

# VITAL SIGNS



MASSACHUSETTS  
MEDICAL SOCIETY

*Every physician matters,  
each patient counts.*

VOLUME 14, ISSUE 4, APRIL 2009



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## Physicians Cite Continuing Problems with Fourth Year of GIC Tiering

BY TOM WALSH

Ann T. Nutt, M.D., a Dorchester pediatrician, vividly recalls the day this past February when she opened her mail to find that she would no longer be a tier 1 physician after July 1 under the state Group Insurance Commission's (GIC) Clinical Performance Improvement program (CPI). The health plans under the aegis of the GIC insure about 300,000 state and municipal workers, their families, and retirees.

In fact, Dr. Nutt discovered she was now ranked in tier 3 — which meant, among other things, higher copays for her patients.

"I was irked, discouraged," she said. "The insurance company's letter was hard to understand. It took a couple of reads to interpret what the numbers meant."

Finally, she called the health plan. A representative told her that the "efficiency" part of her record was excellent. "It's quality that's killing you," she was told.

"I care about my efficiency," Dr. Nutt said. "But I *really* care about my quality." The insurer instructed Dr. Nutt to send a

letter listing the reasons why her rating should be reconsidered. "What they didn't do was give me a list of patients linked to the claims so that I could look in the chart, see what was done, and make an effective case for myself," she said. Eventually she got the insurer to send her detailed information used in her ranking. That data, she said, showed that in 127 opportunities to be "compliant," she had complied 115 times.

"Then I was really irked," Dr. Nutt said. Heeding MMS advice that members move quickly to appeal their rankings, she formally appealed within the tight deadlines set down by insurer.

Dr. Nutt finally determined that her fall from the highest to lowest physician rating occurred because, in treating certain adolescent girls, she prescribed birth control pills without requiring chlamydia screening. Dr. Nutt knew that the girls in question were not sexually active and thus did not need to be screened for the sexually transmitted bacterium. Apart from their use as contraceptives, birth control medications, she added, are appropriate treatment for intense menstrual pain, acne, or polycystic ovary syndrome in such patients.

"But in reviewing my record, they just saw the claim for prescribing the medication without also seeing a claim for ordering the screening," she said.

Despite her clinically sound explanation, the insurer denied Dr. Nutt's appeal of her tier 3 ranking. "The denial was just a form letter," she said. "It seemed as though they hadn't even read my letter explaining everything." After calling the insurer yet again, Dr. Nutt was told that a letter to pediatricians affected by the chlamydia measure was forthcoming and that her rating would probably be upgraded to tier 2. As this issue of *Vital Signs* went to press, she had not received the letter nor confirmation of any tier change.

Dr. Nutt is not alone in her frustration with the controversial GIC rankings. As it has every year since the GIC "Select and Save" tiering program began in 2006, the MMS has been inundated with calls from members unhappy with their rankings.

"We've gotten reports of physicians who are retired being put in tier 1," said Bruce S. Auerbach, M.D., the MMS president. "Clearly one has to ask what the basis is for *them* being tiered."

In May 2008, the MMS and five individual physicians filed a lawsuit against the GIC and two health plans that take part in the GIC program — Tufts Health Plan and UniCare. The suit claims that the tiering program defrauds consumers and defames physicians. In December, a Superior Court judge heard arguments from the defendants to dismiss the suit. As this issue of *Vital Signs* went to press, the judge's decision on whether the suit should proceed had not been handed down.

### "News to Us"

In a message to state employees contained in the winter issue of its newsletter, *For Your Benefit*, the GIC maintained that it "continues to work with physicians in and out of our health plans to refine physician scoring methodology."

"That would come as news to us," Dr. Auerbach said. "I haven't seen anything that indicates any substantial change in

*continued on page 2*

## Payment Reform Unlikely to Hinge on Single Model

BY TOM WALSH

Spurred by an ambitious deadline and an imposing charge by the state Legislature, the Special Commission on the Health Care Payment System hopes to agree on a long-term vision for payment reform this month and send a complete report to lawmakers by the end of May.

"We're trying to build consensus for a future payment methodology that leads to high quality and efficient care," Sarah Iselin, commissioner of health care finance and policy and co-chair of the payment panel, said in an interview with *Vital Signs*.

She added that "according to the feedback I've heard, there may not be a one-size-fits-all solution. There may be different recommendations for different parts of the system. Our long-term vision could have more than one model."

What follows are thumbnail descriptions of four of the several payment alternatives the panel has reviewed. Most experts think that what finally emerges will combine elements from several models.

For more detailed information on these alternatives, go to [www.massmed.org/paymentreform](http://www.massmed.org/paymentreform) or to the commission's website at [www.mass.gov/dhcfp/paymentcommission](http://www.mass.gov/dhcfp/paymentcommission).

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Photo by Mikaela Hood, R.N.

Ann T. Nutt, M.D., helps her young patients relax by encouraging them to blow bubbles.

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## PRESIDENT'S MESSAGE



### All Eyes on Payment Reform

I just returned from the National Advocacy Conference in Washington, D.C., and am very en-

couraged by the groundswell of Congressional support for health reform in general and payment reform in particular. Led by Sen. Edward Kennedy, the entire Massachusetts Congressional delegation is backing an overhaul of the SGR-based Medicare payment formula.

The Society has been fighting to change that dysfunctional formula for years. There now seems to be the political will — and hopefully the investment needed — that will lead to a fair and sustainable way to compensate providers for Medicare services.

I'm also heartened by the ongoing work of the Massachusetts Special Commission on the Health Care Payment System. The panel continues to reach out to all health care stakeholders, and the Society remains committed to helping the commission arrive at sound recommendations for payment reform by the end of May. Their task is huge, and they appear to be meeting it collaboratively and transparently.

In all these conversations about payment reform, the concept of efficiency frequently arises. Physicians in Massachusetts are sensitive about the "E" word because the GIC's tiering program has turned it into a synonym for cheap. By that narrow definition, a doctor would be very "efficient" by seeing many patients very quickly, each with low-level billing. Yet those patients would probably end up

costing the system more down the road because of the subpar but "efficient" care they received.

Through consistent and persistent advocacy at all levels, the Society is making sure that efficiency, as conceptualized during these discussions, will both improve patient outcomes and contain costs, now and in the future.

I've also noticed that fee for service comes under fire in many payment reform conversations. Fee for service does have its problems — overuse of resources being the most important — but for some scenarios in health care, such as for the services of anesthesiologists and pathologists, it may still make sense. And in many of the "blended" payment models our state commission is now considering, fee for service would be combined with other methodologies.

As Commissioner Iselin said in the article on page 1, there may be different optimal payment models for different parts of the delivery system. Thanks largely to physician initiatives, there are small-scale alternative payment experiments in Massachusetts and around the country that are getting good results. I'm gratified that the payment reform commission is looking at those examples closely. Our hope is that public and private stakeholders will make the up-front investments necessary to ensure that the most successful systems are identified and proliferate.

— Bruce S. Auerbach, M.D.

#### GIC Tiering

*continued from page 1*

the methodology and I haven't been hearing from physicians that there is a change."

In the newsletter, the GIC also said that for the 2010 fiscal year, beginning July 1, it "will be using an advanced statistical model developed by a leading biostatistician at Johns Hopkins University that increases the probability that the quality scores are an accurate reflection of physician performance." Physicians are skeptical that the GIC's quality rankings next February will be any more accurate than they have been.

#### No Roadmap for Quality Improvement

Elaine Kirshenbaum, MMS vice president for policy, planning, and member services, said she has heard from many physicians that data used to rank them is difficult to understand and use to improve their quality performance. "If the information doesn't help physicians to understand what's going on quality-wise, the usefulness to the practice is limited at best," she said.

#### Payment Reform

*continued from page 1*

##### Episode-of-Care Payment

This emerging method pays physicians one fixed payment for treating a specific episode of care, which may incorporate diagnosis, treatment, and follow-up care. The payment covers all or part of the services by all doctors for an entire course of treatment over a specified time period. Fixed payments may be adjusted for the severity of the patient's illness or to reward high-quality outcomes.

This payment model seeks to contain the costs of services delivered during the episode and to encourage use of recommended, high-quality services and care coordination.

The diagnostic-related group (DRG) system used to classify hospitalizations is a rudimentary example of an episode-based model. Proponents of episode-of-care payments say they can limit the financial risk for doctors and that they are typically more sensitive to case mix than some other models.

Although episode-of-care payment is being used in Medicare demonstration projects and a handful of other applications, many challenges remain —

Further, Kirshenbaum said, some specialties now being tiered under the GIC program do not have enough quality measures for statistical reliability, so these doctors are tiered only on efficiency. "If there's no quality improvement component, these physicians are tiered based only on cost," Kirshenbaum said.

In addition, last year the GIC mandated that its participating health plans assign no more than 20 percent of doctors to tier 1, 65 percent to tier 2, and 15 percent to tier 3. Kirshenbaum says these arbitrary cutoffs continue to "create a situation that could easily disrupt patient-physician relationships."

Dr. Nutt feels badly that her new tier ranking will mean higher copayments for her patients at the Neponset Health Center. "They are already straining with the current copay," she said. "It's just so discouraging — you work hard to do the right thing. I don't see anything they've done here that will improve my quality or cost."

Still, Dr. Nutt said, "I love my work. I'm happy with what I do. But this is just wrong. There is no justice. It needs to be fixed." **VS**

among them defining what constitutes an "episode" for different types of conditions and fairly attributing episode payments to all physicians who were involved.

#### Capitation

Under some versions of this model, physicians receive a monthly or annual fee for each patient, regardless of the number of services provided. Capitation empowers physicians to make decisions about care, but it also puts them at financial risk if actual costs exceed the allocation.

In global capitation, entire networks of hospitals and doctors receive fixed payments for a group of enrolled health plan members. The providers then determine how to divide up the total capitation payment among themselves.

Some experts believe that capitation fosters accountability by not rewarding entrepreneurial behavior or cost-intensive services such as high-margin treatments. For this system to succeed — which it did not during the managed care heyday of the 1990s — physicians must be able to successfully manage significant risk.

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**EDITOR:** Lloyd Resnick **STAFF WRITER:** Tom Walsh

**EDITORIAL STAFF:** Charles Alagero, Office of General Counsel; Robyn Alie, Public Health; Adam Shlager, Managed Care; Stephen Phelan, Membership; Cathy Salas, West Central Regional Office; Stephen Shestakofsky, Government Relations; Jessica Vautour, Physician Health Services

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

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

**DIRECTOR OF COMMUNICATIONS:** Frank Fortin

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## CMS Recovery Audit Program Ready for Nationwide Rollout

The Centers for Medicare and Medicaid Services (CMS) confirmed that its Recovery Audit Contractors (RACs) will be operational in all 50 states by the end of the year. The stated mission of the recovery audit program is to identify underpayments from and overpayments to Medicare providers.

The contractor operating in Region A, which includes all of Massachusetts, is Diversified Collection Services Inc. of Livermore, California. The CMS issued some initial parameters for the record requests that the RACs might make. For 2009, the limits for Part B providers are as follows:

- Ten medical records per 45-day period for solo providers
- Twenty medical records per 45-day period for offices with 2 to 5 providers
- Thirty medical records per 45-day period for groups of 6 to 15 providers
- Fifty medical records per 45-day period for groups of 16 or more providers

The RAC program limits the medical record review period to three years, and audits on claims paid prior to October 1, 2007, are prohibited. The RAC must also

have a physician medical director, and the contractor must make certified coders available to discuss denials. RAC auditors must also provide clinical credentials upon request.

Physicians have voiced various concerns about this program. Primary among them is the additional administrative burden these audits will place on physician practices. Another concern is how the auditors will interpret documentation and its subsequent application to CPT codes, particularly evaluation and management codes. Physicians are also vexed by the lack of accompanying educational opportunities being offered by CMS to help physicians comply with CMS standards.

Physician advocacy and education organizations such as the AMA, the MMS, and the Medical Group Management Association (MGMA) have been working with the CMS since the program's inception and continue to voice their concerns and make recommendations as the program unfolds. On April 7, the MGMA will host a webinar, "Preparing Your Practice for the Permanent Recovery Audit Contractors," which you can access at [www.mgma.com](http://www.mgma.com). **VS**

— Adam Shlager

## PPRC Resources for MMS Members

The Physician Practice Resource Center (PPRC) was established to assist members of the Massachusetts Medical Society acquire and put to use a broad spectrum of knowledge. Among the most requested areas of expertise and intervention are practice management/operational issues and administrative simplification.

These two topics are clearly among the most challenging aspects of practicing medicine in Massachusetts today. Hearing from practices helps the PPRC craft appropriate responses that are practical and applicable at the practice level.

Calls made to the PPRC are also logged in our own internal-use database, which allows us to look back over time and identify trends in common issues, as well as evaluate our responses. This information is also used to provide input as we address larger policy issues in the broader health care dialogue.



We also use this information to create resources for MMS members. Recently created informational resources, include an EHR cost calculator, a vacation/leave

time calculator, and a guide to records retention in your office. These resources are available to members online at [www.massmed.org/pprc](http://www.massmed.org/pprc).

The PPRC also offers fee-based consulting services. This service is provided at a discounted rate for MMS members and may address more complex matters such as corporate structure, financial analysis, human resource issues, or income distribution design.

The most effective way for us to serve you is to hear from you. You can reach PPRC staff by e-mail at [ashlager@mms.org](mailto:ashlager@mms.org) or [tledin@mms.org](mailto:tledin@mms.org), or by calling (781) 434-7702 or (781) 434-7812. **VS**

— Adam Shlager

## LAW AND ETHICS

### Red Flag Rules Aim to Thwart Identity Theft

On November 9, 2007, the Federal Trade Commission (FTC) published the Red Flag Rules, which define what a creditor must do to implement an identity theft prevention program. These rules apply to any entity that allows for payment of services *after* the services are provided or over a period of installment payments. Thus, any physician who does not provide all services on a prepaid basis likely qualifies as a creditor.

Identity theft can be particularly pernicious in health care. First, the potential financial losses tend to be much greater than in other areas. Physicians who provide care in good faith to patients who are not who they say they are could find themselves responsible for thousands of dollars. A victim of health care identity theft has to contend with the same problems as all identity theft victims, along with the additional complication of worrying that his or her medical history could be confused with that of the thief.

The Red Flag Rules require a creditor to make reasonable attempts to detect and prevent identity theft and to respond appropriately when it suspects identity theft has occurred.

Developing an identity theft prevention program involves a three-step process:

1. Identify relevant "red flags" — patterns, practices, or specific activities that indicate the possible existence of identity theft — such as the following:

- Presentation of suspicious documents or personal identifying information

- Unusual use of a patient's account

- Receipt of notice that identity theft may have occurred

2. Watch out for a patient who refuses to provide personal identifying information or documents, or provides suspicious documents or information, such as:

- An insurance card that appears to have been altered or forged

- A photograph on a driver's license that does not look like the patient

- A physical description on the driver's license that does not match the patient

- An address or phone number that does not match your existing records

- An invalid Social Security number

3. Implement a plan to respond appropriately to any red flags.

Appropriate responses may include contacting the patient, changing passwords, not accepting a particular new patient, or notifying law enforcement.

Physician practices should consult with counsel to assist in developing and implementing an identity theft prevention program. The FTC says it will delay enforcement of these regulations until May 1, 2009. **VS**

— Elizabeth Rover Bailey, Esq.

The "Law and Ethics" column is provided for educational purposes and should not be construed as legal advice. Readers with specific legal questions should consult with a private attorney.

### MMS to Subsidize Inexpensive Quality Surveys for Small Practices

The MMS will subsidize the cost of patient experience surveys for practices of one or two physicians that are not part of a large system.

Since 2005, Massachusetts Health Quality Partners (MHQP) has been surveying and publicly reporting the results of its patient experience surveys for practice sites of three or more physicians. Patients report confidentially on issues such as physician-patient communication, wellness and preventive care practices, and their interactions with practice staff.

"These areas are very strongly related to positive medical outcomes," said MMS President Bruce S. Auerbach, M.D. "For years, larger practices have used this information to make important improvements in their operations. We now want to help

our state's smallest practices get access to this important patient feedback."

The results will not be reported publicly. They will be available only to the practices, health plans, and the MHQP as a quality improvement tool. Health plans have agreed not to use the data to determine incentive payments or quality tiers.

The survey will be fielded in September and October of 2009. Results will be reported in early 2010. Because of the MMS subsidy, this valuable information is discounted by 50 percent, for a cost to the practice of only \$150 per physician. To participate, practices must contact Rose Judge, MHQP project manager, at [rjudge@mhqp.org](mailto:rjudge@mhqp.org). The deadline to respond is April 30. For more information, visit [www.massmed.org/mhqp](http://www.massmed.org/mhqp). **VS**

## From Cigarettes to Fossil Fuels: Combustion Exposures Are Bad for Human Health

Physicians successfully medicalized cigarettes in the twentieth century by educating patients and transforming the public's perception of smoking from an innocent pastime to a dangerous health threat. While there are fewer smokers now than several decades ago, in 2006, there were still 8,045 smoking-attributable deaths in Massachusetts. Those fatalities translated into \$1.7 billion in lost productivity and \$4.3 billion in health care costs statewide.

However, there may be an even larger and more costly public health threat looming. Physicians on the MMS Committee on Environmental and Occupational Health are looking at the scientific evidence linking fossil fuels to disease.

Like smoking, fossil-fuel combustion is strongly linked to respiratory and cardiac diseases. Fine particulates (2.5 microns or less) get into the lung's alveoli and are absorbed into the bloodstream, triggering a macrophage response that promotes vascular plaque development.

Consequently, in high air pollution urban areas there is a 6 percent added risk of cardiovascular disease and an 8 percent added risk of lung cancer, independent of smoking. Furthermore, fetal exposure in utero to polycyclic aromatic hydrocarbons inhaled by mothers living in these urban areas is associated with lower birth weight babies and increased risk of future asthma. In addition, mercury, a known developmental neurotoxin, is released mostly from fossil-fuel combustion, and it then becomes concentrated in large fish. In utero mercury exposure

is associated with measurable cognitive and inattention effects in children.

Fossil-fuel combustion also emits potent greenhouse gasses such as carbon dioxide, which is now associated with global warming. Sudden climate change is driving more extreme weather events in the form of severe storms, droughts, and flooding, as well as climate-sensitive mosquito-borne diseases, ozone-related asthma, and rising sea levels — all of which are projected to increase human suffering on a growing scale.

In response to the public health threat from fossil fuels, in November 2008, the MMS voted to promote education of its membership, patients, and the public about the health impacts of fossil-fuel usage and engage in advocacy to reduce the use of fossil fuels and increase development of healthier and safer energy sources. For its part, the AMA recommends that all physicians become role models in their communities by reducing conspicuous carbon consumption.

Personally, I recently traded my coveted Ford Explorer for a compact hybrid that has surprisingly become a joy to drive. As physicians, we can also help lead energy efficiency efforts in our office and hospital settings.

For more information on what a physician can do, check out the MMS public health website at [www.massmed.org/envhealth](http://www.massmed.org/envhealth).

— Richard Donahue, M.D., M.P.H.

Visiting Scientist,

Harvard School of Public Health

Member, MMS Committee on Environmental and Occupational Health

## MMS Backs Workers' Comp Rate Increases

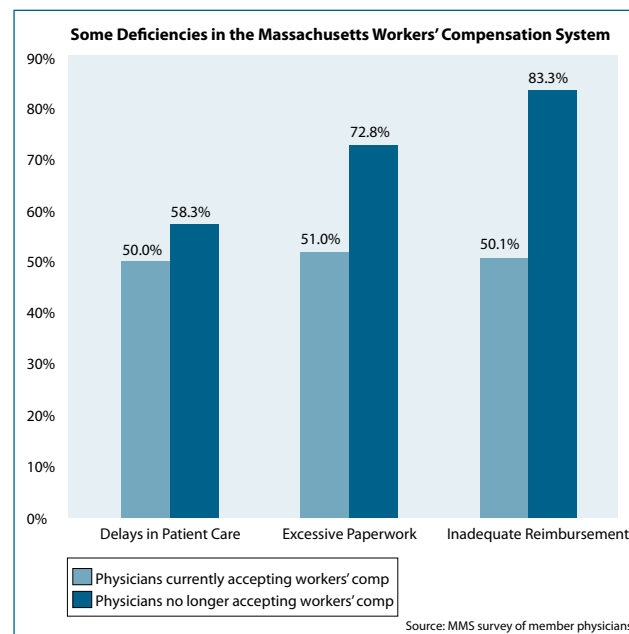
On February 10, the MMS testified before the state Division of Health Care Finance and Policy (DHCFP) in support of proposed amendments to the workers' compensation fee schedule. The Massachusetts workers' compensation fee schedule is the lowest in the country.

The proposed fee schedule, scheduled to take effect this month, includes a 10 to 12 percent rate increase for most physician fees. Proposed increases to anesthesia and surgical fees were significantly greater: base anesthesia fees increased from \$19.86 to \$39. Proposed fees for the 25 most common surgical procedures increased an average of 270 percent.

In its testimony, the MMS thanked DHCFP Commissioner Sarah Iselin for her recognition of the need to raise reimbursement rates to cover the legitimate costs of treating workers' compensation patients. The MMS urged adoption of the amendments to increase the fee schedule while also preserving the rights and abilities of physicians, insurers, and employers to negotiate different rates.

### MMS Survey Highlights System Deficiencies

In December 2008, the MMS conducted an e-mail survey of a sample of its members to learn more about how the workers' compensation system affects physicians.



More than half (51 percent) of the 124 respondents reported accepting workers' compensation patients. Twelve percent of respondents no longer accepted workers' compensation patients, and 15 percent had never accepted them.

The graph above shows the percentages of respondents currently or previously accepting workers' compensation patients who often or always experienced delays in patient care, excessive paperwork, or inadequate reimbursement.

More than 90 percent of physicians no longer accepting workers' compensation patients ranked denial of reimbursement, low reimbursement, and excessive paperwork as being important or very important in their decision not to accept workers' comp patients. **VS**

— Robyn Alie

### Fifth Annual Public Health Leadership Forum: Violence — Implications for Health

April 29, 8:00 a.m.–12:30 p.m. ~ MMS Headquarters, Waltham

Moderated by Liz Brunner, WCVB-TV

#### Faculty presentations include:

*The Impact of Violence on Society* by Mark L. Rosenberg, M.D., executive director, Task Force for Child Survival and Development

*Addressing Domestic Violence in the Commonwealth* by JudyAnn Bigby, M.D., Massachusetts secretary of health and human services

*Systems for Intervention — Examples from the Military* by Judith E. Beals, J.D., OXFAM America

*Urban Trauma as a Public Health Issue* by John A. Rich, M.D., M.P.H., Drexel University School of Public Health

*Immigrant and Refugee Health* by José Hidalgo, M.D., medical director, Latin American Health Institute

*A Call to Action* by Howard K. Koh, M.D., M.P.H., Harvard School of Public Health

Jointly sponsored by the MMS and the Harvard School of Public Health  
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For more information, contact the MMS Department of Public Health and Education at (781) 434-7373 or [jcricones@mms.org](mailto:jcricones@mms.org).

## MMS to Host Program Addressing Water

### Dr. Mike Magee to Present "Drops of Life"

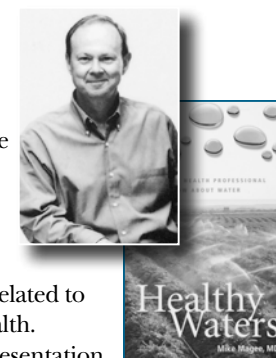
On April 28, veteran medical journalist, author, and media personality Mike Magee, M.D., will visit the MMS to discuss local and global issues related to water and health.

Dr. Magee will deliver a multimedia presentation that will demonstrate the interaction between water and agriculture, industry, urbanization, population growth, war, and disasters and disease. The event is designed to generate discussion among participants.

Dr. Magee was invited by the MMS Committees on Environmental and Occupational Health and Global Medicine to

discuss ways in which the health care community can contribute to discussion and action around local and global policy issues related to water and health.

The free presentation begins at 7:30 p.m. and is open to MMS members with advance registration. To register, contact Robyn Alie at [ralie@mms.org](mailto:ralie@mms.org). **VS**





STATE UPDATE

New Leadership Teams and Committee Chairs in Place at the State House

Even the least experienced physician-advocates among MMS members will notice significant changes in many key legislative leadership positions on Beacon Hill.

The changes are most pronounced in the House, where Rep. Robert DeLeo (D-Winthrop) was elected speaker to replace Salvatore DiMasi (D-Boston), who resigned in January. DeLeo, who had been chair of the powerful House Ways and Means Committee under DiMasi, bested former Majority Leader Rep. John Rogers (D-Norwood) after a sometimes contentious leadership battle. Rep. Charles Murphy (D-Burlington) was appointed to fill the Ways and Means post, while James Vallee (D-Franklin) was chosen as the new majority leader. The Republican House caucus was also split but re-elected Rep. Bradley Jones (R-North Reading) as its minority leader.

The Senate leadership remained stable, but striking changes took place in the House co-chairs of many joint committees that are important to the Society. Rep. Harriet Stanley (D-West Newbury), a past co-chair of the former Health Care Committee, has joined Sen. Richard Moore (D-Uxbridge) on the Health Care

Financing Committee, while Rep. Jeffrey Sanchez (D-Boston) now co-chairs the Public Health Committee with Sen. Susan Fargo (D-Lincoln). Finally, former Public Health Committee co-chair Rep. Peter Koutoujian (D-Waltham) moved to Financial Services, where he is now partnered

with Sen. Stephen Buoniconti (D-West Springfield). The roster of key State House leaders and committee chairs is summarized in the chart below. **VS**

—Steve Shestakofsky

The 2009–2010 Session at a Glance

Key State Senate and House Leaders

Senate President	Therese Murray (D-Plymouth)
Senate Majority Leader	Frederick Berry (D-Peabody)
Senate Minority Leader	Richard Tisei (R-Wakefield)
House Speaker	Robert DeLeo (D-Winthrop)
House Majority Leader	James Vallee (D-Franklin)
House Minority Leader	Bradley Jones (R-North Reading)

Key Committee Chairs/Co-Chairs

Senate Ways & Means	Steven Panagiotakis (D-Lowell)
House Ways & Means	Charles Murphy (D-Burlington)
Health Care Financing	Sen. Richard Moore (D-Uxbridge)/Rep. Harriet Stanley (D-W. Newbury)
Children & Families	Sen. Gale Candaras (D-Wilbraham)/Rep. Kay Khan (D-Newton)
Judiciary	Sen. Cynthia Creem (D-Newton)/Rep. Eugene O’Flaherty (Chelsea)
Financial Services	Sen. Stephen Buoniconti (D-W. Springfield)/Rep. Peter Koutoujian (D-Waltham)
Mental Health & Substance Abuse	Sen. Jennifer Flanagan (D-Leominster)/Rep. Elizabeth Malia (D-Boston)
Public Health	Sen. Susan Fargo (D-Lincoln)/Rep. Jeffrey Sanchez (D-Boston)

LEGISLATOR OF THE MONTH

Representative Peter J. Koutoujian (D)

District: Newton (part), Waltham (part), Watertown (part)

Committee: Financial Services (Chair)



**QUOTE:** As my tenure as chair of the Committee on Public Health comes to a close, I would like to thank the Massachusetts Medical Society for this recognition and for its support, guidance, and expertise over the years.

I take pride in the legislative goals we have accomplished, and I look forward to continuing to work with you on one of the most troubling public health issues that remains: obesity.

Comorbidities from obesity are creating a destructive path through all age levels of our population, from gestational diabetes, to type 2 diabetes, heart disease, and hypertension.

We cannot give up on advocating for healthy behaviors to combat obesity. Instead of placing a bandage on the problem, such as the proliferation of bariatric surgeries for morbidly obese patients, we need to focus on implementing effective and preventive public health measures to reduce this alarming upward trend.

I ask the Society for its continued support of my antiobesity legislation, including promoting workplace wellness initiatives, an artificial trans-fat ban, improved school nutrition standards, and increased physical education.

Although I depart as chair of the Committee on Public Health, I plan to work to see these proposals enacted, and I look to the MMS membership for help.

FEDERAL UPDATE

President’s Budget Includes Proposals to End Medicare Payment Cuts

There are still those who question whether comprehensive reform can actually occur this year, despite the fierce determination by both the White House and Congressional leaders to move swiftly and aggressively on health care reform. The financing and cost implications of those efforts are certain to influence much of the outcome, as both White House and Congressional actions and the President’s proposed budget suggest.

When President Obama first addressed a joint session of the 111th Congress in February to outline his priorities, health care was at the top of a short list that also included energy and education. He said, “I know that nearly a century after Teddy Roosevelt first called for reform, the cost of our health care has weighed down our economy and the conscience of our nation long enough. . . . Health care reform cannot wait and it will not wait another year.” Earlier that same day, the White House convened a Summit on Fiscal Responsibility, where health care costs figured prominently.

The next day, the President released a budget request that reflected these priorities. He proposed creating a \$634 billion “reserve fund” over the next decade to finance expanded health insurance coverage and other health care investments. Approximately half of the reserve fund would be generated by increasing taxes on upper-income taxpayers (couples earning more than \$250,000 a year) and savings from the Medicare managed-care plans and Medicaid programs.

Of particular importance to physicians, the budget proposal included \$329.6 billion “to account for additional expected Medicare physician payments” over the next 10 years. The funds were described as the Administration’s “best estimate of what the Congress has done in recent years.” If adopted, these payments would effectively eliminate the scheduled Medicare physician payment cuts of 40 percent over the next seven years.

The budget proposal also stated that “as part of health care reform, the Administration would support comprehensive but

fiscally responsible reforms to the [Medicare] payment formula,” adding that “Medicare and the country need to move toward a system in which doctors face better incentives for high-quality care rather than simply more care.”

This is the first time any President’s budget proposal demonstrated a willingness to realistically address physician payment reform. It would not only eliminate the projected cuts to physician payment rates, but also “forgive” the mounting accrued “debts” from previous temporary fixes that repeatedly postponed a permanent solution.

The AMA issued a statement applauding the President’s position on physician pay cuts and his commitment to expanding health insurance coverage for the uninsured.

However, as is the case every year, the President’s proposal is the first step in a lengthy and often contentious budget process. **VS**

—Alex. Calcagno

## Provider Directory Helps LGBT Patients Find Physicians

The MMS Committee on Lesbian, Gay, Bisexual and Transgender (LGBT) Matters and the Gay and Lesbian Medical Association (GLMA) have formed an important new partnership to help improve access to care for LGBT patients. Because research has shown that such patients are at risk for disparities in health status and access to health care, this partnership has been working hard to improve the quality of care received by LGBT patients. One result of this effort is the launch of the new GLMA online Provider Directory.

The goal of the directory is to provide an easy way to find physicians and other providers who welcome and accept LGBT patients into their practices. Any physician can create a listing that includes specialty, contact information, certification, and areas of interest. Providers who wish to become involved should visit [www.glma.org/providers](http://www.glma.org/providers). There is no charge for a listing in the directory.

To provide high-quality health care, the MMS Committee on LGBT Matters

believes it is imperative that all patients receive culturally competent care. The committee is therefore committed to working to enhance policy, advocacy, and education on LGBT health and professional issues. To ensure the best care possible, the committee encourages physicians to gain an awareness of a patient's sexual orientation and gender identity and to create a safe and welcoming environment that fosters open communication about all issues that affect LGBT patients' health and well-being.

The MMS Committee on LGBT Matters hosts educational programs (some of which offer CME credit). The GLMA also provides educational opportunities, with CME credit available, at its annual conference (September 30 through October 3, 2009) and through online CME courses.

Visit the GLMA website at [www.glma.org](http://www.glma.org) for more information. Please consider joining this partnership to help ensure that all practices are welcoming of LGBT patients and families. **VS**

## May IMG Event to Probe Organ Trafficking and Transplant Tourism

Organ transplantation is a twentieth-century medical miracle that has prolonged and improved the lives of hundreds of thousands of people worldwide. However, the demand for transplantable organs far outstrips the available supply. That imbalance has led in recent years to the phenomena of organ trafficking and "transplant tourism," where desperate patient-tourists from wealthy countries travel to developing nations to purchase organs from easily exploited populations such as the poor, illiterate, and imprisoned.

The World Health Organization and countless professional groups, including the United Network for Organ Sharing (UNOS) — which manages the U.S. organ transplant system — have condemned such practices. In May 2008, more than 150 health care representatives from 78 countries signed the "Istanbul Declaration" on organ trafficking and transplant tourism. The declaration established proposals to end such practices, concluding that "the legacy of transplantation must not be the impoverished victims of organ trafficking and transplant tourism, but rather a celebration of the gift of health by one individual to another."

One of the declaration's signatories, William Harmon, M.D., will lead a discussion on this controversial topic at the annual reception of the MMS International Medical Graduates Section (see box). Dr. Harmon, chief of nephrology at Children's Hospital Boston and a professor of pediatrics at Harvard Medical School, is a past president of the American Society of Transplantation and a board member of UNOS and the International Pediatric Transplant Association.

All are welcome to attend this event, which is held in conjunction with the MMS Annual Meeting at the Seaport Hotel and World Trade Center in Boston. **VS**

### The MMS International Medical Graduates Section Annual Reception

### Transplant Tourism and the Istanbul Declaration

**Saturday, May 9, 3:00 to 5:00 p.m.**  
**Seaport Hotel, Boston**

For more information or to register, contact Carolyn Maher at (781) 434-7311 or [cmaher@mms.org](mailto:cmaher@mms.org).

## PHYSICIAN HEALTH MATTERS

## Physicians May Be Included in the Ranks of High-Functioning Alcoholics

*Luke is a physician who limited his drinking to weekends during his internship year because of the rigorous schedule. Luke was chosen as the "best teaching resident" and was his medical school class president. He was slated to be the youngest chief of staff at the local hospital and received several professional accolades from physician-colleagues testifying to his high performance.*

Luke is an accomplished physician, but he is also a high-functioning alcoholic (HFA) — now in recovery. His story is not unlike those of other HFAs, people who can maintain their academic standing, career, and personal life while still drinking alcoholically.

Certain personality traits and tendencies allow HFAs, including physicians, to have both professional and personal successes. These traits include a meticulous work ethic, perfectionism, and a drive to overachieve and please other people. Many HFAs also have a competitive nature, "workaholic" tendencies, a strong physical constitution, and high standards of personal achievement.

### Characteristics of High-Functioning Alcoholics

A 2007 study by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) concluded that about 20 percent of alcoholics are "highly functional" and that only 9 percent are of the "chronic severe subtype" — the stereotype of the low-bottom alcoholic. Other addiction experts estimate that as many as 75 to 90 percent of alcoholics are high functioning. The characteristics of HFAs as they relate to physicians include, but are not limited to, the following:

**Denial.** Physicians often have difficulty viewing themselves as alcoholics because they don't fit the stereotypical image and because they are successful. Denial, present in most alcoholics, can be especially pronounced in physicians. Because physicians themselves are knowledgeable about illness and disease, they often believe they can "fix" themselves — increasing both their personal denial and the denial among their colleagues. The usual red flags of many more stereotypical alcoholics that are often recognized by an employer, loved one, therapist, or other health care provider may go unnoticed with HFA physicians because of their ability to hold their outside lives together.

**Drinking Habits.** Many HFAs use alcohol as a reward and/or justify drinking to

relieve stress. But one alcoholic drink sets off a craving, and HFAs often obsess about the next drinking opportunity. They also often display personality changes and/or compromise their usual morals when intoxicated. And they repeat unwanted drinking patterns and behaviors even if they have an inkling that their habits are problematic.

HFAs are often well-respected for job/academic performance, and many are able to maintain somewhat normal social lives. But although they appear to the outside world to be managing life well, they are skilled at living a compartmentalized life and are often adept at hiding their drinking from others.

Often by sheer luck, few HFAs experience significant tangible losses and consequences from their drinking. This reinforces the belief that because they have not lost everything, they have not hit bottom.

Physicians are accomplished professionals, and the very characteristics that so often contribute to their success — intelligence, hard work, and determination — often make them reluctant to ask for help. If physicians are unable to recognize or to seek and accept help for their own alcohol problems, they may not be able to properly treat patients with similar issues.

Therefore, it is crucial that physicians be honest with themselves. If they suspect they have an alcohol problem, they should reach out for help from a safe harbor such as Physician Health Services — for their own sake and that of their patients.

— Sarah Allen Benton, L.M.H.C.

*Author of Understanding the  
High-Functioning Alcoholic: Professional  
Views and Personal Insights*

For confidential alcohol screening, assessment, or referral to treatment, contact Physician Health Services at (781) 434-7404, (800) 322-2303, ext. 7404, or [www.physicianhealth.org](http://www.physicianhealth.org).

### Save the Date

### Managing Workplace Conflict: Improving Personal Effectiveness

**May 21 and 22, 8 a.m. to 4 p.m.**

MMS Headquarters, Waltham  
To register, call (800) 843-6356,  
or visit [www.massmed.org/cme\\_events](http://www.massmed.org/cme_events).



## ACROSS THE COMMONWEALTH

### District News and Events

**Barnstable — Spring Annual Meeting.** Tues., April 14, 6 p.m. Location: Coonamesett Inn, Falmouth. Speakers: Mario Motta, M.D., MMS president-elect, and Ms. Alex Calcagno, MMS director of federal relations. Fee: \$25 per person. For more information, contact the Southeast Regional Office.

**Berkshire — Annual Meeting.** Wed., April 15, 6 p.m. Location: Cork N' Hearth, Lee. Panel discussion focused on primary care. Speakers: Bruce S. Auerbach, M.D., MMS president; Barbra Rabson, executive director of Massachusetts Health Quality Partners; and Robert Jandl, M.D. **High School Doctor for a Day.** Wed., April 29, 7:30 a.m. orientation, 4:30 p.m. debriefing. Location: Berkshire Medical Center, Pittsfield. For more information, contact the West Central Regional Office.

**Bristol North & Plymouth — Joint Annual Spring Meeting.** Thurs., April 23, 6 p.m. Location: Fireside Grille, Middleboro. Speaker: Bruce S. Auerbach, M.D., MMS president. For more information, contact the Southeast Regional Office.

**Bristol South — Spring Annual Meeting.** Fri., May 1, 6 p.m. Location: New Bedford Whaling Museum, New Bedford. For more information, contact the Southeast Regional Office.

**Essex North/Essex South — Joint Annual Meeting.** Wed., April 1, 6 p.m. Location: Hawthorne Hotel, Salem. Speaker: Mario E. Motta, M.D., MMS president-elect. For more information, contact the Northeast Regional Office.

**Hampden — High School Doctor for a Day.** Thurs., April 2, 7:30 to 8:30 a.m. breakfast, 5 to 6:30 p.m. debriefing. **Annual Meeting.** Tues., April, 14, 6 p.m. Location: Delaney House, Holyoke. Speaker: Dr. Edward O'Neil, author of *Awakening Hippocrates: Global Health Inequality*. Jointly sponsored with Holyoke Medical Center. CME credit: 1 AMA PRA Category 1 Credit™ (RM). For more information, contact Suzanne Skibinski at (413) 736-0661 or hdms@massmed.org.

**Hampshire/Franklin — Joint Annual Meeting.** Wed., April 1, 6 p.m. Location: Monkey House, Amherst. Speakers: Jack Evjy, M.D., MMS medical affairs advisor, and Jackie Wolf, Ph.D. Topic: Single-Payer Health Care. For more information, contact the West Central Regional Office.

**Middlesex — Annual Meeting.** Sun., April 5, 12:45 p.m. Location: Fenway Park, Boston. For more information, contact the Northeast Regional Office.

**Middlesex North — Annual Meeting.** Wed., April 29, 6 p.m. Location: Vesper Country Club, Tyngsboro. Speaker: Representative from ProMutual. For more information, contact the Northeast Regional Office.

**Southeast Regional Caucus —** Mon., May 4, 6 p.m. Location: LeBaron Hills Country Club, Lakeville. Delegates from Barnstable, Bristol North, Bristol South, Norfolk South, and Plymouth districts will meet to discuss Annual Meeting resolutions. For more information, contact the Southeast Regional office.

**Worcester — Annual Meeting and Award Ceremony.** Wed., April 1, 5:30 p.m. Location: Beechwood Hotel, Worcester. For more information, contact Joyce Cariglia at (508) 753-1579.

**Worcester North — Annual Meeting.** Thurs., April 30, 6 p.m. Location: Chocksett Inn, Sterling. Guest Speaker: Bruce S. Auerbach, M.D., MMS president. Topic: MMS Update. 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.

## MMS to Sponsor Seventh Conference on Men's Health

The death rate for men far exceeds that of women in many disease areas — from cancer and cardiovascular disease to HIV/AIDS. Men are also disproportionately the victims of suicide, homicide, and motor vehicle accidents.

On June 10, the MMS Committee on Men's Health will present the 7th annual Symposium on Men's Health (see box). The symposium, entitled "Continuing Progress: New Gains, New Challenges," will address a wide array of topics related to the physical and mental health of men. These topics include the use of testosterone in men treated for prostate cancer, the prevention of chronic disease through diet, and sleep deprivation. **VS**



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### 7th Annual Symposium on Men's Health — Continuing Progress: New Gains, New Challenges

**June 10, 8 a.m.–3 p.m.**  
**MMS Headquarters, Waltham**

6.0 AMA PRA Category 1 Credits™ (RM)  
For more information and to register, call (800) 843-6356 or visit [www.massmed.org/cme/events](http://www.massmed.org/cme/events).

## Upcoming MMS Events of Note

### 4th Annual Poster Symposium for Residents, Fellows, and Medical Students

**Saturday, April 25, 10:00 a.m.–2:30 p.m.,**  
**MMS Headquarters, Waltham**

RSVP to Lindsay Pollard at [lpollard@mms.org](mailto:lpollard@mms.org) or (781) 434-7315.

### Career Development and Financial Planning Workshop for Young Physicians

**Saturday, May 2, 9:00 a.m.–12:00 p.m.,**  
**MMS Headquarters, Waltham**

Free to MMS members

Sponsored by the Committee on Young Physicians

Subject to demand, childcare will be available for a small fee to those who register by April 29.

RSVP to Lindsay Pollard at [lpollard@mms.org](mailto:lpollard@mms.org) or (781) 434-7315.

### Reception to Honor Women in Medicine

**Thursday, May 7, 7:00 p.m.,**  
**Seaport Hotel and World Trade Center, Boston**

All are invited to join the MMS Committee on Women in Medicine at a reception to honor the 125th anniversary of the first woman physician member of the Massachusetts Medical Society.



## MASSACHUSETTS MEDICAL SOCIETY

EVERY PHYSICIAN MATTERS, EACH PATIENT COUNTS.

### WHAT'S ON THE WEB?

#### ► Physician Payment Reform

Stay up to date on how your practice will be affected.

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

#### ► Student Grants, Loans, and Scholarships

Browse a comprehensive list of what's available to medical students in Massachusetts.

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

#### ► Keep Up with Daily Medical News

Daily news feeds on developments in clinical medicine

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

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

### Payment Reform

*continued from page 2*

Capitation critics have long claimed that this system discourages physicians from accepting sicker patients and encourages underuse of appropriate services. When certain patients require more services, doctors have to decide how to adjust levels of care for their remaining patients to stay within prepayments.

In blended capitation models, basic capitation is combined with add-ons. The Blue Cross Blue Shield Alternative Quality Contract is a risk-adjusted capitation model blended with a performance-based bonus.

### Medical Home

The medical home is a system of health care delivery that is accompanied by an alternative payment model. Patients in a medical home receive accessible, continuous, coordinated, and comprehensive patient-centered care managed by a primary care physician. The physician's role is not insurance-company gatekeeper but rather patient advocate and care coordinator.

Medical home practices strive to improve patient access through open scheduling, expanded hours, and improved communication among patients, their personal physicians, and medical home staff.

Payment in a medical home model often involves a global payment for primary care services, including care coordination, coupled with a fee-for-service payment for required services not normally associated with primary care. Some medical homes build in extra reimbursement for achieving measurable and continuous quality improvements, including health IT implementation.

### Pay for Performance (P4P)

This model (or add-on to other models) rewards physicians for meeting pre-set targets for delivering health care services or for improving care by meeting established standards. The P4P movement began with primary care but has begun to include specialists as well. Medicare's current bonus program for e-prescribing is an example of P4P.

Experience up until now shows that pay for performance works best in promoting behavioral change for a small set of carefully selected measures known to have a direct impact on outcomes.

P4P programs that are too narrowly focused may entice providers to focus more on achieving a few quality measures while paying less attention to non-measured but important aspects of care. Evidence that these programs improve quality and save money remains modest.

According to Elliott Fisher, director of the Center for Health Policy Research at Dartmouth, performance-based systems must evolve from technical quality measures to health outcome and patient experience measures. **VS**

## In Memoriam

The following deaths of MMS members were reported to the Society in February and March 2009. We also note member deaths on the MMS website at [www.massmed.org/memoriam](http://www.massmed.org/memoriam).

**George H. Carter, M.D.**, 92; Duxbury, MA; Harvard Medical School, 1943; died February 23, 2009.

**John H. Fisher, M.D.**, 87; Marshfield, MA; Harvard Medical School, 1946; died February 4, 2009.

**Frank H. Healey Jr., M.D.**, 83; Marblehead, MA; Tufts University School of Medicine, 1951; died February 19, 2009.

**Martin Nissel, M.D.**, 87; Eugene, OR; New York Medical College, 1944; died January 28, 2009.

**Peter E. Sifneos, M.D.**, 88; Belmont, MA; Harvard Medical School, 1946; died December 9, 2008.

**Bruce B. Stoler, M.D.**, 81; Longmeadow, MA; Harvard Medical School, 1954; died February 27, 2009.

**Richard Wolff, M.D.**, 85; Brookline, MA; Harvard Medical School, 1950; died February 14, 2009.

## 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).

#### 5th Annual Public Health Leadership Forum: The Cost of Violence

April 29, 8:00 a.m.–12:30 p.m.

MMS Headquarters, Waltham

Jointly sponsored by the MMS and the Harvard School of Public Health Division of Public Health Practice.

4.0 Credits (RM)

#### 2009 Annual Meeting Ethics Forum: Racial and Ethnic Disparities in Care

May 7, 3:30–5:30 p.m.

Seaport Hotel, Boston.

Sponsored by the MMS and its Committee on Ethics and Grievances.

2.0 Credits (RM)

#### 2009 Annual Education Program — To Age or Not to Age: Health and Wellness for Physicians and Patients

May 9, 8:00 a.m.–12:00 p.m.

Seaport Hotel, Boston.

Sponsored by the MMS and its Committee on Medical Education.

3.5 Credits

#### 2009 Shattuck Luncheon and Lecture — The Hypertension Paradox: Remarkable Advances in Therapy

May 9, 12:30–2:00 p.m.

Seaport Hotel, Boston.

Sponsored by the MMS and the *New England Journal of Medicine*.

1.0 Credit

#### Managing Workplace Conflict

May 21, 8:00 a.m.–4:00 p.m.

May 22, 8:00 a.m.–3:00 p.m.

MMS Headquarters, Waltham.

Jointly sponsored by the MMS and Physician Health Services.

12.5 Credits (RM)

#### Pioneering Women Physicians of the Past and Present: What's Been Accomplished and What Lies Ahead

June 24, 6:30–8:00 p.m. MMS

Headquarters, Waltham. Sponsored by the MMS and its Committee on Women in Medicine.

1.5 Credits

### Online CME Activities

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

*Massachusetts Medical Law Report Quarterly Risk Management CME Series*

#### MinuteClinics Raise Round-the-Clock Risks

1.0 Credit (RM)

#### How to E-mail Patients without Worrying about Liability

1.0 Credit (RM)

#### Reducing Errors and Liability in Patient Handoffs

1.0 Credit (RM)

#### A New Kind of Bedside Manner: The Rise of Apology Policies

1.0 Credit (RM)

*Preparedness Risk Management CME Series*

#### Pandemic Flu: Practical Information and Strategies for Preparedness

2.0 Credits (RM)

#### Know the Response: Disaster Management and Communication for the Health Care Provider

3.0 Credits (RM)

#### More E-Prescribing Courses

#### Electronic Prescribing Education

2.5 Credits (RM)

#### National E-Prescribing Conference (15 courses) 1 or 2 Credits each

### Save the Date

**June 10 — 7th Annual Men's Health Symposium — Continuing Progress: New Gains, New Challenges**

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.