Leading and Working in Teams: The New Care Paradigm

MMS Introduces Physician-Led Team Legislation; Creates New Inter-professional Teams Task Force

BY VICKI RITTERBAND
VITAL SIGNS STAFF WRITER

As the health care system moves toward new models of care delivery and alternative ways of paying for that care, the idea of team-based care is gaining traction. Inter-professional teams, the thinking goes, can provide better-coordinated, higher quality care — physical and mental health — to individuals and populations. And thanks to increased collaboration, more attention can be paid to prevention and wellness, advocates say.

But who should lead those teams? What does leading a team mean exactly? And as inter-professional collaboration becomes increasingly common, do team members understand the capabilities of colleagues from other professions?

At Family Practice Group in Arlington, team-based care takes the form of the daily morning huddle where a physician or a physician assistant, a medical assistant, and an administrative assistant review the patients on that day’s schedule. In Dr. Hugh Taylor’s family practice in Hamilton, nurse practitioners team up with a physician and a medical assistant to care for a panel of patients. Lately, the medical assistants have taken on a critical piece of population management — making sure patients are up-to-date on their preventive measures.

But organizations that accredit medical homes, including the National Committee for Quality Assurance and the Joint Commission, do not require physician leadership in their criteria.

Many physicians, however, feel they should. MMS policy on accountable care organizations (ACOs) includes language endorsing doctors as team leaders, a preference that the Society hopes will become law in the next session of the state legislature, which begins in January. (See adjacent Vital Signs story, MMS to Propose Health Care Team Legislation.) The AMA recently approved policy to the same effect. Physicians are the obvious choice to lead teams because they have the most medical education and training and can take on the more complex, difficult, and unusual cases, argue supporters of physician-led teams.

MMS President-Elect Dennis Dimitri, M.D., said leadership can take different forms, and in some cases the operational head of a team may be a non-physician. But when it comes to ultimate decision making about the “quality and direction of care, particularly for complex issues, patients need to know that there will be a physician who can take the lead,” he said.

continued on page 2

Team-Based Health Care Bill Would Give Patients Highest Quality Care

BY BRENDAN ABEL, ESQ.
REGULATORY AND LEGISLATIVE ASSISTANT COUNSEL

Health care across the delivery spectrum has become a team sport. Even many small medical practices rely upon a team of health professionals (e.g., physician assistants, nurse practitioners, registered nurses) to provide the highest quality, most efficient care.

Despite this trend towards teamwork, countless scope-of-care bills have been filed in Massachusetts over the past several years to expand independent practice of various health professionals; all which run counter to the integrated future of health care practice.

This January, the MMS plans to file legislation to promote team-based care, and to ensure that such collaborative care continues to be provided at the highest level of quality by requiring that patient care teams are led by physicians.

continued on page 5

Board of Medicine Approves EHR-Meaningful Use Regulations

The Board of Registration in Medicine has adopted final changes to regulations that implement a state law requiring physicians to demonstrate proficiency in the use of electronic medical records, as well as the skills to achieve the federal Meaningful Use standard.

There are also a broad set of exemptions for certain license categories, where electronic health record use is intrinsic or not relevant.

Demonstrating Proficiency

Under the regulations, physicians are considered to have demonstrated proficiency if they meet any one of the following conditions:

- Participating in the Meaningful Use program as an Eligible Professional
- Having a relationship with a hospital that has been certified as a Meaningful Use participant. This relationship would be satisfied by any one of the following conditions:
  - Employed by the hospital
  - Credentialed by the hospital to provide patient care
  - Having a “contractual agreement” with the hospital
- Completing at least three hours of accredited CME program on electronic health records. Such a program must, at a minimum, discuss the core and menu set objectives, as well as the clinical quality measures for Meaningful Use.
- Participating or being an authorized user in the Massachusetts Health Information Highway (the state’s official health information exchange)

continued on page 5
Leading and Working in Teams
continued from page 1

Alternatives to Physicians as Team Leaders

That position, however, has bumped up against a long-time campaign by advance practice registered nurses (APRNs), such as nurse practitioners and clinical nurse specialists, to gain more practice autonomy from physicians. In many states, nurse practitioners are allowed to practice independently. And with an acute shortage of primary care physicians that just keeps getting worse, APRNs argue they are ideally suited to fill the gap.

“We’ve built up great relationships with our physician colleagues — including pulmonologists and cardiologists. If there is an issue that is beyond our scope, that we’re not comfortable with, we’ll reach out to our physician colleagues,” said Wendy Wright, the nurse practitioner who owns and heads up the eponymous Wright and Associates Family Healthcare in New Hampshire.

Wright believes that experienced NPs are capable of leading care teams not only because of their clinical expertise, but also because they are accustomed to working closely with other allied health professionals. In her office, a physical therapist, a phlebotomist, a diabetes specialist, and a nutritionist are onsite part-time to collaborate on patient care.

MMS Creates New Inter-professional Teams Task Force

Leadership issues aside, Dr. Dimitri believes that in this new world of team-based care, it’s incumbent upon health care professionals of every ilk to learn more about the training and capabilities of those they’re working with. He’s pleased that the MMS’s board of trustees recently approved a new task force on inter-professional health care.

“We need to create a better understanding on everyone’s part of what physicians and non-physicians bring to the care of our patients,” said Dr. Dimitri.

“And I’m not referring only to physicians, NPs, and PAs, he said. “We need to learn to work better and understand what pharmacists, social workers, and behavioral health specialists bring to the table as well.”

Third-year medical student and Delegate to the MMS House of Delegates, Aimie Zale, the prime mover behind the task force, is already well-versed in professional silos thanks to her clinical rotations and her work as a nurse’s aide prior to medical school.

“I’ve talked to a lot of other professionals, whether midlevel providers, occupational therapists, hospital nutritionists or lactation specialists. They tell me that the referrals they get are often inappropriate or that they’re not being utilized to the full extent of their training and education,” she explained.

She gave the example of lactation experts: the best trained are professionals I’ll be working with. I’m not getting that training in medical school and I’m not sure I will get it in residency either.”

Zale said she hopes the new task force spawns greater cooperation among different health care professionals on a more global scale as well. “I’d like the MMS to invite professional societies from other professions to talk to us about policy issues,” she said. “Let’s come to mutually satisfactory conclusions instead of arguing these issues at the statehouse.” Such efforts would also help counter the public perception that physicians are unduly concerned about protecting their turf, she added.
Three Important Trends That Will Impact Your Practice in 2015

Registration and Certification of Certain Provider Organizations. The registration of provider organizations and certification of risk-bearing provider organizations processes have begun. Many provider organizations must register and obtain certification to continue to engage in risk-based contracting. Additional processes, clarification, and other steps will continue to roll out in early 2015.

Prior Authorizations. The Division of Insurance is in the process of creating standardized prior authorization forms for medical services, prescriptions, behavioral health, and other related areas. Once final, all physicians and Massachusetts payers will be required to use the forms.

How will this impact your practice? Physicians will want to stay on top of these new requirements in order to not delay patient access to medical services and/or medications.

Massachusetts Payer Contracts: Payers will continue to expand on alternative payment models with a strong focus on maintaining high quality care while reducing cost. Global budgets and other alternative reimbursement structures will continue to develop. High-deductible and limited network product offerings will likely continue to grow as employers seek ways to reduce cost. Wellness programs may expand and patient engagement/satisfaction will likely remain a focus point for physicians and health care organizations working to improve metrics in this area.

How will this impact your practice? Physicians will bear more responsibility when it comes to the clinical management of patient populations and data will be the key driver for success. It’s extremely important for physicians to understand their data and to have the tools necessary to track their high-risk patients. Furthermore, as high deductible health plans continue to expand, physician practices will have to develop new strategies for staying on top of patient-owned balances.

Physician Reimbursement: Reimbursement in 2015 will likely be impacted by physicians achieving high quality and patient experience scores. Payers are developing new reimbursement strategies that incentivize physicians to meet metric targets for quality and utilization.

How will this impact your practice? Whether a physician accepts fees-for-service or operates within a global budget, he or she will be asked to reduce cost while providing the best quality care and patient experience possible. It is also important to regularly review payer and employment contracts and align internal processes to successfully meet contract-based goals.

As physicians continue to align with ACOs, they may be required to shift referral patterns. It is very important for practices and physicians to understand and stay on top of organizational policies.

Sign up for our PPRC newsletter, the PPRC Practice Pulse, so you can stay on top of the latest changes.

Key Topics in Massachusetts Health Policy for 2015

BY LINDSAY GARITO, MPH
MMS HEALTH POLICY ANALYST

Over the past year health care cost containment has been a state and national priority. As these efforts continue into 2015, we expect key issues to include the integration of behavioral health services, adoption of alternative payment methodologies, and new cost-containment approaches to hospital utilization and post-acute care.

Behavioral Health
Behavioral health care remains largely disjointed from the primary care system, despite evidence that independently functioning physical and behavioral health services lead to worse health outcomes and higher total spending. Coordinating the medical and behavioral health care needs of patients is complex and time-consuming. Further complicating the delivery of care are the varied policies surrounding reimbursement and associated billing practices. The lack of cohesion between medical benefits and behavioral health services makes it challenging for patients to navigate, and providers to deliver care. Efforts will continue at the state level and among payers to place behavioral health services on par with physical health services to create cost savings and improve patient outcomes.

Alternative Payment Methodologies
Movement away from the fee-for-service model and interest in exploring alternative payment methodologies will continue in the upcoming year. Chronic and co-morbid conditions often require assistance from an array of providers that historically have worked independently. Alternative payment methodologies encourage collaboration across providers and incentives for improving patient outcomes. Research indicates that alternative payment methodologies, such as Alternative Quality Contracts operating with global budgets, can slow health care spending while improving the health of patients.

It is likely that integrating behavioral health into emerging alternative payment methodologies and exploring episode-based bundled payments will also be key in the coming year.

Hospital Utilization and Post-Acute Care
In a July 2014 report, the Health Policy Commission found that Massachusetts residents utilize 10 percent more hospital services than the average U.S. resident, and they are also much more likely to be discharged to a post-acute care facility. Since there is no clear explanation for the high use of post-acute care and high readmission rates, we expect more research and resources to be directed toward this problem.
Public Health: The Year Ahead

Focus on Opioid Abuse, Preparedness, and End of Life

BY ROBYN ALIE
MMS PUBLIC HEALTH MANAGER

The year 2014 began with rising numbers of deaths from suspected opioid overdoses in communities around the state, prompting Massachusetts Gov. Deval Patrick to declare a public health emergency in March.

In August, an international public health emergency was declared by the World Health Organization, as the death toll from Ebola virus mounted in Africa. After the first cases were diagnosed in the United States, we saw tension between public health experts and politicians, with some states attempting to impose mandatory quarantines. Massachusetts’ response, led by the DPH, has focused on preparing health care workers, hospitals, laboratories, and emergency responders for the possibility of a local case.

Meanwhile, efforts to combat existing public health threats, such as vaccine-preventable diseases, violence, and chronic disease, continue. Working toward reducing health care disparities and ensuring that the health care needs of vulnerable populations are met will also continue to be a focus of public health efforts statewide.

Progress toward better integration of primary care, mental health and substance abuse services, and development of a “robust community system” to provide preventive behavioral health services to avoid the need for more acute care where possible, as recommended by a 2014 DPH analysis of statewide behavioral health resources and utilization, will be significant.

MMS’s Public Health Leadership Forum, scheduled for April 8, 2015, will examine the status of efforts to reduce opioid abuse, and explore how the health care community and the state can contribute to greater success.

On Beacon Hill, Governor-elect Charlie Baker will take office in 2015. He has stated that the opioid crisis and health care cost will be top priorities. He has announced the appointment of former Department of Mental Health Commissioner, Marylou Sudders, as Secretary for Health and Human Services.

WHAT WILL 2015 BRING?

Vital Signs asked five committee chairs what they expect in the year to come.

“There’s the massive question of opioid use and addiction in Massachusetts and how that interdigitates with the whole health care system. The question goes beyond the drugs, but what happens to people who are addicted to drugs, how are they cared for, what things are available to them, and what’s not… We were focused on infectious diseases before the Ebola crisis, thinking about the diseases we faced, whether it was Chikungunya or H1N1, and thinking about a public health strategy in terms of evaluation and prevention. With Ebola, we see the inter-relationship between public health and disaster planning. And it raises issues of what are the rights and responsibilities of public health. What are the limits of what the government can do? At what point do individual rights get superseded? That’s a persistent issue.”

— Steve Ringer, M.D., Chair, Committee on Public Health

“With the transition from frenzied planning and extreme anxiety to more long-term and sustained planning, we need to consider what Ebola and, before that, other emerging infections like MERS and SARS mean for our health care system. I believe that we will continue to see more zoonoses and emerging infections, with some that are very serious. We need to think about what it takes to invest in preparing for that threat, both in the health system and in public health infrastructure. Do we need to invest more? I think so.”

— Paul Biddinger, M.D., Chair, MMS Committee on Preparedness

“Let’s continue to encourage healthy food choices at work and in our schools, and support the use of bikes. And encourage everyone to get a flu shot!”

— Denise Rollinson, M.D., Chair, Committee on Nutrition and Physical Activity

“In the later stages of life, what’s important are comfort, dignity, love, and peace. In September, the Institute of Medicine released ‘Dying in America,’ which takes head-on … the false accusations that there would be death panels if doctors were paid to discuss advance care directives. That political fallout still distracts the public and politicians from the real issues: that people are suffering and need appropriate care for their suffering.”

— Eric Reines, M.D., Chair, Committee on Geriatric Medicine

MMS Anti-Tobacco Contest Entries Due Feb. 13

The MMS is accepting entries to its annual Anti-Tobacco Poster Contest. For a contest kit, email jcricones@mms.org or call (800) 322-2303, ext. 7372. The annual contest is open to children in grades one through six. The contest aims to encourage children to keep away from tobacco and to carry anti-tobacco message to their friends and loved ones. In addition to entry information, the contest kit includes a 2015 calendar featuring the 12 winning entries from last year’s poster competition. Entries must be received by February 13, 2015. Entries will be judged on originality, creativity, and adherence to the contest themes. (Pictured above are the 2014 poster contest winners. View the 2014 contest winning posters at www.massmed.org/tobacco.)
GOVERNMENT AFFAIRS

Republican Congress in 2015: What Does It Mean for Health Care?

ACA, Medicare Expected to be Targets

BY ALEX CALCAGNO
MMS FEDERAL RELATIONS DIRECTOR

The Republicans trounced the Democrats in the November midterm elections and picked up more seats in the House and the Senate than most experts predicted. They made President Barack Obama the focus of their strategy, and it worked.

But now the real question is what does this mean for the 115th Congress? Republicans are in the majority in both chambers, but they most likely do not have enough votes to override a presidential veto. Republicans will now assume the chairmanship of all Senate committees, and they will have more members on each committee. And as the majority party in each chamber, they will set the Congressional agenda. But what can they get done?

Whether Washington will become any more productive than it has been probably rests on what each party sees at its best strategy for 2016. The Republican conservatives, who will feel empowered by the election, will push for a full repeal of the Affordable Care Act (ACA) — the legislative piñata of the Republican Party. But without the votes to override an Obama veto, any attempts will fail. Republican leaders in the Senate have already said they will go for any incremental changes, such as repealing the medical devices tax and repealing the Independent Payment Advisory Board, which was empowered to make cuts to Medicare should spending increase beyond targets.

Should they succeed in this effort, expect other industries taxed as part of the ACA to come to the table. The problem with this strategy is that these tax dollars are a very important funding source for the ACA. Other provisions on the Republican hit list, including repealing the individual mandate, are less likely to succeed.

In terms of health care, the biggest changes may come to Medicare via a “reconciliation” bill, which will attempt to cut the costs of social programs like Medicare and ease the passage of a simplified tax code.

Should Rep. Paul Ryan take over the House Ways and Means Committee, we would also expect a renewed push to transform Medicare into a premium support program which was one of the hallmarks of his vice presidential campaign. Republicans will also have an opportunity to make significant legislative changes through appropriations bills.

Whether Washington will become any more productive than it has been probably rests on what each party sees at its best strategy for 2016. Now that the Republicans are the majority in both chambers, will they be held responsible if DC continues its gridlock and face ballot box defeat in 2016? Will the Democrats want to find compromises with the Republicans in light of the upcoming presidential election in 2016? And how will the GOP balance the demands of its conservative arm particularly in light of presidential election where the electorate is much more diverse? We will be watching all of this very closely in the coming months.

Health Care Team Legislation
continued from page 1

While respecting the value of all team members, the Team-Based Health Care bill will ensure that a physician leads each patient care team, and that the physician provides structured collaboration and consultation (when appropriate) to advanced practice nurses and physicians assistants. The bill reaffirms the need for such allied health professionals to develop written practice guidelines and to have periodic discussions and chart reviews of practice and prescribing activities.

This proposed legislation would promote the care paradigm that has worked so effectively in Massachusetts for many years, and is the method by which many health professionals have been trained, as well. It would also allow maximum transparency for patients, who deserve to be treated by the most experienced and highly trained provider.

Physician-led teams are firmly in line with patient preferences. A recent AMA survey showed that 88 percent of patients with one or more chronic conditions benefit when a physician leads a primary care team, and four out of five patients prefer a physician to have the primary responsibility for leading and coordinating care.

Physician-led health care teams are also consistent with evolving health care reforms. The state legislature has required MassHealth to explore payment structures such as bundled payments as alternatives for fee-for-service, and practices of all sizes are moving towards capitated, risk-based contracts that reward overall care rather than a volume of individual services. Additionally, movements towards ACOs and patient-centered medical homes have been promoted upon the assumption that care is best delivered by a team. With such momentum towards team-based care, the MMS is pleased to offer this important bill to ensure that these health care teams are led by the health care professionals with the highest education and training.

The MMS looks forward to continuing to engage in discussions with members and other stakeholders to promote policies that ensure quality, reliability, and efficiency for patients in Massachusetts. As the team aspect of practicing medicine continues to evolve, the MMS looks forward to promoting thoughtful policies that place physicians as the captains of the clinical teams.

EHR
continued from page 1

Proposed Exemptions

• Applicants for a Limited License, such as interns and residents
• Applicants for a Volunteer, Administrative or Emergency Restricted License
• License applicants not engaged in the practice of medicine
• Applicants on active duty in the National Guard or in military service who are called into service during a national emergency or crisis

Physicians may ask the Board of Registration in Medicine for a 90-day waiver to delay implementation of the requirements due to “undue hardship.” With only rare exceptions, this request must be made at least 30 days before the license renewal date. The demonstration of proficiency is a one-time requirement.

The MMS is grateful to the Board’s chair, Candace Sloane, M.D., and its members, who voted to implement the regulations in a responsible manner that will help move physicians towards adoption of electronic records without denying access to care for patients with physicians without access to meaningful use certified systems.

The MMS is also grateful to those many physicians, specialty societies, the Conference of Boston Teaching Hospitals and Massachusetts Hospital Association who provided supportive, constructive testimony on the regulations.

Foundation Grant
Deadline January 15

The MMS Foundation is seeking applicants for its Care for the Medically Uninsured and Community Action grant programs. Letters of Inquiry are due by January 15, 2015.

Visit www.mmsfoundation.org for more information.
Physician Burnout: Where Do We Go from Here?

Originally, the term “burnout” referred to what happens to jets or rockets when the last ounce of fuel is consumed. Without fuel to power the engine, the flight path is taken over by gravity, and a crash landing is inevitable. The epidemic of physician burnout suggests that the practice of medicine in the United States is becoming hazardous to the emotional health and well-being of many doctors and other health professionals. What can the system do to burn up less of the fuel of physicians whose daily work experience may feel like front-line duty in a war zone? When Dr. Diane Shannon left medical practice 18 years ago, she decided to use medical writing as a tool for helping to identify and cure the ills of the entire system.

— Steve Adelman, M.D., PHS Director

BY DIANE W. SHANNON, M.D., M.P.H.

When I made the decision 18 years ago to leave clinical medicine, after three years in general practice, I felt chronically stressed and had trouble sleeping. I practiced with a general feeling of unease, sensing that the environment was not set up to catch inevitable human errors before they would cause harm to a patient.

Once I transitioned to freelance writing two years ago, I learned that about half of practicing physicians report at least one burnout symptom. I read the formal definition of professional burnout: emotional exhaustion, de-personalization, and feeling ineffective at work. I finally understood why I had left.

Recently I’ve been writing about potential remedies for physician burnout. Based on interviews and my review of published studies, I believe individual, structural, and cultural interventions are needed.

Individual physicians can take several steps to mitigate stress. They can practice stress-reduction techniques, such as meditation and mindfulness. They can make it a priority to take breaks, even brief ones, during the workday. They can access peer support when dealing with stressful cases, or if needed, they can seek help from professional groups, such as Physician Health Services.

However, individual solutions are not sufficient to deal with the degree of stress present in most clinical environments today—structural changes are also needed. These changes should ensure that physicians have sufficient support staff to ensure efficient patient flow and help with required documentation. These changes should also include giving physicians more control over their schedules by offering shared positions, flexible hours, and some protected time each week to pursue the aspects of medicine that are personally meaningful to them.

Although hospital and physician practice leaders may balk at the initial outlay of resources needed to make some of these changes, many of them, such as flexible scheduling, are inexpensive in the longer term. Any funds spent to reduce practice stressors will likely be rewarded with less physician departure and lower recruitment costs, which were estimated in a 1999 study to be $250,000 per physician.

Changes in organizational culture are required if individual and structural solutions are going to stick. Leaders need to encourage and model a healthy balance between work and personal responsibilities. They need to take steps to create a culture of trust and respect. They need to monitor the level of stress among physicians and pay attention to reducing work-related hassles.

Although structural and cultural changes often require action on the part of leadership, physicians can play an active role in promoting these changes. They can advocate for specific improvements and seek leadership positions to directly shape the practice environment in the organizations in which they practice.

Burnout is a solvable problem. It is my hope that in the future, no physician will need to leave practice for self-preservation and all patients will be cared for by energized physicians who are able to practice with the passion that drew them to medicine in the first place.

For more information, please contact Physician Health Services at (781) 434-7404 or visit www.physicianhealth.org.

MMS Mourns
C. Nason Burden, M.D.

The MMS mourns the death of Past President C. Nason Burden, M.D., who passed away November 8 at his home in Taunton. He was 97.

An orthopaedic surgeon, Dr. Burden served as chief of the medical staff at Morton Hospital and cared for generations of patients in the Taunton area, including many members of the Taunton High School football team.

He served as president of the MMS from 1976–1977 and also served as president of the Bristol North Medical Society. In addition, Dr. Burden served as a member of the House of Delegates to the American Medical Association and was a longtime member of the Taunton Board of Health.

He is survived by his wife of 72 years, Lois Peckham, and their four daughters, as well as 14 grandchildren and 11 great-grandchildren. A memorial service will be held in July in Mattapoisett.
2014 AMA House of Delegates Interim Meeting

Your AMA delegation was involved in negating and improving on other resolutions from different states through their participation in all five reference committees. Their understanding and knowledge of current MMS policies allows them to move the Massachusetts agenda forward with great care taken in adhering to those policies.

Along with the full delegation, Massachusetts helps affect policy nationwide by having the following individuals also participate on the AMA Councils.


We would like to thank our delegates for their knowledge, expertise and their commitment to organized medicine. There is no doubt that their time out of their daily office practice and personal lives is a tremendous sacrifice on behalf of all of our colleagues.

To review all the outcomes and details of the meeting, please visit www.massmed.org/madelegation.

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.

Dennis B. Baily, D.O., 66; Scituate, MA; New England College of Osteopathic Medicine, 1982; died June 21, 2014.

Dibyendu B. Basu, M.D., 86; Andover, MA; University of Calcutta, 1953; died February 4, 2014.

Peter J. Ferrino, M.D., 99; Winthrop, MA; Kansas City University of Physicians and Surgeons, 1938; died February 9, 2014.

Bruce M. Meth, M.D., 58; Springfield, MA; New York University School of Medicine, 1982; died October 28, 2014.

Franco Navazio, M.D., 88; Davis, CA; University of Rome, 1949; died August 15, 2014.

James D. Sullivan, M.D., 85; West Roxbury, MA; Tufts University School of Medicine, 1956; died September 30, 2014.

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION


Middlesex Central — Executive/Delegates Meeting. Thurs., Jan. 15, 7:45 a.m. Location: Emerson Hospital, Concord. Executive/Delegates Meeting. Thurs. Feb. 19, 7:45 a.m. Location: Emerson Hospital, Concord.

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 mjissaume@mms.org or lhoward@mms.org.

SOUTHEAST REGION

Norfolk South — Holiday Feast with Ebenezer Scrooge. Thurs., Dec. 11, 6:00 p.m. Location: Gainsborough Hall, Plymouth Plantation, Plymouth.

Plymouth — Executive Committee. Wed., Jan. 28, 6:00 p.m. Location: MMS Southeast Regional Office, Lakeville.

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

WEST CENTRAL REGION

Hampden — District Meeting. Tues., Jan. 20, 6:00 p.m. Location: Springfield Marriott, Springfield.


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

We also note member deaths on the MMS website, at www.massmed.org/memoriam.
LIVE CME ACTIVITIES

Unless otherwise noted, event location is MMS headquarters, Waltham.

Managing Workplace Conflict
Thurs. and Fri. March 19 and 20, 2015

Public Health Leadership Forum
Wed., April 8, 2015

MMS and Rhode Island Medical Society Directors of Medical Education Conference
Thurs., May 14, 2015

13th Annual Symposium on Men’s Health
Thurs., June 18, 2015

ONLINE CME ACTIVITIES

Go to www.massmed.org/cme

Risk Management CME

Electronic Health Records Education (3 modules)
- Module 1 — Guide to Health Information Technology
- Module 2 — Making Meaningful Use Meaningful
- Module 3 — Meaningful Use Stage 2

End-of-Life Care
- End-of-Life Care (3 modules)
- The Importance of Discussing End-of-Life Care with Patients
- Legal Advisor: Advance Directives

Pain Management
- Principles of Palliative Care and Persistent Pain Management (5 modules)
- 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 (2 modules)
- Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
- Effective Chart Review for Quality Improvement

Other CME
- Genetically Modified Foods: Benefits and Risks
- 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
- Preventing Overuse of Antipsychotic Drugs in Nursing Home Care

CME CREDIT: These activities have been approved for AMA PRA Category 1 Credit™.

FOR ADDITIONAL INFORMATION AND REGISTRATION DETAILS GO TO WWW.MASSMED.ORG/CMECENTER, OR CALL (800) 843-6356.