Baystate Medical Practices

THE BMP VOICE

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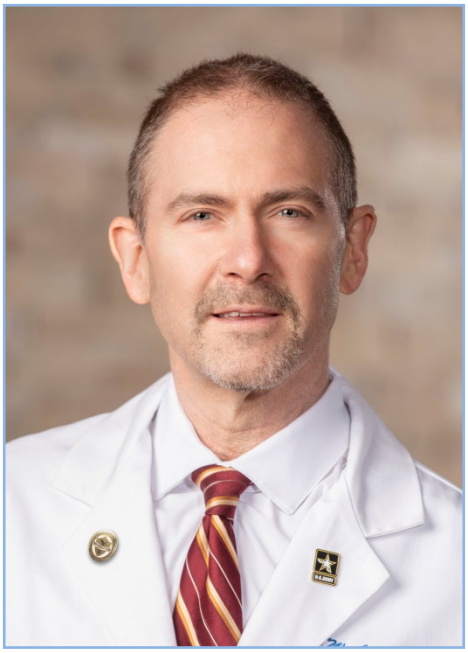
View from the PURCH*



Andrew W. Artenstein, M.D.
Chief Physician Executive &
Chief Academic Officer, BH
President, BMP
Regional Executive Dean,
University of Massachusetts
Medical School-Baystate

It has been approximately 18 months since we created and chartered six, new BMP committees that are responsible for taking up, discussing, and vetting many of the important issues involved in the operations of a 1,000-plus member employed, academic provider group—Baystate Medical Practices. These committees: Finance, Compensation, Policy and Enterprise Risk, Quality Council, Clinical Practice, and the Provider Wellness Council, are chaired by clinical leadership and populated by volunteers from among the ranks of Physician Leadership Academy alumni (the concept was to provide a type of 'post-graduate' experience for these burgeoning- and future leaders), other BMP members, and specific content experts whose roles are solicited by the committee chairs. These groups each are tasked with providing recommendations directly to the BMP Board of Directors at our bimonthly meetings. Why did we create this previously non-existent structure? What is its purpose? The structure was created as an engagement vehicle. I had observed throughout my organizational travels that BMP members, from all walks of professional life and in all different settings, were feeling both uninformed- and somewhat uninvolved in the governance, functions, and operations of our organization. Yet I heard a yearning by many to participate in a more meaningful way. It is important to me that our members and colleagues feel that they have a stake in the direction of BMP; to do this, we must all have the same level of understanding of the complex issues and challenges faced by provider groups such as ours. Frankly, the volume of volunteers for these committees supports their utility. In this issue of The BMP VOICE, we provide updates from each committee on their important and exciting work to date. *The Interview* features a more in depth discussion of the Provider Wellness Council, which has engaged a large number of our members and whose work will be vital to our future success. We are closing in on a new solicitation for volunteers for the next cycle of committee membership. I hope that many of you will be moved to participate in this process for the health of BMP.

***PURCH = Population-based Urban and Rural Community Health, the UMMS – Baystate track**

The Interview

The concepts of provider wellness, resiliency, and "burnout" are nearly ubiquitous in the news, literature, and lay press. For this issue of ***The BMP VOICE*** members of our investigative staff sat down for an in-depth discussion of provider well-being and its evil cousin, provider burnout with the co-chairs of the BMP Provider Wellness Council, Dr. Beth Brady and Dr. Barry Sarvet.

The BMP VOICE: There has been a lot both written- and spoken about the whole concept of provider well-being and burnout. Can either of you give our readership a clear, understandable definition of this phenomenon and some sense of its prevalence in health care?

Dr. Sarvet: Unfortunately, there are not any universally accepted definitions for these terms. Burnout is generally defined as a state of emotional and physical exhaustion characterized by loss of energy, motivation, and interest for one's work, loss of empathy and compassion, as well as persistent frustration and helplessness. The symptoms of burnout overlap with clinical depression; however, depression is generally more pervasive, affecting both home and work. Depression can also be more severe and dangerous with causal factors and their impact going far beyond one's experience at work. Of course, burnout can progress to clinical depression. Additionally people with burnout often develop chronic physical illnesses presumably stemming from a loss of work/life balance resulting in inadequate self-care, including poor sleep, poor nutrition, lack of exercise, and self-medication with alcohol and other drugs. The known connections between burnout and physical- and psychological health have led to the increasingly common use of the term "provider wellness" to signify the opposite of burnout. While we need to acknowledge the reality of burnout, we feel that it is more useful to focus on provider wellness in our improvement initiative since it is more motivating and empowering to people. "Resilience" is another useful, positive construct which is measurable, emphasizes individual protective factors, and is also an important aspect of individual health and well-being. Studies of prevalence have used differing methodologies. A systematic review in 2018 in the peer reviewed medical literature reported burnout prevalence rates ranging from 0-80% in physicians. In our view, the most methodologically sound studies have reported rates of approximately 40% overall, and higher rates—50%, for female physicians.

The BMP VOICE: What factors contribute to provider exhaustion/burnout/lack of resiliency?

Dr. Sarvet: The answer is complex. Most of the literature points to characteristics of the systems surrounding health care providers as the most important causes of burnout. Physicians and advanced practice providers (APP) around the country report feeling like cogs in a machine or on a treadmill, struggling to keep up with clinical schedules and spending an inordinate amount of time after work to catch up on documentation. As is now well recognized, electronic medical record systems have resulted in an increased clerical burden for providers which alternatively diverts time away from the actual clinical encounter and results in a great deal of after-hours work. This after-hours work diverts time from rest, regeneration, personal relationships with family and friends, and pursuit of interests outside of work, all of which would otherwise be protective against burnout. Taking care of patients is inherently rewarding and deeply satisfying, and many of us feel privileged to have a career in which

The Interview cont'd.

we have the opportunity do this. It is a bitter irony that this sense of professional satisfaction frequently becomes eroded in the context of contemporary medical practice, and the suffering of providers may be compounded by the dissonance between how one is "supposed" to feel caring for patients and the actual experience of doing so. Physicians across the country also report a loss of control within their professional lives, which limits opportunities to design adaptations to improve their experiences at work, self-care, and work/life balance.

Actually, one of the complications of utilizing the term "resiliency" as a central concept is that it appears to imply that the individual physician or APP is personally responsible for his/her suffering. This implication is extremely provocative as it may be experienced as "victim-blaming". Engineers think about resiliency as the ability of a system to absorb damages or disturbances without breaking or failing, to return to a state of equilibrium. Granted, certain personal characteristics, for example, the need for perfectionism can contribute to a lack of resiliency and serve as a predisposing risk factor for burnout. But more commonly, systemic factors beyond the individual's control are found to be the most powerful causes of burnout. As the process of burnout sets in, medical providers gradually lose the resilience which helped them get through all of the trials and tribulations encountered in completing their education and training. The buffering factors which we know are necessary for the health of our patients, such as adequate sleep, nutrition, exercise, and healthy relationships are jeopardized in this context and may lead to a vicious cycle when resulting problems related to work performance inevitably result in increased stress.

The BMP VOICE: Do we have recent survey data regarding the prevalence of provider wellness/burnout at BH?

Dr. Brady: We certainly do. Initially, thanks to funding provided by the Medical Staff Office at BMC, we offered the Well-Being Index survey developed at the Mayo Clinic to all physicians on the medical staff at all of the BH hospitals. This survey is an anonymous, validated, web-based tool that evaluates "distress" through nine, distinct questions. It was designed to measure risk of burnout, provide resources, and allow users to compare their scores to their peers as well as track progress over time to promote self-awareness. In 2017, we had a 27% participation rate, with 450 Baystate Health physicians taking the survey and demonstrating a higher rate of distress than the national sample of 7,300 U.S. Physicians. We subsequently chose to engage with Press Ganey (PG) for our survey now, since it gives us more actionable data and can be incorporated into the annual employee engagement survey that allows us to survey both physicians and APP (and also helps mitigate an unforeseen additional burden of surveys—'survey fatigue', which could further contribute to provider exhaustion). The PG survey measures two areas: the ability to "decompress" from work (i.e. focus on non-work activities when outside of work) and the ability to "engage" at work (i.e. level of energy brought to bear at work).

The Interview cont'd.

In their most recent white paper entitled: "Burnout and Resilience: A Framework for Data Analysis and a Positive Path Forward", Press Ganey describes the need for organizations to adopt an agile, individualistic plan that examines the different sources of stress and reward for individual providers that categorizes stressors and rewards according to whether they are "inherent to the role of care provider or are a function of external forces". This allows determination of engagement or burnout in terms of the balance of stress and reward experienced by individual clinicians and allows segmentation, benchmarking, and detection of change. The resiliency survey measures agreement (i.e. reward) and disagreement (i.e. stress) with specific questions, including "I like the work I do", and "the amount of job stress I feel is reasonable". It asks providers to rate the following eight statements:

- I can enjoy my personal time without focusing on work matters
- I am able to disconnect from work communications (emails/phone, etc.) during my free time
- I rarely lose sleep over work issues
- I am able to free my mind from work when I am away from it
- I see every patient/client as an individual person with specific needs
- I care for all patients/clients equally even when it is difficult
- My work is meaningful
- The work I do makes a difference

We had a 68% participation rate (639 respondents) in our recent survey of BMP providers. Here are the data from the 2019 survey:

- Resilience 3.90 (-.30 versus the National Physician Average) defined as "the ability of providers to recover and remain engaged even in challenging work environments"
- Activation 4.58 (+.06 vs Natl Phys Avg) defined as "the ability to engage patients and others as individuals and derive intrinsic satisfaction from work"
- Decompression 3.22 (-.66 vs Natl Phys Avg) defined as "the ability to disconnect and 'recharge' outside of work"

The information can be segmented by age, gender, years of service, practice, specialty and other criteria, and it allows benchmarking and detection of change over time. Stressors and rewards define the clinician experience, and the balance between them influences clinicians' vulnerability to burnout. The fulcrum upon which stressors and rewards are balanced is where resilience is determined. Our results really demonstrate cause for both concern and hope. The "concern" is that our providers appear to have less capacity for resiliency and more difficulty in decompressing outside of work than our national peers. The reason for optimism is that our providers still remain significantly more engaged and 'mission-driven' (i.e. to the provider mission) than our national peers. If we can work together to chip away at the barriers that compromise decompression and enhance resilience, we may have a way forward.

The Interview cont'd.

The BMP VOICE: Tell us about the Provider Wellness Council—how did it come to be and what is its charter? Who participates as members? What is its role?

Dr. Sarvet: The Council is a remarkable body. It began with a grass-roots effort. Upon hearing from numerous different providers in several distinct venues (open forum sessions, faculty meetings, anonymous comments, etc.) in 2016-2017, Dr. Artenstein convened a dinner meeting with a group of physician and APP volunteers to learn more about what they were experiencing in their clinical practices at BMP. This led to his ask: for the assembled group to become a task force and develop a set of recommendations for how we could address the issue of prevention- and mitigation of provider burnout at BH. Four months later, with this 'roadmap' of recommendations in hand, he created the Provider Wellness Council, populated by provider volunteers from throughout our organization who are passionate about this work. He asked Beth Brady and I to co-lead the Council. To emphasize the importance of this effort, Artenstein has this body reporting to the BMP Board.

The Council now has approximately 35 members—nearly 4% of the BMP work force—including physicians and APP from across the organization, representing a diversity of clinical departments, roles, career stages, and personal backgrounds. Many of the members of the council have had organizational leadership training through our Physician Leadership Academy and thus are developing leaders in our organization. All have a passion for working to stamp out provider burnout. By necessity, we all recognize that there are no easy solutions and that the process of improving our organization will take a long time. The purpose of the council is to serve as a catalyst, clearing house, and oversight body for organizational improvement initiatives designed to address factors contributing to burnout and to improve the wellness of our providers. Our group is too large to do the actual designing and planning of initiatives, so we have formed a number of smaller subcommittees; the overall Council functions to oversee and steer the activities of the committees. The committees are organized according to areas of focus, including Work-Life Balance; Efficiency of Practice; Electronic Medical Records; Humanism in Medicine; and Team-based Care.

The BMP VOICE: Can you describe the work of the Council over the past year? What have you done to date?

Dr. Brady: Inherent stressors for provides include the emotional toll of caring for sick patients; the heavy responsibility associated with making clinical decisions; and the pressure of leading the team of care givers. Inherent rewards include the joy of helping those in need; doing meaningful work; and being respected by patients and colleagues. The external stressors include the burden of the electronic health record (EHR); suboptimal staffing; excessive workloads; increased productivity pressures; inefficiencies of the practice environment; and diminished autonomy. Since these stressors and rewards define the clinician experience, the balance between them

The Interview cont'd.

influences our vulnerability to burnout. The Council's efforts to date reflect this dynamic. Our subcommittee structure allows this large Council to address issues in a meaningful way. Our EHR Committee works with I&T to address specific pain points and advocate for changes that will impact documentation challenges, one of the primary causes of provider distress. We are working closely with the current teams who are optimizing the ambulatory EHR (as was described in detail most recently in the August issue of The BMP VOICE) and have a seat at the table providing input to these ongoing efforts. Other advances/accomplishments in the past year include:

- Post-call day guidelines
- Monthly Clinician Wellness Lunch: started 9/17
- Schedule Flexibility Policy (working with the BMP Policy and Enterprise Risk Committee)
- PTO policy (seat at the table)
- EHR optimization work (seat at the table)
- BH Foundation Fund development, including support from the Medical Staff and individual donors, that will allow us to fund worthy wellness initiatives
- Events: Schwartz Rounds
- "Narrative Medicine" pilot
- "Finding Meaning In Medicine" pilot
- Peer Support Program
- Advisory role regarding the Physician Health Committee
- ED: pod huddles, EM Provider Wellness Council , wellness resiliency journal club, fellowship program
- Website: online repository of resources
- Resiliency survey
- Identifying and disseminating information on high performers

We still have Opportunities/Gaps, including: improving access in practices; enhancing bi-directional communication between the Council and individual providers; and further event planning

The BMP VOICE: Are there plans for pilot- or trial interventions? If so, what might they be?

Dr. Brady: There have been several small pilots to include post-call day guidelines that allow a provider to work an abbreviated day following call. Several other practices are looking at schedule flexibility that allows leaving work for specific personal/family reasons and making up that time. This is complex, since it requires many moving parts, e.g. staffing hours, patient scheduling, etc. The Council has sponsored several dinners to support "Finding Meaning in Medicine". Monthly provider lunches are being trialed over the next few months to allow for increased collegiality (the next one is Wednesday, October 23rd from 11 to 1 PM in the Lundy Board Room – contact christina.fitch@baystatehealth.org for questions). The Council is assessing our present state of peer support on several fronts (e.g. the 'second victim' phenomenon, impaired provider, support for malpractice occurrence, and behavioral issues affecting providers).

The Interview cont'd.

The BMP VOICE: Do these challenges (i.e. wellness, exhaustion, resiliency) affect other team members at BH such as nurses, etc? If so, what should we be doing to help them?

Dr. Sarvet: Yes, definitely. There are certainly differences in the nature of the stress for different healthcare professionals based on differences in work responsibilities, training, professional culture, and professional risk. However, we know that all of our caregivers are experiencing significant stress and are prone to burnout. We also know that the well-being and experience of all of our team members have a critical impact on the quality and experience of care for our patients. We are pleased that there is robust work underway to address these challenges in other parts of the organization, including Nursing and Graduate Medical Education. I expect that we will all be learning from each other as we discover and test strategies to work on these challenges.

The BMP VOICE: Let's follow up on one point you made in the last response. Aside from a negative toll on providers, does clinician burnout have any consequences for our patients?

Dr. Brady: Yes, it certainly does and in negative ways. Burnout experienced by any of our team members (providers, nurses, clinical staff, or non-clinical staff) directly affects patient care, quality, safety, and experience. Data have clearly shown that burnout negatively affects performance and outcomes. It makes sense - if the tank is 'empty', there is no remaining fuel to power us effectively. It makes it very difficult to deliver effective, compassionate care to those we serve.

AJ's News Bites

Compensation Committee: The Year in Review

Chair: Charlotte M. Boney MD

MEMBERS

BMP Providers	Content Experts
Dr. Glenn Alli	Dr. Doug Salvador
Dr. Kathaleen Barker	Dr. Niels Rathlev
Dr. Fadi Bsat	Pam Snyder
Dr. Daniel Engelmann	Ray McCarthy
Dr. John Romanelli	Paul Gosselin
Dr. Orlando Torres	Kristin Morales-Lemieux
Dr. Karin Johnson	Michelle Logan
Dr. Scott Barnett	
Kathleen Kalmbach, PA	

The Comp Committee held its first meeting on March 6, 2018. The Committee's primary responsibilities involve review, vet, and recommend approaches or changes regarding all aspects of compensation within BMP, including base salary, recruiting bonuses, benchmarks, gender equity, incentive compensation, and provider-specific benefits. The goal is to ensure appropriate representation of physician members and advanced practice providers so that they may be a voice for their constituents as well as the organization. The committee has met nine times to date and has addressed several important issues:

Activities:

- The base salary grid tool was reviewed and discussed at length, specifically its components (productivity 50%; rank or reputation 15%; leadership roles 15%; citizenship 20%), how each component is weighted, and its relative effectiveness and fairness. The group supported the tool, noting there was flexibility and clarity. Conditions justifying adjustments in base salary were discussed.

  Recommendations: There was strong recommendation for more transparency of how the grid is scored and how the score is used in conjunction with benchmark salary ranges to determine base salary. Members felt that it also needs to be better communicated to rank and file and reviewed yearly so that physicians understand the information specific to their score, salary range, and salary placement.

  Members recommended that if a provider loses points on productivity or other factors enough to decrease base salary, system issues should be considered, coaching provided, and consideration of unique circumstances understood. A reduction in base salary was fair if the physician had given up call and coverage at the same FTE or if productivity failed to improve the year after coaching.

AJ's News Bites cont'd.

- The committee was asked to discuss a draft version of the new PTO policy being considered by the Policy Committee.

  Recommendations: A majority of members did not support moving to a "use it or lose it" PTO policy unless consideration is made for maternity leave. This has since been addressed as part of the state's new family leave provisions

- Members reviewed the four Incentive Comp (IC) "buckets": both the weight (% IC) and content for Plan A (RVU-based value metric) and Plan B (non-RVU-based value metric). At the time, IC was based on Value 60%, Quality and Safety (access) 10%, Patient Experience 10%, Academics 10% and BH system-level performance 10% with no RVU "trigger".

  Recommendations:
  There was unanimous agreement that Access goals be an option and not a mandate under Patient Experience. The majority felt that Access goals were unlikely to incentivize physician performance because so many variables are out of their direct control. Re-implement a "trigger/threshold" at the 25th% percentile. If productivity was <25th%ile for the year, then IC would be forfeited, expectations reviewed, and coaching provided to the physician. Retain a 60% weight for Value. Increase the BH system-level weight to 20% because it includes patent experience and is system-wide. Increase flexibility for service lines/departments/divisions to address their unique challenges in quality, safety and academics by giving 20% to Service lines (+/- academics10%). This would also increase physician engagement. This recommendation was ultimately adopted by the BMP board and put into effect for FY2019.

- Members discussed IC options for physicians for whom research/ investigation is the major focus of their effort. Most physician/scientists "live" in clinical divisions and are subject to that division's IC goals. A few physician/scientists carry the division's academic goals to balance the clinicians carrying the productivity goals. Dr. Peter Friedmann, Chief Research Officer, estimated <20 physicians are grant-supported for >0.5FTE, and another 20 may have 20-50% research effort. There was general consensus that research goals for these physicians should align with their professional focus. There was no consensus on options.

  Recommendation: Investigate IC plans for physician scientists from other comparable academic medical centers and physician practice plans.

- Members began reviewing IC goals for FY2020 with the intent of optimizing financial stewardship while maintaining incentives in patient experience, quality/safety, and academics. There was unanimous agreement in preserving flexibility for units/division in service lines so that unique challenges could be supported and engagement fostered.

  Recommendation: Ask finance to analyze potential savings to the institution if IC buckets were revised to: Value 70%, BH financial performance 15% and Service line/academics 15%.

AJ's News Bites cont'd.

BMP Policy and Enterprise Risk Committee: Year in Review

Chair: Elizabeth Boyle, MD

The primary purpose of the BMP POLICIES AND ENTERPRISE RISK COMMITTEE is to periodically review BMP policies and potential risks and provide updates and bring forward recommendations to the BMP Board regarding potential policy changes/creation and risk mitigation strategies. The past year we have retired numerous BMP policies and adopted the overarching, comprehensive Baystate Health equivalent policies for the following topics:

- Confidentiality
- Release of Medical Records
- Conflicts of Interest
- Record Retention
- Non-retaliation and Non-retribution for Reporting Actual or Potential Wrong-Doing
- Advance Directives and Health Care Proxy
- Patient Rights
- Facsimile Policy
- Medical Record Copy Charging Policy
- Immigration Policy & Procedure
- Medical Records Establishment and Protection
- Patient Satisfaction Survey Process
- Severe Weather

We have updated and modernized two older BMP Policies: Corrective Action–Physicians and Payment to BMP Physicians for Outside Activities. In addition, we retired BMP Policies that were actually descriptions of processes/procedures that were no longer current practice or covered under other regulatory bodies such as the Prescribing of Level II Drugs by Non-physician Providers Policy and the Policy on closing of PCP Panels. Upcoming work for the Committee includes reviewing the following BMP Policies on these subjects: Texting, Injections by Medical Assistants, Professional Expense Account (PEA) and CME, Clinical Documentation and Billing, Managing Medical Emergencies in Ambulatory Based Sites, and BMP Interpreter Services.

AJ's News Bites cont'd.

BMP Finance, Billing and Compliance Committee: Year in Review

Chair: Ari Kugelmass, MD

The committee typically meets bi-monthly. The group is composed of PLA graduates, and finance, billing, and compliance leaders, and reviews current BMP financial performance, monthly and year to date in detail, as well as a more general review of the health system's financial status. The financial performance of each department/service line is included in this review. In addition, the group reviews the annual budget process and timelines as proposed by the finance department. Specific budgetary challenges are identified and discussed, as is the capital budget. These activities have significantly promoted member finance literacy and a better understanding of the challenges and financially influenced decision making within BMP and Baystate Health.

The committee also reviews PBO performance and challenges on an annual basis, or as needed. The committee has also reviewed such issues a "uncompensated care" from a medical practice perspective and appropriately referred this to the system level.

A member of the committee presents the BMP's finances to the larger BMP board as part of the bi-monthly board meeting. This has been facilitated by the coaching of Mr. Gosselin and finance colleagues. These have been very well received by the board, and have further promoted committee member financial fluency, as well as providing critical presentation skills as part of their leadership development.

BMP Quality Council

Co-Chairs:
P.J. Helmuth, MD
Diane Russell, RN

The BMP Quality Council has recently celebrated the successful conclusion of the inaugural class of Learning Collaboratives and is now assessing applications for the second cycle. Learning Collaboratives, are small, site-based quality improvement teams that meet weekly over a six- month time frame with the support of a process improvement specialist to work on a quality, patient safety, or patient experience goal. We have recently received 11 applications for new Learning Collaboratives in a competitive process and will support four or five of these to begin in the fall of 2019.

Other activities of the Quality Council include oversight of patient safety processes, including 1) implementing new infection control procedures in ambulatory sites, 2) working to streamline and standardize medication reconciliation processes, and 3) establishing standards for ambulatory anti-coagulation protocols. Additionally, we continue to engage specialists in the outpatient quality program, identifying clinically meaningful measures of quality. Finally, we are reviewing data on Patient Experience and are beginning work to understand what factors improve patient perceptions of care with a goal of spreading that knowledge across the Baystate Medical Practices.

AJ's News Bites cont'd.

Clinical Practice Committee

Chair: Abraham Thomas, MD

The Clinical Practice Subcommittee of the BMP board is composed of clinicians (many who are graduates of our Physician Leadership Academy) and administrative leaders representing different specialties and regions within BMP. The subcommittee meets almost every month to discuss areas that impact clinical care, so we can improve the overall experience for our patients and colleagues. We have presentations from members of Baystate Health, including members of the subcommittee, regarding innovations that could be shared within BMP as well as opportunities for improvement that are discussed and passed onto leadership and other committees as areas to work on in the future. Here is a brief selection of topics addressed over the past 18 months:

- Drafted guidelines for specialists to follow so the specialist will determine the need for follow-up care upon discharge from an inpatient stay or ED visit and assist in arranging such care.
- Review and development/adoption of a risk stratification tool to help determine the need for and timing of PCP post hospital discharge based on readmission risk.
- Discussion of issues regarding current pre-operative assessment and charging a group to continue to work on this to decrease cancellations of procedures and improve the patient/family experience.
- Review of scanning paper at Baystate and strategies by department on how to reduce the total amount of paper scanned.
- Discussion of who owns the patient during an inpatient or ED visit when multiple providers/specialties are involved in the care of medically complicated patients.
- Discussion with ED leadership on determining timing or need for follow-up with PCP.
- Discussion of flexible schedules for providers and how to best use administrative/ protected time. Invitation of a group at the community health centers that are piloting a model on how best to share the work among APPs and physicians to improve well-being to help further discussion and possible recommendations to help improve this issue.

Please Welcome Our New BMP Providers Who Recently Joined Us!

Name	Department
Joshua Allgaier, DO	BH Hospital Medicine BMC
Robert Baldor, MD	Chair, Department of Family Medicine
Sarah Barton, CNM	Baystate Midwifery & Women's Health
Tyler Branco, PA	Wilbraham Adult Medicine
Samridhi Chikersal, MD	Pioneer Valley Family Medicine
Mina Ferig, MD	BH Hospital Medicine BMC
Edward Kelly, MD	Chief, Trauma / Acute Care Surgery
Wendy Kwartin, MD	OB/GYN
Nathan Macedo, MD	Greenfield Family Medicine
Rochelly Martinez Maldonado, CNM	Baystate Midwifery & Women's Health
Elizabeth Morgan, MD	Maternal Fetal Medicine
Sharjeel Panjwani, MD	Neurology
Paul Pirraglia, MD	Chief, General Medicine & Community Health
Rhoit Rattan, MD	BH Hospital Medicine BMC

Save the Date

BMP Quarterly All Provider Open Forum Dinner Meeting
November 20, 2019
5:30 – 7:00pm