

# VITAL SIGNS



MASSACHUSETTS  
MEDICAL SOCIETY

*Every physician matters,  
each patient counts.*

VOLUME 13, ISSUE 9, OCTOBER 2008



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## What's on the Lists?

In 2002, the National Quality Forum (NQF) identified 27 serious adverse events that it deemed "largely preventable and of concern to the public and health care providers." According to an NQF update in 2006, the original list was intended to "bring order to adverse event reporting in the United States," and it was confined to events whose occurrence the NQF found to be "significantly influenced by the policies and procedures of the health care organization."

Also, in 2006, the NQF added one new event to the list, for a total of 28, as shown below.

In 2007, the Massachusetts Hospital Association (MHA) asked its member hospitals to adhere to a voluntary policy whereby they would not charge patients or insurers for treatments rendered to address nine preventable errors that occur in hospitals. The nine MHA no-charge events, selected from the NQF list, are marked with an asterisk (\*) below.

In addition, as of the first of this month, Medicare will no longer pay for certain conditions that develop in hospitals. The Medicare nonpayables that match or approximate items on the NQF list are marked with a dagger (†). In addition to those, Medicare is ending payments for catheter-associated urinary tract and vascular infections and mediastinitis.

### Surgical

- Surgery on wrong body part \*
- Surgery on wrong patient \*
- Wrong procedure performed on a patient \*
- Foreign object left in patient after surgery \* †
- Intraoperative or immediately postoperative death in an ASA Class 1 (healthy) patient

### Product or Device

- Death or serious disability caused by contaminated drugs, devices, or biologics
- Death or serious disability when device used other than as intended
- Death or serious disability associated with intravascular air embolism \* †

### Patient Protection

- Infant discharged to wrong person \*
- Death or serious disability when a patient disappears
- Death or serious disability after a patient suicide attempt

### Care Management

- Death or serious disability from medication error \*
- Death or serious disability from incompatible blood or blood products \* †
- Maternal death or serious disability in low-risk pregnancy
- Death or serious disability from hypoglycemia
- Neonatal death or serious disability from failure to identify and treat hyperbilirubinemia

### Care Management, cont.

- Stage 3 or 4 pressure ulcers acquired after admission †
- Death or serious disability from spinal manipulative therapy
- Artificial insemination with wrong donor sperm or egg \*

### Environmental

- Death or serious disability from electric shock †
- Wrong gas or contaminated gas in a line designated for oxygen or other gas
- Death or serious disability from any burn †
- Death or serious disability from a fall †
- Death or serious disability from use of restraints or bedrails

### Criminal

- Care ordered by someone impersonating a physician, nurse, pharmacist, or other licensed provider
- Patient abduction
- Sexual assault
- Death or significant injury to patient or staff from physical assault on facility grounds



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## "Never-Event" Lists and Their Use Create Confusion for Physicians

BY TOM WALSH

The ink was barely dry on the state's new health care cost containment law (see *Vital Signs*, September, page 5) when members of the Massachusetts Coalition for the Prevention of Medical Errors (MCPME) gathered for a meeting. What ensued, recalled one member, was a "hot discussion" fraught with confusion and nervousness. The uncertainty concerned how the new statute's language prohibiting health care facilities from charging patients who experience a "serious reportable event" will translate into practice.

In the abstract, barring payment for such occurrences — often referred to as "never events" (shorthand for things that should never happen to patients if health care systems work properly) — is ethical and fair for affected patients and their families. But such policies are proliferating around the country as caregivers, payers, and now governments seek to improve the quality of patient care and contain health care costs.

### State Agencies Already Had Policy

In June, Gov. Deval Patrick announced that four state agencies that insure or purchase care for more than 1.6 million Massachusetts residents would no longer pay for costs associated with 28 serious

reportable events identified by the National Quality Forum (NQF), a nonprofit coalition of physicians, hospitals, businesses, and policymakers (see box at left). The Massachusetts policy applies to the Office of Medicaid (MassHealth), the Group Insurance Commission, the Commonwealth Health Insurance Connector Authority, and the Department of Correction. The move made Massachusetts the first state in the nation to establish a uniform nonpayment policy across state government, although 12 states use the NQF list as criteria for state-based public reporting.

The nonpayment stipulation in the new state law would extend the nonreimbursement policy to the entire health care system in Massachusetts.

Barring payment for reportable medical events is intended to improve patient care and safety. Some also promote it as a step toward containing health care costs — even though these events do not happen frequently enough to represent a substantial amount of overall health care spending.

### What Seems Simple Is Not

Bruce S. Auerbach, M.D., MMS president, said confusion and consternation among physicians have arisen because "true" never events — removing the

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## PRESIDENT'S MESSAGE



### Physician Input Necessary in Debate about Serious Adverse Events

The issue of nonpayment for serious adverse events is both complex and volatile. It sparked

intense debate at our Annual Meeting in May and will come up again next month at the Interim Meeting of the House of Delegates.

Preventability is a core concept in any discussion of serious adverse events. I personally think a nonreimbursable adverse event is one that is reasonably preventable — that is, one for which sound evidence exists that following certain guidelines will reduce the occurrence of that event to zero or near zero for a diverse patient population.

Many of the items on the various lists of so-called never events do not meet that standard. The physician community must stay involved in conversations about these events to ensure fairness and quality of patient care — just as we must stay involved in conversations about physician performance ratings and other crucial matters. Neither apathetic silence nor an entrenched “no way” attitude on our part will work for our patients or for us.

Similarly, insurers and other stakeholders in eliminating adverse events also need to maintain a creative, middle-ground approach. For an insurer simply to say it won't pay is shortsighted. All stakeholders need to take their bit of responsibility in zeroing out preventable errors.

If an event is determined to be preventable after a thorough, independent

case review that includes a robust root-cause analysis, those demonstrated to have caused the event should not bill or receive reimbursement for the event. On the other hand, if additional post-event care is necessary and is provided by physicians not directly involved in the original event, those doctors should have the right to bill and receive payment for their services.

Of course, our Society's concern about preventable events goes way beyond payment issues. We have a long and laudable history of improving patient safety and preventing medical errors that includes educational programs, legislative and regulatory advocacy at state and federal levels, and helping to found and support organizations such as the Massachusetts Coalition for the Prevention of Medical Errors and the Betsy Lehman Center for Patient Safety and Medical Error Reduction.

Massachusetts physicians will continue working with all relevant entities to help eliminate serious preventable adverse events. Those entities include, but are not limited to, the Massachusetts Hospital Association, the AMA, state and federal agencies, the Joint Commission, and the National Quality Forum.

I personally invite anyone who has thoughts and ideas about preventable events to attend the relevant reference committee hearing at the Society's Interim Meeting on November 14.

— Bruce S. Auerbach, M.D.

#### Never Events

*continued from page 1*

wrong organ, surgery on the wrong side of the body or on the wrong patient, for example — are being “mixed up” with other occurrences that are not so easily defined as preventable.

“Once you get past the unequivocal events to some of the other things on these lists, you are dealing with a much less well-defined arena,” he said. “These things, like infections or skin breakdowns, are not as black and white as wrong-site surgery.” Dr. Auerbach said more equivocal events sometimes occur because of preventable human error or systemic lapses — but not always.

“To cast a wide net and say that *any* time these things happen they were preventable is not based in evidence,” he said. “That's where the confusion arises.”

Dr. Auerbach's concerns were echoed by Paul M. Schyve, M.D., co-chair of NQF's National Voluntary Consensus Standards Maintenance Committee on Serious Reportable Events. Dr. Schyve said the NQF list was formulated to encourage learning and education about these events. He agreed that some events on the list may not always result from error. He also said there was no discussion at the NQF about using the list to determine whether hospitals or physicians should be paid. In fact, he said, linking these events to nonpayment might have “unintended negative effects” on reporting and learning — and therefore hamper the effort to improve patient safety.

While public reporting of such medical events may be straightforward, tying such events to nonreimbursement policies is anything but, as physicians, state health care policymakers, and organizations such as the MCPME are now discovering.

#### Many Unanswered Questions

The language in the new state law regarding nonpayment for serious adverse events specifically pertains only to hospitals, ambulatory surgical clinics, and — because of long-standing language in previously enacted state law — institutions “for the care of unwed mothers.” Nowhere does it mention “physicians” or “doctors.” However, doctors do see patients, perform surgeries,

and render other patient-care services in those health care settings. So, what if a patient who experiences one of these events requires substantial follow-up treatment by a physician who was not previously involved? Does the law allow that doctor to be paid for those services?

“I don't have an answer for that,” said Paula Griswold, executive director of the Massachusetts Coalition for the Prevention of Medical Errors. “There are a huge number of complexities about this that need to be addressed to make this workable.”

Karen Nelson, senior vice president for clinical affairs at the Massachusetts Hospital Association, concurred, saying, “It's a simple approach, but the side effect of this simple approach is that it creates a huge amount of confusion.” The MHA's list of nonpayable events, promulgated to member hospitals in November 2007, has only nine items on it (see box on page 1). Nelson said the new Massachusetts law “definitely raises more questions than it answers. It will be

very challenging to figure out a way to do this that is fair to hospitals, fair to physicians, and fair to downstream providers such as the consulting

or secondary physician who is called in to fix something.”

#### Tall Task for DPH

The statute leaves it to the state Department of Public Health (DPH) to draft regulations that answer these fairness questions and address the many other complexities about implementing this policy.

“This will be a daunting task,” said Paul Dreyer, director of the DPH Division of Health Care Quality, who will spearhead the effort to draft regulations. “There are a number of very interesting questions posed by people who have studied the language of this bill.”

Dreyer said he has been doing this type of work for four decades and is no stranger to tough regulatory assignments. “I would say this has to be right up there in difficulty,” he said. When asked what he would say to physicians wondering how the law will be applied, he said, “Good question. I'd tell them to stay tuned.”

Dreyer said he hopes to have a first draft of regulations for the new law by January 2009. After that, he said hearings will be held to gather opinions on the proposals.

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**VITAL SIGNS** is the member publication of the Massachusetts Medical Society.

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**PRODUCTION AND DESIGN:** Department of Premedia and Publishing Services; Department of Printing Services

**PRESIDENT:** Bruce S. Auerbach, M.D. **EXECUTIVE VICE PRESIDENT:** Corinne Broderick

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*Vital Signs* is published monthly, with combined issues for June/July and December/January, by the Massachusetts Medical Society, 860 Winter Street, Waltham, MA 02451-1411. Circulation: controlled to MMS members. Address changes to MMS Dept. of Membership Services. Editorial correspondence to MMS Dept. of Communications. Telephone: (781) 434-7110; Toll free outside Massachusetts: (800) 322-2303; Fax: (781) 642-0976. E-mail: [vitalsigns@mms.org](mailto:vitalsigns@mms.org).

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## Clarify Your Hospital's Policy on Reimbursement for Never-Event Aftermaths

There are many unanswered questions about how the health care system will handle so-called never events (see related article on page 1).

Even if you or your partners were not directly involved in the event itself, depending on the circumstances and your specialty, it's entirely possible that you or your colleagues may be called upon to render care subsequent to a never event. What should you know about preparing for this possibility, rare as it is?

The most well-known list of never events was created by the National Quality Forum (NQF) ([www.qualityforum.org](http://www.qualityforum.org)). In Massachusetts, the term "never event" is applied according to the Massachusetts Hospital Association's (MHA's) policy ([www.mhalink.org](http://www.mhalink.org)), which essentially states that Massachusetts hospitals will not charge patients or payers for care related to the occurrence of certain serious ad-

verse events. As of November 2007, the MHA had applied its policy to 9 of the current 28 NQF never events.

Before you render care to a patient who has experienced a never event, you should seek some clarity regarding payment. Will the care you provide be billable, and if so, to whom? Clarifying such issues up front with the hospitals you work with may prevent confusion or frustration later on.

As rare as never events are, subsequent care for such an injury may require substantial effort and time. Take the administrative initiative and clarify reimbursement questions with the hospitals you work with. And keep in mind that the chance of subsequent involvement after never events is likely to increase if the MHA adds more of the NQF-listed events to its own list. **VS**

—Adam Shlager

## Merger of E-Prescribing Portals Could Boost Adoption and Enhance Patient Safety

On a national scale, the recent merger of RxHub and SureScripts portals could result in e-prescribing adoption levels rising above their current 2 percent. But what does this merger mean to your practice?

Current e-prescribing systems transmit an electronic order from a device in your office to a central exchange, where the order is processed and in most cases, faxed to the appropriate pharmacy or agency. Many times, decision-support software helps identify potential drug-drug interactions, and additional features are often available through vendors.

*The combined system will allow physicians to cross-reference patient drug histories and thus improve patient safety.*

What doesn't currently exist is any sort of cross-referencing, which would allow a physician to know if the patient had received another prescription from a different provider that might lead to an adverse interaction. The merger may help address that information gap, because it will combine SureScripts' electronic drugstore routing system with RxHub's insurance information database. The combined system will allow physicians to review patient insurance coverage and drug histories and may thus further promote patient safety.

While the merger — and e-prescribing in general — has raised some privacy concerns, John Halamka, M.D., chief information officer at Harvard Medical School and Beth Israel Deaconess Medical Center, opined that "as long as the information is used properly — it isn't resold [and] the patient can say 'I don't want to participate' — then these are good developments."

Make sure you understand the effect of the merger on your current e-prescribing vendor. If you are e-prescribing through your electronic health record, make inquiries about the merger's impact before it becomes an issue. You should also make sure patients understand the consequences of your use of e-prescribing on their health information. **VS**

—Adam Shlager

## Disease Registries: A Tracking and Quality-Improvement Option for Practices without an Electronic Health Record

Tracking treatments and outcomes through disease registries is an old methodology. But boosted by new IT support systems, it's re-emerging to improve health care for patients with chronic diseases and to help practices make quality improvements.

In New England, two major initiatives have taken hold, one in Vermont and one in Maine. In Maine, primary care providers working with Maine Medical Center in Portland are required to input certain metrics about their chronic disease patients. This system assists users in tracking the care provided, establishing quality measures, and evaluating costs associated with longitudinal disease management.

More recently, Vermont's Blueprint for Health — a statewide partnership seeking to improve health care for Vermonters with chronic conditions — announced it would start using DocSite's patient registry with point-of-care decision support to track and manage chronic disease care and quality improvements. This site captures and organizes relevant clinical information



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*Creating a registry at the practice level is possible without an EHR or extensive IT knowledge or support.*

from the patient record for use in clinical care at both the patient and population level. It shows care elements that are due and those that are out of range based on nationally recognized, evidenced-based guidelines. Measurement is allowed on both the individual doctor and physician-group levels.

The AMA, as far back as 2005, recognized the value of registries, noting that appropriate uses include:

1. Tracking patient appointments
2. Classifying patients according to severity of disease
3. Generating reminders for certain tasks
4. Identifying opportunities for possible quality improvements

The AMA further noted that such registries could work in either manual (paper) or electronic formats.

Creating a registry at the practice level is possible without an EHR or extensive IT knowledge or support. Spreadsheet applications such as Excel provide the software capability for analysis, and the data can be easily exported from this type of program to most databases for combination with other groups.

The biggest challenge is determining which metrics and conditions should be tracked. Typical registries include metrics for diabetes, asthma and other

respiratory conditions, and cardiovascular disease. There are online applications available, as well, such as DocSite, which may serve a practice's purposes.

Each practice should evaluate the clinical and administrative burden versus the potential benefits of tracking care with a disease registry. As physician profiling, pay-for-performance, and evidence-based guidelines become more prevalent, it will become more important to capture your clinical information and have it easily available for analysis. **VS**

—Adam Shlager

## One Health Initiative Seeks Optimal Health for People, Animals, and Environment

As a physician trained in tropical medicine and a veterinarian board certified in pathology, Leonard Marcus, V.M.D., M.D., knows firsthand about the importance of enhancing the integration of animal, human, and environmental health. So do his colleagues at the American Veterinary Medical Association (AVMA) and the American Medical Association (AMA). To encourage the collaborative efforts of multiple disciplines to attain optimal health for people, animals, and the environment, in 2007 the AVMA established the One Health Initiative Task Force. The task force was organized to study how collaboration and cooperation among health science professions, academic institutions, governmental agencies, and industries could help assess, treat, and prevent cross-species disease transmission and mutually prevalent but not transmitted human and animal diseases and medical conditions.

Just two months later, the AMA House of Delegates unanimously approved a resolution in support of One Health. Soon after that, the Centers for Disease Control and Prevention (CDC), the American Public Health Association, and numerous businesses and academic institutions joined the initiative.

Dr. Marcus, an active member of the MMS and a recognized leader in encouraging collaboration between the health professions, serves on the One Health Task Force. "My major professional interests are vector-borne diseases, zoonoses, parasitology, and vaccine-pre-

ventable diseases," he said. "The One Health Initiative is a step in the right direction, as the health professions realize we must work together to protect the health and safety of our patients and our communities. The task force developed a series of recommendations that will inform, engage, and solicit the support of medical, veterinary medical, and public health professionals."

The One Health Initiative has broad significance for human health and medicine. According to the CDC, approximately 60 percent of all human pathogens are zoonotic — transmissible between animals and people. Moreover, an estimated 75 percent of recently emerging infectious diseases affecting humans — such as avian influenza and SARS — are of animal origin. The relationship between human and animal health also has implications for food and water systems, sanitation, and preparedness. For example, 80 percent of recognized or potential bio- and agro-terrorism agents are zoonotic pathogens.

"The concept of One Health has been around for centuries, but collaborations have languished in the 21st century," said Roger Mahr, D.V.M., immediate past president of the American Veterinary Medical Association. "The challenges of the 21st century demand that we invigorate them." **VS**

— Susan Webb

For more information on the One Health Initiative, go to [www.avma.org](http://www.avma.org) and click on the "One Health" button under Public Health.

## Sixth Annual "Make a Difference Day"

The MMS, the MMS Alliance, and the MMS and Alliance Charitable Foundation are again sponsoring "Physicians and Their Families Make a Difference Day." This project benefits local domestic-violence shelters by providing needed toiletries, clothing, toys, and comfort items.

Most residents at domestic-violence shelters are women and children. Participants contact local shelters to ensure the collection drive meets each shelter's particular needs. Throughout October, volunteers distribute donation bags to physician offices, neighbors, and coworkers. The filled bags will then be delivered to the select-

ed shelter in each district on or about October 25. Donations may also be left at the Alliance exhibit on Friday, November 14, during the Society's Interim Meeting at MMS headquarters in Waltham.

Our local effort coincides with the annual "Make a Difference Day," which is coordinated nationwide by *USA Weekend Magazine* and the Points of Light Foundation.

Please contact Candace Savage at [csavage@mms.org](mailto:csavage@mms.org) if you are interested in participating. For more information about this effort, visit [www.mmsalliance.org](http://www.mmsalliance.org). **VS**

— Candace Savage



## Fall Prevention Brochure Now Available

Nationwide, falls are the leading cause of fatal and nonfatal injuries in older adults. In addition to reduced physical functioning, falls can produce or exacerbate an elder's feeling of isolation, depression, and helplessness.

According to the Centers for Disease Control and Prevention, costs for treating elder falls is more than \$19 billion annually, with a projected cost of at least \$43 billion by 2020.

The fact is that many falls — and the costs associated with them — are preventable. In addition to comprehensive clinical assessments including vision screening, physicians can review their elderly patients' use of alcohol, prescribe exercise programs to improve balance and strength, regularly review and man-

age medications, and alert patients to hazards at home.

The MMS Committee on Geriatric Medicine has added a new brochure entitled "Preventing Falls" to its Successful Aging Series. This brochure includes tips for staying physically fit, sensible shoe guidelines, how to police the home for obstacles and dim lighting, and tips on preventing or slowing osteoporosis.

The brochures are available for a nominal fee by e-mailing [dph@mms.org](mailto:dph@mms.org) or calling MMS Customer Service at (800) 843-6356. You can also download the brochure for free on the Public Health section of the Society's website ([www.massmed.org](http://www.massmed.org)). **VS**

— Candace Savage

## New Guidance on Electrical Shock Injuries

From 1991 through 2005, 39 Massachusetts workers died from electrocution. From 2002 through 2005, nearly 1,000 workers were treated for electrical injuries in our state's emergency departments.

Although these statistics are not staggering, electrical workers and occupational health professionals believe that electrical injuries are far more widespread than the numbers available through emergency departments. In fact, the International Brotherhood of Electrical Workers (IBEW) Local 103, which represents more than 6,000 electrical workers in Massachusetts, estimates that a majority of its members have experienced electrical shock at least once — and many have sustained electrical shock multiple times.

There are no standard protocols for assessing injury and treating electrical shock injuries. To address this information vacuum, a group of physicians and occupational health professionals — convened by the Massachusetts Coalition for Occupational Safety and Health (MassCOSH) and the IBEW Local 103, with technical support from the Massachusetts Department of Public Health (DPH) — developed a guidance document for the treatment of electrical shocks.

Piper Lillard, M.D., who conducted the research, said, "A formal consensus and protocol among emergency department physicians of how to manage these injuries [will] benefit the health of injured electrical workers."

Electrical injuries run the gamut from entry and exit skin burns, compartment syndrome, and vascular ischemia, to

cardiac arrhythmias and neuropsychiatric symptoms. The comprehensive guidance document addresses pre-hospital management, emergency department assessment and treatment, consultations and/or transfers, recommended laboratory analyses, and burn and cardiac management.

The document emphasizes the importance of obtaining a clear history of the injury in the ED. Direct-current exposure generally throws the person from the source, increasing the risk of traumatic injury. Alternating-current exposure generally involves a "no let go" response that prolongs exposure and can lead to much more severe injuries, including extensive tissue destruction and/or cardiac abnormalities. The document also provides a thorough guide to follow-up treatment after the initial examination.

Fueled by Dr. Lillard's findings, the IBEW is designing a program that educates its members about the potential health risks of electrical shock, encourages reporting, and promotes safety and prevention. "We hope this project raises a red flag that electrical shocks are no small matter," said MassCOSH Executive Director Marcy Goldstein-Gelb. "Electrical hazards should be corrected so that no one will face the potentially lifelong consequences of electrical injuries."

— Greg DeLaurier, Assistant Professor  
Salem State College

For more information, visit the MassCOSH website at [www.masscosh.org](http://www.masscosh.org).

## STATE UPDATE

## Election 2008: Be Sure to Vote — and Advocate

Election Day is fast approaching, and although the presidential election has appropriately received the most coverage, you will again find that there is a lot more than the White House at stake when you go to the polls. Other state and federal races as well as ballot proposals all await disposition. The decisions made on Election Day will not only affect you as a citizen, they will also affect you as a physician and could have a significant impact on the health of your patients.

While voting is a critical part of the political process, it's not enough for physicians just to cast their ballots in November and then become spectators. Physicians must make political advocacy a year-round priority to ensure that the voices of physicians and their patients are heard at all levels of government.

## The Ballot and Health Care

The President and the Congress elected this year will have a significant influence on how the health care system is structured for years to come. Both leading presidential candidates have outlined their proposals for health care reform, and not surprisingly, they take different approaches. While the McCain plan focuses on deregulation, market forces, and individually purchased coverage, the Obama approach calls for market regulation, the creation of new public and private programs, and employer mandates. A useful article by Jonathan Oberlander, Ph.D., outlining both plans appeared in the August 21 issue of the *New England Journal of Medicine*.

With regard to health care and other legislation, the President proposes, and Congress disposes. This certainly has been made clear over the decades regarding initiatives promoting universal access to health care coverage, as Presidents Truman, Nixon, and Clinton all painfully learned. One-third of the U.S. Senate and the entire House of Representatives will be up for election this year. In Massachusetts, Sen. John Kerry's seat is being contested.

There are many federal health issues that will need to be resolved over the next congressional session, not the least of which is the thorny question of physician reimbursement under Medicare. Under legislation enacted this year, proposed cuts to physician reimbursement were deferred for 18 months (see *Vital Signs*, August 2008, page 5). That legisla-

tion will expire at the close of 2009. The President and the Congress elected this year will be responsible for fixing the reimbursement formula, or at least for protecting physicians from drastic payment reductions beginning in 2010.

There will also be issues galore on the state level, and the entire Legislature is up for re-election. Over the next two years, the legislators elected next month will have to address the continued implementation of the health reform law

con Hill and in Washington, D.C. Traditionally, physicians have shied away from the political process, often viewing legislation as a messy process best left to others. However, physicians don't have that luxury today. Politics is too important to be left to the politicians. We can't just look the other way and leave it to "the professionals."

The Massachusetts Medical Society maximizes its strength whenever physicians effectively meet with legislators in

*The President and the Congress elected this year will be responsible for fixing the Medicare reimbursement formula, or at least for protecting physicians from drastic Medicare payment reductions beginning in 2010.*



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and how to pay for it. Questions relating to the overall cost and quality of health care will also be on the front burner following this year's passage of comprehensive cost-containment legislation (see *Vital Signs*, September 2008, page 5), as well as efforts by allied and alternative health care providers seeking to expand their scope of practice. Numerous public health initiatives related to tobacco, seat belts, the environment, school nutrition, and physical education are all expected to be in play.

## Advocacy Beyond the Ballot Box

With governmental entities facing so many important issues affecting physicians and their patients, it is critical that the voice of physicians be heard on Bea-

their home districts, at the State House, or in Washington, D.C., to articulate our legislative agenda. We are most effective at communicating our message whenever a physician-constituent develops and maintains a good relationship with a lawmaker. To maximize our influence as a Society, we need you to do two things:

- **Stay informed regarding legislative issues.** During the legislative session, the Society keeps its members up to date through the Advocacy and Policy page of the website ([www.mms.org](http://www.mms.org)), where members can also identify and e-mail their legislators via the Legislative Action Center. In addition, all of the Society's testimony is posted there.
- **Build long-term relationships with your legislators.** Relationship-building involves keeping in contact with a senator or representative so they know you and you know them. This takes time — but if you develop a working relationship with your lawmakers, they will trust your judgment and recommendations on issues relating to the health of your practice and the health of your patients. The MMS Government Relations staff is always available to advise physicians seeking to take this important step. We want to help you become a more effective legislative advocate.

Election Day is important, but it should mark the *start* of your advocacy, not its totality. **VS**

— Steve Shestakofsky

## LEGISLATOR OF THE MONTH

Representative  
Allen J. McCarthy (D)

District: Abington, East Bridgewater, Whitman

**Committees:** Community Development and Small Business, Public Service, Veterans and Federal Affairs



**QUOTE:** One of my many priorities during my freshman term as a state representative has been combating the escalation of opiate addiction in my district and across the Commonwealth. Unfortunately, greater access to the powerful painkiller oxycodone has led to significant abuse, especially among young people. All too often, these abusers move on to the cheaper drug, heroin — a tragic path that often leads to overdose and death.

The top killer of young adults in Massachusetts is now opiate overdose. On the South Shore alone, between August 2006 and August 2007, 54 overdose deaths were reported. At all income levels, in every kind of neighborhood, across all social and economic strata, people are struggling with addiction — and they need help.

This epidemic motivated me to request that funds be earmarked for Learn to Cope, an organization that provides support services for families affected by heroin and oxycontin addiction. When families are desperately fighting for the life of a loved one suffering from addiction, they need a place to turn for help. Learn to Cope is one such place. During the past year, Learn to Cope has made remarkable progress toward addressing this critical and growing problem.

## Joseph H. Kanter Prize Nominations Due Nov. 14

Nominations for the recently announced Joseph H. Kanter Prize are now being accepted. The prize was established by the Health Legacy Partnership — a public-private partnership between the Agency for Healthcare Research and Quality and the Joseph H. Kanter Family Foundation — to recognize a U.S. physician who has created a way to enhance the delivery of health care by minimizing health care disparities.

The Health Legacy Partnership is inviting each state medical association to nominate one physician from its state or territory for the Kanter Prize. One community physician practicing in the United States will receive the \$100,000 prize for the best effort to reduce disparities in health care delivery, which may include inequality due to race, religion,

language, geographic constraints, bias, or socioeconomic status, among others. The inaugural Kanter Prize is scheduled to be awarded in April 2009.

The Health Legacy Partnership established the Kanter Prize with the hope of discovering and disseminating original ideas and to stimulate creativity among physicians to improve the quality of health care delivery.

The deadline for submitting a nomination to the MMS is November 14.

Please send nominations to Sandra Manchester at [smanchester@mms.org](mailto:smanchester@mms.org). Visit the Health Legacy Partnership website at [www.healthlegacy.org](http://www.healthlegacy.org) for additional information and to learn more about the nomination process. **VS**

— Becca McDade

## National e-Prescribing Conference Coming to Boston

The Centers for Medicare and Medicaid Services (CMS) and dozens of industry partners are hosting a national conference in Boston on electronic prescribing this month. The goal of the conference is to educate physicians about the new federal incentives for e-prescribing.

The MMS is one of 35 conference co-sponsors, and is the only entity providing physician CME credits for the program.

The conference is designed to educate physicians about e-prescribing in general, with a focus on Medicare's five-year program of incentive payments for implementing electronic prescribing that

begins on January 1, 2009 (see *Vital Signs*, September 2008, page 3).

Speakers will include Health and Human Services Secretary Michael Leavitt; U.S. Sen. John Kerry of Massachusetts; former U.S. House Speaker Newt Gingrich, founder of the Center for Health Transformation; and David Brailer, M.D., chair of Health Evolution Partners and former director of the federal government's health information technology program.

The conference will be held on October 6 and 7 at the Sheraton Boston. Admission is free, but attendees must preregister by visiting [www.e-prescribeconference.com](http://www.e-prescribeconference.com). **VS**



## Call for Nominations — 2009 MMS Awards

The Massachusetts Medical Society's Committee on Recognition Awards is currently seeking nominations for the 2009 Annual Meeting Awards Program in May. Nominate your colleague today for one of these prestigious awards!

For more information regarding awards criteria, application information, and submission deadlines, please visit [www.massmed.org/awards2009](http://www.massmed.org/awards2009), or call (800) 322-2303, ext. 7208.

## PHYSICIAN HEALTH MATTERS

### Recognizing Stress Is First Step in Easing It

*Editor's note: Physician stress was one of many topics covered at the Caring for the Caregivers Conference sponsored by the MMS and Physician Health Services in November 2007.*

Stress is part of all of our lives — and medical practice. Some stress is positive, promoting accomplishment and creativity. Negative stresses can arise from a crisis within one's practice or challenges in one's personal life, such as the breakup of a marriage, a pregnancy loss, or the death of a friend or family member.

These are universal sources of distress, and each of us responds in our own unique way. Some of us become despondent, depressed, or substance abusers — with its attendant impairment in functioning. Others react with increased activity and greater involvement in work. While this may seem like a positive means of channeling stress, sometimes this increased focus on work can be so intense that good judgment can be affected. Such stress can result in leaving out important details of patient care, such as carefully checking medication orders or taking a comprehensive history.

Most physicians are oriented to functioning competently and independently and thus may be reluctant to acknowledge a mental health problem. We often view these signs and symptoms as indicative of weakness or inadequacy, and we are fearful of the stigma this could impose. Yet, we tell our patients that recognition and acknowledgement of early signs of any disease can prevent serious impairment of functioning.

All physicians should be aware of the signs and symptoms of anxiety and depression in their patients and themselves:

- Feeling sad, empty, helpless, hopeless, undeserving, purposeless
- Inability to concentrate or make decisions
- Suicidal thoughts
- Changes in sleep, appetite, or cognition
- Panic, agitation, paranoia
- Abrupt/uncharacteristic disruptive, provocative, or threatening behavior
- Uncharacteristic performance failure
- Rumination, self blame

#### What Should You Do?

Don't ignore or minimize the problem. Seek feedback on your performance and interactions from family, staff, and patients. Talk to a family member, friend, or colleague who cares about your welfare and who you trust will be honest with you. Obtain a consultation from a respected professional in whom you have confidence and who will respect confidentiality and be objective. Seek help from Physician Health Services (PHS) early if you have signs or symptoms that could interfere with your performance as a physician, such as substance abuse or depression. **VS**

— Carol C. Nadelson, M.D.,  
and Malkah T. Notman, M.D.

To contact PHS, call (781) 434-7404 or visit [www.physicianhealth.org](http://www.physicianhealth.org).

### Pri-Med East Coming Back to Boston

The MMS is pleased once again to be a sponsor of Pri-Med East, a comprehensive medical conference that provides extensive continuing medical education opportunities. The conference will be held at the Boston Convention and Exhibition Center from November 6 through 9.

The conference is organized along two tracks. The "Current Clinical Issues in Primary Care" curriculum consists of more than 50 sessions developed and presented by Harvard Medical School faculty. The "Practice Solutions" track focuses on technology, practice management, patient care, and other topics.

During Pri-Med East, keynote presentations will include "Voodoo Death Revisited: The Modern Lessons of Neuro-

cardiology," by Martin Samuels, M.D.; "Honoring a Father's Dream: The Story of the Sons of Lwala," by Milton and Frederick Ochieng; and "Reverence for Life in Medicine: Ethics, Skills, and Professional Satisfaction," by Lachlan Forrow, M.D.

Participants can earn additional CME credits at independent symposia beginning on Thursday, November 6. An extensive exhibit area will provide opportunities to review the latest in pharmaceuticals, medical devices, and technologies. The MMS, the *New England Journal of Medicine*, and *Journal Watch* will be among the exhibitors.

For more details or to register, go to <http://primed.com/PMO/ViewEvent.aspx?EventCode=10EST08A#>. **VS**

## ACROSS THE COMMONWEALTH

### District News and Events

**Barnstable — Family Event.** Sat., Oct. 4, 2 p.m. Location: Plimoth Plantation, Plymouth. Members and their family members are invited to attend a tour followed by a New England Clambake. For more information, contact the Southeast Regional Office.

**Bristol North — Fall Meeting.** Wed., Oct. 22, 6 p.m. Location: Luciano's Restaurant, Wrentham. Guest speaker: Jeffrey Drazen, M.D., editor-in-chief, NEJM. For more information, contact the Southeast Regional Office.

**Bristol South — Fall Meeting.** Thurs., Oct. 30, 6 p.m. Location: Venus de Milo, Swansea. Guest speaker: Jack T. Evjy, M.D., MMS medical affairs advisor. For more information, contact the Southeast Regional Office.

**Charles River — Delegates Meeting.** Mon., Oct. 27, 6 p.m. Location: MMS headquarters, Waltham. For more information, contact the Northeast Regional Office.

**Essex North — Membership Meeting.** Tues., Oct. 7, 6 p.m. Location: Diburro's, Ward Hill. Speaker: Daniel Palestrant, founder and CEO of Sermo, Inc. For more information, contact the Northeast Regional Office.

**Hampden — 24th Annual Medical Ethics Seminar.** Thurs., Oct. 23, 6 p.m. registration. Location: Baystate Conference Center, Holyoke. Title: Ethical Issues in Aging. Keynote Speaker: Leon M. Cooney Jr., M.D. Panel Members: Mary Beth Dowd, Greater Springfield Senior Services; Honorable Judge David M. Fuller, Probate and Family Court of Springfield; Lindsay Rockwell, D.O., coauthor of *In Defiance of Death*; and Deacon Ute Schmidt, Baystate Spiritual Services. For more information, contact Suzanne Skibinski at (413) 736-0661 or hdms@massmed.org.

**Middlesex Central — Annual Breakfast.** Fri., Oct. 17, 7:30 a.m. Location: Emerson Hospital, Concord. Speaker: Luis Sanchez, M.D., director, Physician Health Services. For more information, contact Carol Marshall at (978) 287-3017.

**Norfolk — Fall Meeting.** Tues., Oct. 21, 6 p.m. Location: Sheraton Hotel, Needham. Speaker: Kanchun Gunda, M.D. For more information, contact George Benjamin, M.D., at (781) 434-7403.

**Plymouth — District Meeting.** Thurs., Oct. 16, 6 p.m. Location: Radisson Hotel, Plymouth Harbor, Plymouth. CME program: "Performance Measures and You." For more information, contact the Southeast Regional Office.

**Southeast Regional Caucus — Delegates Meeting.** Wed., Nov. 5, 6 p.m. Location: LeBaron Hills Country Club, Lakeville. Delegates from Barnstable, Bristol North, Bristol South, Norfolk South, and Plymouth will discuss resolutions prior to the 2008 Interim Meeting. For more information, contact the Southeast Regional Office.

**Worcester — Fall District Meeting.** Wed., Nov. 12, 5:30 p.m. Location: Beechwood Hotel. The dinner meeting will include presentation of the A. Jane Fitzpatrick Community Service Award, the WDMS Career Achievement Award, and scholarship awards. For more information, contact Joyce Cariglia at (508) 753-1579.

**Worcester North — Executive Committee Meeting.** Tues., Oct. 7, 6 p.m. Location: Chocksett Inn, Sterling. For more information, contact the West Central Regional Office.

### Statewide News and Events

**Arts, History, Humanism, and Culture Member Interest Network — Poetry, Music, and Medicine Program.** Tues., Oct. 28, 6 p.m. Location: MMS headquarters, Waltham. For more information, contact the West Central Regional Office.

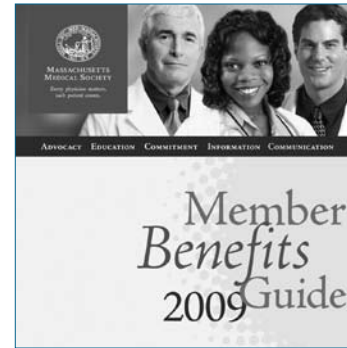
If you have news for Across the Commonwealth, contact Florence Keefe, Northeast Regional Office, at (800) 944-5562 or fkeefe@mms.org; Linda Howard, Southeast Regional Office, at (800) 322-3301 or lhoward@mms.org; or Cathy Salas, West Central Regional Office, at (800) 522-3112 or csalas@mms.org.

*For In Memoriam, please see page 8*

## 2009 Member Benefits Guide Now Available

The 2009 MMS *Member Benefits Guide* is hot off the presses! The 28-page, user-friendly guide is a comprehensive reference to the many valuable benefits available only to MMS members. Current members will receive their copies when they renew their 2009 membership. It will be sent to new members in their welcome packet.

The *Guide* is your one-stop resource for information on MMS advocacy, educational services, practice management and professional resources, patient education, and public health campaigns.



The contact information section provides phone numbers, e-mail addresses, and websites for all the benefit programs and services.

An online version of the *Guide* is accessible through the member benefits and services section of the MMS website ([www.massmed.org](http://www.massmed.org)).

Renew your membership now, and watch for your 2009 *Member Benefits Guide* in the mail. **VS**

If you have questions about your benefits, call the Member Information Center at (800) 322-2303, ext. 7311, or e-mail [info@massmed.org](mailto:info@massmed.org).

## 2008 Interim Meeting Set for Nov. 14 and 15

**Hotel Registration Deadline: Oct. 8**

Planning is under way for the 2008 Interim Meeting of the MMS House of Delegates, which will be held on November 14 and 15 at the Massachusetts Medical Society headquarters and the Westin Hotel in Waltham.

Some of the issues scheduled for discussion include an update on reducing medical student debt and reports on public health, patient safety, and technology issues.

Recently appointed delegates are encouraged to attend the new delegate orientation luncheon on Friday, November 14. In addition, the Committee on Ethics, Grievances, and Professional Standards will convene its biannual Ethics

Forum on Friday, November 14, at 3:30 p.m. Also, the Committee on Gay, Lesbian, Bisexual, and Transgendered Issues will hold a CME program on Thursday, November 13, at 6:30 p.m. called "Caring for Your Gay and Lesbian Patients."

**The deadline for booking hotel reservations at the Westin at the \$133 group rate is October 8.** Reservations may be made by calling the Westin Hotel directly at (781) 290-5600; please let the representative know you are with the Massachusetts Medical Society. **VS**

For more information regarding the upcoming meeting, contact the Department of Governance Meetings and Services at (800) 322-2303, ext. 7206.

## Recruit Your Colleague Campaign Ramping Up

As the largest physician advocate in the state, the power and influence of the MMS grows with each new member. To continue protecting the interests of all physicians and patients, we are appealing to you to recruit one new member.

If each MMS member recruited one new colleague, our increased strength in numbers would help us be even more effective at tackling crucial issues that affect all physicians and their patients.

All MMS members will receive a \$25 reward for each new physician they recruit, and additional rewards of up to \$300 are available for recruiting physician groups.

Let's work together to unite all physicians in Massachusetts and continue to ensure that *every physician matters, and each patient counts*. **VS**

For more information about the Recruit Your Colleague Campaign, contact Carolyn Maher at (781) 434-7311.



MASSACHUSETTS  
MEDICAL SOCIETY

EVERY PHYSICIAN MATTERS, EACH PATIENT COUNTS.

## WHAT'S ON THE WEB?

### ► Physician Focus on the Web

Watch the MMS-produced 30-minute monthly TV program, *Physician Focus*. Visit [www.massmed.org/physicianfocus](http://www.massmed.org/physicianfocus).

Catch *Physician Focus* audio clips, available for download to your iPod and to share with your patients. Visit [http://massmed.typepad.com/mms\\_podcasts/](http://massmed.typepad.com/mms_podcasts/).

### ► Physician Payment Models Analyzed

MMS analyzes and assesses various proposals for improving physician payment. Go to [www.massmed.org/paymentmodels](http://www.massmed.org/paymentmodels).

### ► For Patients: Test Your Flu IQ

[www.massmed.org/fluIQ](http://www.massmed.org/fluIQ)

[WWW.MASSMED.ORG](http://WWW.MASSMED.ORG)

## Never-Events

*continued from page 2*

### Case-by-Case Review and RCA Needed

Dr. Auerbach said one way to address questions now being raised about this issue would be to establish a retrospective process “that allows for a robust root cause analysis after an event has occurred to ensure it was in fact preventable.” He also suggested that money an insurer would have paid for a never event go into a pool to ensure that doctors and other providers called on to treat patients who experience such events can be compensated for their services. The NQF’s Dr. Schyve agreed with Dr. Auerbach on the need for postevent analysis to determine preventability.

The MMS president said the Society is working to develop a policy to address these issues (see President’s Message on page 2).

The MHA also seems to concur with Dr. Auerbach regarding case review and root-cause analysis. In June 2008, as Gov. Patrick was about to announce the state government policy, the hospital association sent a letter to JudyAnn Bigby, M.D., secretary of the Department of Health and Human Services. It said, in part, “MHA is supportive of nonpayment as a fairness issue, but encourages rational criteria for its application. We’ve learned from Minnesota, the first state to adopt such a practice, that

despite the seeming clarity of the list of serious reportable events, a case-by-case review is still necessary to apply a nonpayment process to the reporting process. We request a similar approach here in Massachusetts.”

The MHA letter went on to suggest that decisions about nonpayment be “criteria based” and that occurrence of one of the 28 NQF events is not “a *priori* judgment either of a systems failure, hospital error, or lack of due care.” The hospital organization offered three criteria for determining whether payment should be withheld. A nonchargeable event, it said, should be:

- Determined to be preventable
- Within control of the hospital
- Specific to the care that resulted in or was made necessary by the serious adverse event

“We’re not saying don’t do it,” said the MHA’s Nelson. “We’re saying do it, and do it well.”

The new Massachusetts prohibition against charging for a never event has, of course, come to the attention of the state’s health insurers. As this issue of *Vital Signs* went to press, a spokesperson for Blue Cross Blue Shield of Massachusetts said the state’s largest health plan had scheduled a top-level meeting to discuss how it would approach these aspects of the new state law. **VS**

## In Memoriam

The following deaths of MMS members were reported to the Society in August and September 2008. We also note member deaths on the MMS website at [www.massmed.org/memoriam](http://www.massmed.org/memoriam).

**John S. Bockoven, M.D.**, 92; Lincoln, MA; University of Vermont College of Medicine, 1942; died June 30, 2008.

**Robert B. Brendze, M.D.**, 86; Chestnut Hill, MA; University of Texas Southwestern Medical School, 1949; died August 6, 2008.

**Ferdauz N. Canteenwalla, M.D.**, 61; Springfield, MA; University of Bombay Medical College, 1969; died August 30, 2008.

**Stephen J. Fricker, M.D.**, 80; Lexington, MA; Yale University School of Medicine, 1962; died May 21, 2007.

**John G. Guillemont, M.D.**, 71; Lewiston, NY; University of Pennsylvania School of Medicine, 1962; died July 29, 2008.

**Harry L. Kozol, M.D.**, 102; Boston, MA; Harvard Medical School, 1934; died August 27, 2008.

**Alan R. Spievack, M.D.**, 74; Cambridge, MA; Harvard Medical School, 1959; died March 15, 2008.

**Rocco A. Verrilli, M.D.**, 85; Longmeadow, MA; Albany Medical College, 1951; died August 6, 2008.

**Leonard R. Weiner, M.D.**, age unknown; Boston, MA; University of Wisconsin Medical School, 1944; died April 28, 2008.

**Thomas H. Weller, M.D.**, 93; Needham, MA; Harvard Medical School, 1940; died August 23, 2008.

## MMS Sponsored & Jointly Sponsored CME Activities

To register for any of these activities, call (800) 843-6356.

For additional information, contact the Department of Continuing Education and Certification at (800) 322-2303, ext. 7306, or go to [www.massmed.org/cmecenter](http://www.massmed.org/cmecenter).

### Live CME Activities

Go to [www.massmed.org/cme/events](http://www.massmed.org/cme/events).

#### Breast Health Forum

October 31, 8:00 a.m.–12:15 p.m.  
MMS headquarters, Waltham.  
Sponsored by the MMS and its Committee on Women in Medicine.  
4.0 Credits (RM)

#### Strategies for Safely Managing Patients on Warfarin

November 4, 8:00 a.m.–12:30 p.m.  
MMS headquarters, Waltham.  
Jointly sponsored with the Mass. Coalition for the Prevention of Medical Errors. 4.25 Credits (RM)

#### Managing Workplace Conflict

November 5, 8:00 a.m.–4:00 p.m.  
November 6, 8:00 a.m.–3:00 p.m.  
MMS headquarters, Waltham.  
Jointly sponsored with Physician Health Services. 12.5 Credits (RM)

#### Caring for Your Gay and Lesbian Patients

November 13, 6:30–8:00 p.m.  
MMS headquarters, Waltham.

Sponsored by the MMS and its Committee on Gay, Lesbian, Bisexual and Transgendered Issues.  
1.5 Credits (RM)

#### Ethics Forum: Poverty, Access, and Health Status

November 14, 3:30–5:30 p.m.  
MMS headquarters, Waltham.  
Sponsored by the MMS and its Committee on Ethics and Grievances.  
2.0 Credits (RM)

#### Impact of Health Care Reform on Minority Populations and Their Providers

November 20, 6:30–9:00 p.m.  
MMS headquarters, Waltham.  
Sponsored by the MMS and its Committee on Diversity in Medicine.  
2.5 Credits (RM)

### Online CME Activities

Go to [www.massmed.org/cme](http://www.massmed.org/cme).

#### **NEW** Massachusetts Medical Law Report Quarterly Risk Management CME Series

#### Dealing with Difficult Patients

1.0 Credit (RM)

#### A New Kind of Bedside Manner:

##### The Rise of Apology Policies

1.0 Credit (RM)

*The following audio and/or PowerPoint activities are available online:*

#### Electronic Prescribing Education:

##### How to Improve Medication Safety and Reduce Drug Costs through e-Prescribing

2.5 Credits (RM)

#### Physician-Hospital Relationships:

##### Where Do You Stand?

3.0 Credits (RM)

#### Balancing Your Practice: Protecting the Public Health and Preserving Your Patients’ Privacy

2.5 Credits (RM)

#### Avian Flu and Pandemic Preparedness

2.5 Credits (RM)

### Save the Dates

*November 6, 2008*

**2008 Directors of Medical Education Conference**

*November 18, 2008*

**Computerized Prescription Order Entry**

*January 30, 2009*

**Health Policy Forum**

*February 6, 2009*

**Women’s Cardiac Health Conference**

CME CREDIT: Unless otherwise noted, each activity is designated for *AMA PRA Category 1 Credits™*.

RM indicates that the activity or a portion thereof meets the Massachusetts Board of Registration in Medicine criteria for risk management study.

CME ACCREDITATION: The Massachusetts Medical Society is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.