentleness, and compassion have been an inspiration to nearly a generation of medical students. Hundreds of medical students, and later their patients, have benefitted from his mentoring and personal example of dealing with terminally ill patients.

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.

Milton J. Hirschberg, M.D., 90; South Harwich, MA; Yale University School of Medicine, 1955; died December 16, 2013.

John L. Goodman, M.D., 68; Wellesley, MA; Boston University School of Medicine, 1974; died July 13, 2013.

Op-in to Receive Vital Signs Online

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

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

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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.

Electronic Health Records: The Next Chapter — Optimizing and Connecting
Wed., April 30, 2014

2014 MMS and Rhode Island Medical Society Directors of Medical Education Conference
Thurs., May 1, 2014, 8:00 a.m. to 2:30 p.m.

Enhancing Community Resiliency Conference and Webinar
Wed., May 21, 2014, 5:15 to 9:00 p.m.

12th Annual Symposium on Men's Health
Wed., June 11, 2014, 8:00 a.m. to 5:00 p.m.

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

End-of-Life Care
• Principles of Palliative Care and Persistent Pain Management (6 modules)
• End-of-Life Care (3 modules)
• Communication and Conflict Resolution in End-of-Life Care
• The Importance of Discussing End-of-Life Care with Patients
• Legal Advisor: Advance Directives

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

Other Risk Management CME
• Preventing Falls in Older Patients: A Provider Toolkit

• Guide to Accountable Care Organizations: What Physicians Need to Know
• HIPAA 2.0: What's New in the New Rules?
• Cancer Screening Guidelines
• Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
• Effective Chart Review for Quality Improvement

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

TO REGISTER FOR ANY OF THESE ACTIVITIES, CALL (800) 843-6356.

CME CREDIT: These activities have been approved for AMA PRA Category 1 Credit™.
For additional information, contact the Department of Continuing Education and Certification at (800) 322-2303, ext. 7306, or go to www.massmed.org/cmecenter.