

VITAL SIGNS



MASSACHUSETTS
MEDICAL SOCIETY

*Every physician matters,
each patient counts.*

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Fledgling Reform Plans Hold Promise for Physicians

BY TOM WALSH

Washington is abuzz with health care reform plans proposed by President-Elect Barack Obama during his campaign and, more recently, by Sen. Max Baucus (D-Montana). Both plans would address issues important to physicians, such as inadequate reimbursement and professional liability reform.

But the plans also diverge on several important issues. For example, the Obama plan would mandate coverage only for children, while the Baucus plan, like Massachusetts at the state level, would require all Americans to be insured.

Meanwhile, Sen. Edward M. Kennedy is also fashioning a health care reform package for introduction in January (see related article on page 5). With the nation's economic struggles ranking as everyone's number-one issue, the question is how high health care reform will be on Washington's priority list.

Is Now the Time?

"We are in the best time to have health care reform that we have seen in my lifetime," Stuart H. Altman, the Brandeis University professor who serves as a health care adviser to Barack Obama, told a New England Society for Health Care Strategy forum shortly after the November election. "But I think it needs to be done fairly quickly." Dr. Altman added that he believes the president-elect is focused on physician

issues as an important aspect of health care reform.

Another forum presenter, Beatrice Grause, president and CEO of the Vermont Association of Hospitals, did not share Dr. Altman's optimism. "There are cold hard facts," she said. "The big one is that there is no money, and certainly health care is a big driver of the federal budget and state budgets."

Plans Target Physician Concerns

Political operatives agree that whatever eventually emerges on health care reform will differ from any of the plans in process. But physician reimbursement is likely to be addressed.

President-Elect Obama told the American Academy of Family Physicians (AAFP) that "any serious proposal to reform this nation's health care system must prioritize fair and reasonable payment to doctors to ensure access to high-quality care for seniors."

In his recently released 89-page health care reform "Call to Action," Sen. Baucus,

the Senate Finance Committee chair, said, "Movement toward quality-based payment must start with fixing the unstable and unsustainable Medicare physician payment formula."

Specialist Reimbursements Could Drop

In his comments to the AAFP, President-Elect Obama said to bolster the ranks of the primary care workforce, his plan

Plans Align with MMS Advocacy

Both the Obama and Baucus reform proposals support changes long fought for by the MMS and its 20,000-plus members:

- Scrapping the current Medicare sustainable growth rate (SGR) reimbursement formula
- Strengthening the nation's corps of primary care physicians
- Supporting and promoting the advanced medical home
- Providing incentives for doctors to adopt electronic health records
- Revamping the nation's medical liability system

MMS Study Puts \$1.4 Billion Price Tag on Defensive Medicine in Massachusetts

BY TOM WALSH

As Massachusetts continues trying to keep up with the rising cost of its widely acclaimed health care reform program, a first-of-its-kind study by the MMS reveals that most of the state's doctors practice defensive medicine for fear of malpractice lawsuits — at a cost to the state's health care system of more than \$1.4 billion a year.

"This survey clearly shows that the fear of... being sued is driving physicians to defensive medicine and dramatically in-

creasing health care costs," said Manish K. Sethi, M.D., one of the study's lead researchers and a member of the MMS Board of Trustees and its Committee on Professional Liability. "This poses a critical issue, as soaring costs are the biggest threat to the success of Massachusetts health reform efforts."

The "Investigation of Defensive Medicine in Massachusetts" is the first survey to directly link defensive-medicine practices with Medicare cost data. The survey is also believed to be one of the largest

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2008 Interim Meeting



Photos by Doug Bradshaw

House Speaker Lee Perrin, M.D., and Vice Speaker Richard Pieters, M.D., (inset) presided over this year's MMS Interim Meeting in November. The House of Delegates adopted positions on retail clinics, primary care, and adverse events. For more details, go to www.massmed.org/2008InterimNews.

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PRESIDENT'S MESSAGE



Why — and How — Physicians Must Lead Health Care Reform

Cost has commandeered the spotlight among the many urgent health care concerns we face. Therein lies a compelling reason why physicians must take a leadership role in fixing the system: While the actual fees paid to physicians consume only a small percentage of the health care dollar, what we order and recommend drives a very large percentage of total health care costs.

Another reason physicians must lead is that we know what an efficient, equitable health care system should look like. No other group of stakeholders has the daily interaction with patients and the system and the professional training to identify where waste is and how to eliminate it.

Furthermore, everyone is looking to us to lead the change to help create a system that meets the Institute of Medicine's criteria — one that's safe, effective, patient-centered, timely, efficient, and equitable.

Even the health plans are clamoring for physician leadership. At our State of the State's Health Care Conference in October, Cleve Killingsworth, chair and CEO of Blue Cross Blue Shield of Massachusetts, said, "I invite the Medical Society to talk with us about what needs to be done to reduce errors and eliminate waste. Blue Cross will do its part to carry out the plan."

The "hows" of leadership begin with the words we use to discuss reform and the actions we take to support it. Both must be totally patient-centered. We must

place an effective, sustainable health care system that meets patient needs ahead of our own personal desires.

Physician leadership is also about doctors collecting and disseminating important data and educating people with it. Our recent report on defensive medicine practices (see article on page 1) shows that it is possible to create a system where quality goes up and errors go down, where patients are compensated quickly and fairly, when appropriate, and where physicians don't order tests or procedures solely to establish a defensible position just in case something goes wrong.

Physician leadership also entails fighting for access to crucial data from other health care system stakeholders that will help us contribute even more meaningfully to cost-containment conversations. Many physicians don't know the true cost of most of the tests they order. If the stakeholders that possess that information were more open with it — if true transparency existed — physicians could make decisions that are both patient-centered and cost-conscious.

Our Society will continue to lead the remaking of the health care system by convening all the players and breaking down barriers between them. Stakeholders enthusiastically come to our headquarters not only for its first-class meeting facilities, but also because we've created an environment where effective collaboration and negotiation are possible.

— Bruce S. Auerbach, M.D.

Federal Health Care Reform

continued from page 1

would "expand funding — including loan repayment, adequate reimbursement, grants for training curricula, and infrastructure support to improve working conditions." The Baucus plan would strengthen primary care by "ensuring accurate prices for primary care services in Medicare and by providing an add-on bonus payment for primary care services." Both plans would also rely on new systemic efficiencies and curbing waste to help pay for the reforms.

But according to Sen. Baucus, paying for higher primary care payments must be "budget-neutral." The senator's plan says that "any increase to primary care providers requires a corresponding cut to specialist services."

While conceding that such a strategy would be controversial, Sen. Baucus adds that "any reforms along these lines must be crafted in collaboration with the entire physician community and other practitioners."

The MMS, while working hard to revitalize primary care, insists that effective health care reform will not be achieved if one aspect of medical practice is fixed at the expense of another.

"There is an emerging crisis in primary care," said MMS President Bruce S. Auerbach, M.D. "But our annual workforce study showed that the two primary care specialties are only 2 of 12 that are under stress in Massachusetts. A strategy targeting only primary care will fail. We need systemwide reforms that make the best overall use of resources."

Plans Embrace Medical Home Idea

Reimbursement reform is seen as central to implementing the patient-centered medical home concept. The concept, according to the AAFP, involves transforming the traditional doctor's office into the central point to coordinate patients' overall health care. Both the Obama and Baucus plans embrace this concept.

The president-elect told the AAFP he would "encourage and provide appropriate payment for providers who implement the medical home model, including physician-directed, interdisciplinary teams," and that he would support care coordination programs that will help improve care for those with chronic conditions.

The Baucus plan would expand Medicare's role in piloting medical homes. "Providers seeking to participate in a Medicare medical home expansion program should meet a set of stringent ser-

vice and capacity criteria in order to qualify and be willing to have additional payments based in part on the quality of care they deliver," the senator's plan says.

Health IT Grants Eyed

Under the Obama plan, the federal government would invest \$10 billion each year for five years "to promote broad adoption of standards-based electronic health information systems, including electronic health records." The plan would give priority support to small practices and those serving rural and underserved populations.

The Baucus plan specifies a combination of "direct grants, loans, and financial incentives provided through Medicare pay-for-performance initiatives to promote adoption of health IT."

Malpractice Reform Proposed

Both plans also include proposals to revamp the current professional liability landscape.

The president-elect told the AAFP that he opposes caps on jury awards for medical malpractice because they "do not reduce insurance rates and they limit the rights of patients." However, he pledged an effort to strengthen antitrust laws to prevent insurers from overcharging physicians for malpractice insurance.

He said he will also promote new models for addressing physician errors that improve patient safety, strengthen the doctor-patient relationship, and reduce the need for malpractice suits.

The Baucus plan would support the Fair and Reliable Medical Justice Act, which seeks to "ensure safe and effective medical care while working to limit malpractice insurance premiums." The bill would provide grants to states to develop alternatives to current tort litigation, such as early disclosure and compensation, administrative determination of compensation, and health courts. The MMS strongly supports such sensible alternatives to the tort system.

With high stakes in the outcome, physicians and their patients will watch the legislative action closely. Dr. Auerbach assured attendees at the New England Society for Health Care Strategy forum that the physician community stands ready to take a leading role. "No stakeholder is more aware of the problems in health care than physicians," he said. "We experience its strengths and weaknesses every day. Physicians are ready to step up and participate in these discussions to help our health care system into a new era." **VS**

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Get to Know the Organization behind Health IT Standards

The focus on electronic health records, health information exchanges, and clinical data repositories is intensifying for a variety of reasons, including legislative impetus, IT-related incentives for physicians, and a new emphasis on data aggregation. In today's health care climate, it is important to have a general understanding of how the standards for these technologies are shaped behind the scenes.

One organization central to the process is the Health Information Technology Standards Panel (HITSP). HITSP was created in 2005 from a vision of widespread adoption of interoperable electronic health records. The panel is a cooperative public-private partnership that was formed to harmonize and integrate standards to meet the needs of business and clinical entities that share information. The ultimate goal is to foster better and more efficient health care while maintaining privacy and security standards.

HITSP is a truly transparent organization. Membership and participation are open to anyone who wants to contribute, and work products are widely published for review and comment. HITSP members comprise four primary groups: standards developing organizations (SDOs), non-SDOs, government bodies, and consumer groups. The panel's work is guided by priorities issued by the American Health Information Community (a federal advisory body) and administered by the American National Standards Institute.

An example of HITSP's work is Interoperability Specification 03 (IS-03), nicknamed the "consumer empowerment" standard, which defines parameters for data exchange between patients and caregivers. IS-03's intent is to reduce medical errors and unnecessary duplication of treatment. Its specific goals are as follows:

- Provide medical status and patient data to the provider at the point of care
- Alert caregivers to possible drug interactions
- Help patients and clinicians locate test results, medical histories, and prescription data
- Indicate to providers if other physicians have information on a patient
- Reduce redundant collection of demographic and basic health information
- Promote active consumer involvement in health care management

As HITSP continues to issue and refine standards — and as electronic methods of tracking health data proliferate on both the payer and provider sides — all health care providers will be increasingly affected. While it may not be necessary to track HITSP's every move, it is worth being aware of the panel's organizational objectives and ensuring that physicians remain well represented, as they are currently by virtue of the medical degree status of HITSP's chair and vice chair. **VS**

— Adam Shlager

For more information, go to www.hitsp.org.

Implementing ICD-10 by 2011 Will Be Daunting

More than 10 years ago, it became clear that the current system of classifying diagnoses would become woefully inadequate. The coding scheme now in place, called ICD-9, contains approximately 27,000 codes to distinguish various diagnoses made during an exam.

The first revision occurred when the original four-digit ICD-9 codes (000.0) were expanded to five digits (000.00), resulting in greater diagnostic specificity. Implementing even this minor change posed various challenges for practices. It involved everything from redesigning encounter forms (or superbills) to updating practice management systems and providing additional training for billing staff and physicians.



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ICD-10, when implemented, will pose even greater challenges. It increases the number of diagnostic codes to a whopping 150,000 or so — codes that already exist, but have not yet been implemented. This difference alone will necessitate major overhauls of both medical practices and the insurance industry. In spite of this, the U.S. Department of Health and Human Services (HHS) has issued a rule requiring adoption of ICD-10 by October 2011.

With that deadline looming, the Medical Group Management Association, the American Medical Association, and America's Health Insurance Plans have all stated that three years is simply not enough time to allow for the investment in necessary systemic changes. By one es-

timate, a 10-doctor group would incur approximately \$285,000 in transition expenses. A 3-physician group might spend as much as \$83,000.

The American Health Information Management Association (AHIMA) initially supported the HHS timeline, claiming the deadline was feasible. At that time, AHIMA noted that the cost to maintain a set of codes that had never

been used was hard to justify. The American Hospital Association also backed the original timeline, but AHIMA later backed off, and requested an additional year to make the transition.

While all of that is being debated, what can you do in your practice to make sure you're ready? First, check now with all your vendors to make sure they are prepared

for the transition, whenever it may occur. If you use a billing company, ask for a statement of progress on the ICD-10 transition and a timeline for their plans. If you have a practice management or electronic health record system, ask the vendor for a similar statement and timeline. Be wary of vague answers that merely suggest vendors will be ready at the point of transition. You rely on these systems to keep your revenue cycle tight and deserve more evidence of preparedness than a promise that they will work when they are supposed to.

Finally, make sure your practice's physicians and billing staff receive ICD-10 training so they can help facilitate what could be a difficult process. **VS**

— Adam Shlager

Reining in Labor Costs: Incremental Steps Can Ease the Pain

Labor costs are generally the largest expense a practice carries. Expenses associated with actual salaries, such as benefits, state and federal taxes, and unemployment insurance, add to this burden.

Yet labor costs are often undermanaged in many medical practices, especially in small practices, where a family-like culture may make the imposition of structure feel unnatural. Even in larger practices where attention is paid to the "bucket" of labor expenses, there may be insufficient analysis of supporting, incremental, or allocated costs.

Regardless of the size of your practice, some degree of labor-cost management

will help you control this potentially overwhelming expense. The following incremental steps will help — and your staff's response to them will allow you to determine how much cost control you want to impose on the practice's culture.

Create job descriptions. Make sure staff are operating within the purview of their positions and their qualifications. When analyzing labor costs, allocate expenses to administrative staff or clinical staff for a more accurate picture of operations.

Watch overtime closely. Too much overtime is expensive, and productivity will likely drop. Reassess staffing levels at least annually.

Implement a time-management structure. Often in medical practices, employees show up and leave at will. The assumption is that if the practice is open and the employees are working, they must be working a 40-hour week. Consider using a simple spreadsheet-based timesheet for each employee to accurately record time and track expenses.

Track time off, as well. Again, a simple spreadsheet can help you monitor these expenses more accurately. Examples of both of these tools can be found at www.massmed.org/timecalculator and www.massmed.org/leavecalculator.

You should also examine your benefits package annually. Few practices can afford to provide a full palette of benefits, and some are being forced to make difficult choices in this area that require employees to bear more of the costs.

But before you make any changes, examine the culture of your practice. Determine how stringent you're willing to be and how much "reining in" your staff will tolerate. Thoughtful decision making about these expenses may help you avoid conflicts later by creating a clear understanding at the outset. **VS**

— Adam Shlager

State Budget Cuts Affect Public Health Programs

This fall, Gov. Deval Patrick announced significant cuts in the state budget to overcome an anticipated \$1.4 billion deficit resulting from the economic downturn.

While health care does not appear to be disproportionately affected overall, the state Department of Public Health (DPH) was hit with cuts totaling \$28.1 million — approximately 4.75 percent of its appropriation. Those cuts will eliminate most of the \$40.4 million increase the DPH had secured for the 2009 budget and will result in staffing and program reductions across the board.

DPH Cuts Vaccines

Six million dollars was cut from the immunization program, which represents 11 percent of the state's vaccine budget. In response, the DPH announced that the state will no longer supply most adult vaccines to private providers and will sharply reduce the amount of vaccine it provides for adults seen in public settings.

Private providers who normally obtained vaccine from the state for hepatitis A and B, MMR, pneumococcus, polio,

and varicella must now buy it from private sources. Flu and tetanus-diphtheria vaccines are not affected by the cuts.

In addition, beginning July 1, 2009, the DPH will supply rotavirus vaccine only to children eligible for the federal Vaccines for Children program.

The DPH is urging health plans to reimburse providers for these formerly state-supplied vaccines.

Other Programs Also Affected

Cuts totaling more than \$18 million were also made to other health programs, including substance abuse services, public health hospitals, family health services, HIV/AIDS programs, and health promotion and disease prevention initiatives.

Also hit hard were smaller programs, such as those for pediatric palliative care, dental health, and teen pregnancy prevention. In addition, all the boards of registration operating under the aegis of the DPH, including the Board of Registration in Medicine, were cut by 10 percent. **VS**

2009 Anti-Tobacco Poster Contest Under Way

The MMS and the MMS Alliance are now seeking entries for the 2009 Anti-Tobacco Poster Contest.

Youngsters in grades one through six throughout Massachusetts are invited to create an original poster that depicts the theme for their grade level:

- Grades 1 and 2: Tobacco Is Bad for Your Body
- Grades 3 and 4: Tobacco Affects Other People
- Grades 5 and 6: Why I Won't Start Smoking

Contest kits were mailed to pediatricians and general and family practitioners, as well as all public, private, and charter elementary schools in Massachusetts. Detailed submission information is

also available on the MMS website (www.massmed.org/tobacco), where you will find additional resources about smoking and tobacco dangers.

All entries must be received by February 13, 2009.

Four winning posters will be selected in each grade category. Each winner will receive a \$50 gift certificate and will be honored at a State House ceremony in the spring. In addition, winning posters will be posted on the MMS website and will appear in a Society-published full-color calendar. **VS**

— Candace Savage

For more details about the contest or additional information about smoking and tobacco, e-mail dph@mms.org.

Foundation Letters of Inquiry Due Jan. 15

The MMS and Alliance Charitable Foundation seeks letters of inquiry for its next round of grantmaking.

Last year, the Foundation awarded \$122,500 to 10 grantee organizations that address issues such as violence, mental health, and access to primary care.

Letters of inquiry are due on January 15. Grant decisions will be made in April. **VS**

For more information, visit www.mmsfoundation.org, or contact Jennifer Day at (781) 434-7044.

Maintaining Healthy Holiday-Season Weight

Coinciding with the caloric challenges the holidays present, the December *Physician Focus* TV program spotlighted healthy nutrition and physical activity. Denise Rollinson, M.D., R.D., chair of the MMS Committee on Nutrition and Physical Activity, appeared on the program with Ed Saltzman, M.D., former chair of the committee and chief of the Division of Clinical Nutrition at Tufts Medical Center. The show, co-produced by the MMS and HCAM-TV of Hopkinton, was distributed to public access TV stations across Massachusetts.

"The monthly holiday celebrations with high-calorie foods, combined with fewer daylight hours and colder weather, make it hard to control caloric intake and caloric expenditure," Dr. Rollinson told *Vital Signs*. So we asked her for some specific tips for staying healthy during the holidays and starting the New Year off on the right foot.

Healthy Holiday Habits

Pay attention to what you consume. You'll gain one pound in a month by eating just 100 additional calories a day. Foods typically available during the holidays will quickly put you over that threshold: one cup of eggnog has 343 calories; two donut holes have 150 calories; and just four of those festively foil-wrapped chocolate kisses account for more than 100 calories.

In the face of these temptations, Dr. Rollinson recommends the following:

- Don't deprive yourself, but do have a game plan each morning of what you're going to eat.
- Take advantage of winter fruit such as oranges and clementines.
- Choose healthy snacks such as air-popped popcorn and nuts in the shell.



Photo by Rick Gulla

Denise Rollinson, M.D., R.D., and Ed Saltzman, M.D., (seated) discussed nutrition and health on the MMS *Physician Focus* TV program with host Bruce Karlin, M.D. (standing).

On the calorie-expenditure side, fewer daylight hours and colder weather can discourage you from getting exercise. Dr. Rollinson suggests finding creative ways to get at least 30 minutes of exercise each day:

- Plan fun seasonal activities such as ice skating or sledding.
- Incorporate activity into your daily routine — take the stairs, and park a bit farther away from your destination.
- Plan indoor physical activity, such as walking on the treadmill or at the mall.
- Get outdoor exercise early in the day if early-evening darkness tends to discourage you.
- Take advantage of special offers on gym memberships and other physical activity discounts. A 10-week yoga class can keep you active through much of the winter. These make great gifts, too! **VS**

WEBSITE OF THE MONTH

Tools to Help Your Patients Track Calories

Most people *think* they take in about 25 percent fewer calories than they actually do. The MMS Committee on Nutrition and Physical Activity recommends that patients track their calorie consumption with an Internet-based food log. Using fee-based or free websites, including the U.S. Department of Agriculture's website at www.mypyramidtracker.gov, patients can determine calories and nutritional value by looking up foods consumed, from potato pancakes to champagne. A physical activity section also allows patients to track calories burned. The website also directs users to additional information about diet, physical activity, and health.

STATE UPDATE

MMS Prioritizes Practice Environment on Beacon Hill

As the last legislative session ended, there was a growing consensus on Beacon Hill that the practice environment in Massachusetts made it difficult to recruit and retain physicians. As a result, legislation was enacted with the support of the MMS that sought to strengthen the physician practice environment with workforce incentives, a review of payment practices, and standardization of coding and claims (see *Vital Signs*, September 2008, page 5).

Nonetheless, the problem is far from being solved. In addition to preserving last session's gains, the Society is planning to file legislation during the 2009–2010 legislative session to address other factors that affect the practice environment:

- **Professional Liability:** The MMS is filing five bills directly aimed at reducing the cost of professional liability insurance. The recently published MMS study on “defensive medicine” (see article on page 1) cites a minimum of \$1.4 billion in health care costs annu-

ally attributable to our current liability system. Given the Legislature's need to contain health care costs, we believe lawmakers should be more willing to entertain new solutions in this area. One of our bills would promote the “timely notice” and “apology” initiatives that have proven so successful elsewhere in reducing litigation, while fairly compensating injured patients and promoting patient safety. The other measures would focus on regulating expert witnesses and reducing pre-judgment interest rates.

- **Quality Measures:** Last year, the MMS sued the Group Insurance Commission (GIC) and various insurers regarding the GIC's initiative that tiered physicians on the basis of purported measures of quality. This session, the MMS will maintain its efforts both in the courthouse and at the State House by filing legislation that would limit how “quality measures” can be used by the GIC and insurers.

- **Contracting Concerns:** The MMS will file legislation to level the playing field between physicians and payers. One bill will be filed in the area of antitrust reform; another will address an array of managed care contracting standards, while a third would eliminate many of the administrative hassles burdening physicians in the Medicaid program.

The Society will be filing other bills, as well, on topics relating to credentialing, hospital medical staffs, peer review, sharing of prescription data, and the sale of tobacco products at pharmacies and other health care venues. In addition, the MMS will continue to work with broad-based coalitions in advocacy on issues related to expanding health care access and improving public health and safety. Members will be able to view the legislation and track its progress on the MMS website at www.massmed.org. VS

— Stephen Shestakofsky

FEDERAL UPDATE

Federal Health Care Reform: So Close, Yet So Far

With the country expecting significant health care reform, the 111th Congress, now in session, and the Obama Administration, set to take office on January 20, are faced with an extraordinary opportunity — and a formidable challenge.

President-Elect Obama made health care a key issue during his campaign, and health care still ranks high among the electorate's list of key issues, even as the economy sours. In fact, if more Americans lose their jobs — and their health insurance — an even stronger case can be made for comprehensive reform.

Both the new Congress and President will undoubtedly take lessons from the Clinton Administration's failed efforts with health care reform. Two of the most emphatic lessons are clear: a total overhaul of the system is probably more than the country can tolerate, and edicts that emanate from the White House without sufficient Congressional and interest-group involvement are doomed to the political graveyard.

Leading the charge for comprehensive reform is Massachusetts Sen. Edward Kennedy, chair of the Senate Committee

on Health, Education, Labor, and Pensions, who has already begun bipartisan meetings to frame reform proposals that address expanded coverage and quality.

At the same time, committees in the House and Senate with jurisdiction over health care financing are drafting proposals to change the structure and delivery of health care (see related story on page 1). Meanwhile, Pete Stark (D-CA), chair of the House Ways and Means Subcommittee on Health, will be leading Medicare reform efforts. A centerpiece of his proposal is to give physicians significant financial incentives to invest in electronic health record technology.

There's also significant momentum for permanently changing the physician Medicare payment formula. While the precise solution is not clear, the following premises are:

- Payment will not be based on volume, but rather on some assessment of cost-effectiveness and value.
- Payment for “silos” of care will be replaced by payment based on the patient's condition as a whole.
- The “medical home” model will be part of the mix.

The infrastructure and funding challenges in making such dramatic changes are daunting. One of the micro-level challenges is how to pay primary care and specialty physicians appropriately. If budget neutrality remains the rule, it will be difficult for Congress and the physician community to move beyond turf-based rhetoric.

On a more hopeful note, the new Congress and Administration will probably reauthorize and expand the State Children's Health Insurance Program (SCHIP). While it is unlikely that the Obama mandate for children will be enacted quickly, expansions to SCHIP will significantly reduce the number of uninsured children in the country.

At this point, it is impossible to forecast the prognosis for health care reform in the next session, especially in light of the deteriorating economy and the political power of groups that stand to lose if significant changes are made. Hopefully the stakeholders will keep in mind the cost to our society — both human and economic — if they fail to act. VS

— Alex. Calcagno

LEGISLATOR OF THE MONTH

Senator Cynthia Stone Creem (D)

District: Brookline, Newton, Wellesley (part)

Committees: Revenue (Chair); Public Health (Vice Chair); Senate Ways and Means; Judiciary; Bonding, Capital Expenditures, and State Assets; Telecommunication, Utilities, and Energy



QUOTE: I continue to advocate for health care legislation that benefits physicians and the general public. We have greatly increased the number of insured through health care reform. However, newly insured individuals are having difficulty finding a primary care doctor. The lack of physicians in internal medicine and family care is exacerbated by the high cost of malpractice insurance and by the debt load of recently graduated physicians, who increasingly locate in lower cost states. In response, my colleagues and I enacted a series of financial incentives and loan repayment options for primary care physicians.

Massachusetts is justifiably proud of its medical schools and highly regarded hospitals and medical services. This environment encourages job creation in related health, biotech, and pharmaceutical areas, benefiting all our residents. I have been a leader in promoting stem cell research and was very pleased that the Legislature and governor supported a life sciences economic stimulus package that promotes advanced biotech research.

We must also promote wellness initiatives to save both costs and lives. I have been working on legislation to increase restaurant employee awareness of issues concerning food allergies, and I am very supportive of efforts to combat obesity through better school nutrition and fitness for people of all ages.

Writing a CV that Leads to Interviews

Experts agree that an effective curriculum vitae (CV) has certain key characteristics. For example, according to the Colorado College Career Center, a well-written CV should conform to the five “Cs”:

- Clear — well organized and logical
- Concise — relevant and necessary
- Complete — includes everything you need
- Consistent — uniform style and font
- Current — up to date

Ideally, a CV should be between two and three pages long and should list experience in chronological order, from most current to least recent. The CV

should be printed on white or light-colored paper and should omit information irrelevant to the available position, such as hobbies. Such “extracurricular” information can be raised in the interview, if appropriate.

Most importantly, have your CV critiqued and proofed by a professional who is experienced in such matters. At the MMS Career Day/Job Fair in February, you will have an opportunity to meet one-on-one with such a professional. Space

is limited and available on a first-come, first-served basis. To register for an individual CV consultation, e-mail etally@mms.org, or call Erin Tally at (800) 322-2303, ext. 7413. **VS**

17th Annual Career Day/Job Fair
Saturday, February 7, 2009
9 a.m. to 1 p.m.
MMS Headquarters, Waltham
Co-sponsored by the MMS Resident and Fellow Section and the Committees on Young Physicians and Diversity in Medicine
 For more information or to register, e-mail etally@mms.org, or call Erin Tally at (800) 322-2303, ext. 7413.

How to Prescribe Exercise for Your Patients

The American College of Sports Medicine (ACSM) launched the “Exercise is Medicine” campaign last year with the goal of promoting the concept that exercise is medicine and encouraging physicians to write exercise prescriptions. An article in the November/December issue of *Fitness Magazine* (www.fitnessmagazine.com) quotes Robert Sallis, M.D., who was the ACSM president at the time the campaign was launched: “Working out is the

single most important thing you can do to live longer,” Dr. Sallis said. Directly below the quote is an image of a prescription pad that says, “Move your butt for thirty minutes 5 days a week.”

In medical school, we learn about exercise physiology and the benefits of exercise, but classes on prescribing exercise and motivating patients to exercise are not part of the routine curriculum. Many practicing physicians do not have the knowledge or skills to write an effective exercise prescription.

To help close that gap, the Institute of Lifestyle Medicine (ILM) — part of the Department of Physical Medicine and Rehabilitation at Spaulding Rehabilitation Hospital — joined forces with the

ACSM to help educate physicians about the exercise prescription.

A textbook due out in March titled *ACSM's Exercise is Medicine: A Clinician's Guide to Exercise Prescription*, by Steve Jonas, M.D., and Edward Phillips, M.D., will serve as a reference and learning tool for physicians.

The ILM is also providing lectures for physicians. You can hear mine, titled “The Exercise Prescription,” at the MMS's 4th Women's Cardiac Health Con-

ference on February 6, 2009 (see box).

The full-day conference will also feature David Katz, M.D., of Yale University School of Medicine, who will speak about nutrition, weight control, and chronic disease prevention. In addition, the American Heart Association (AHA), an event co-sponsor, will explain the personal health record.

“Exercise is Medicine” is an important campaign to help make physical activity a vital sign. Join the wellness revolution and prescribe exercise.

— Elizabeth Frates, M.D.

For more information about educational events from the ILM, go to www.institutelifestylemedicine.com.

4TH ANNUAL WOMEN'S CARDIAC HEALTH CONFERENCE
Heart Healthy Strategies to Empower Your Patients
Friday, February 6, 2009
8:00 a.m. to 3:15 p.m.
MMS Headquarters, Waltham
 5.5 AMA PRA Category 1 Credits™ (3.25 RM)
 To register, call (800) 843-6356, or visit www.massmed.org/cme/events.

PHYSICIAN HEALTH MATTERS

Survey Shows High Level of Satisfaction with Physician Health Services

Physician Health Services, Inc. (PHS) has conducted two surveys to assess the satisfaction of clients monitored by its program. The first, conducted in 1999, found that responding clients had generally high levels of satisfaction, and that satisfaction was significantly associated with successful outcomes and gender.

What remained unknown at that time, however, was how other stakeholders in physician health monitoring contracts perceived the PHS program. These other stakeholders include chiefs of service, workplace observers, psychiatrists, and therapists (hereafter collectively referred to as “monitors”).

The objective of the second survey, conducted in 2007, was to assess satisfaction among clients and monitors. PHS client monitors agree to report to PHS any evidence of noncompliance with the monitoring contract. Chiefs and observers additionally report on episodes of concerning behaviors or workplace problems, and they submit structured report forms every three months.

The prospective, observational study surveyed a cross-section of monitors and clients under contract between January 1, 1998, and March 31, 2006. The anonymous 19-item survey recorded demographics and assessed satisfaction with PHS on a four-point scale (1 = very dissatisfied; 4 = very satisfied) in the following realms:

- Career, personal recovery, and family life
- Staff courtesy/efficiency
- Contract and advocacy effectiveness
- Legal assistance
- Handling of relapse
- Sensitivity to women's issues

The response rate for the client survey was 48.1 percent, and 61.2 percent responded to the monitor survey. Overall, satisfaction was very high, but there were some significant differences between client and monitor ratings. Monitors were significantly more satisfied than clients with effects on career (mean for monitors was 3.44, versus 3.21 for clients). Monitors were also more satisfied than clients with monitoring of general health (3.50 for monitors versus 3.24 for clients) and sobriety/mental health (3.56 for monitors versus 3.35 for clients), but there were no significant

group differences in satisfaction with the contract for documenting recovery for third parties or facilitating client involvement in support groups.

Clients and monitors were equally satisfied with the way PHS handled relapse, compliance letters, and provision of legal information, but monitors were significantly more satisfied than clients with PHS's response to feedback (3.69 for monitors, versus 3.32 for clients).

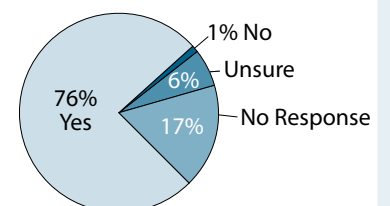
Client and monitor total satisfaction was high (89 percent of the total possible score for both), and total satisfaction was significantly associated with gender (men reported higher satisfaction than women) and type of monitoring contract (substance use contracts generally scored higher than mental/behavioral health contracts).

We concluded that satisfaction with the PHS program is high among both monitors and clients, but that PHS should explore new ways to meet the unique needs of women physicians. **VS**

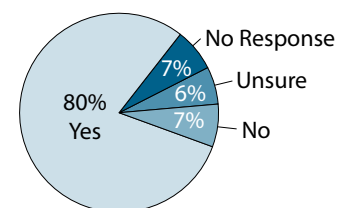
For more information about the survey or PHS, call (781) 434-7404 or go to www.physicianhealth.org.

Recommend PHS to a Colleague? (2007 Monitors vs. Clients)

Monitors: n=431



Clients: n=126



High satisfaction ratings for PHS services among clients and monitors are reflected in these would-you-recommend results.

ACROSS THE COMMONWEALTH

District News and Events

Charles River — District Meeting. Wed., Jan. 28, 6 p.m. Boston Marriott Newton Hotel. Speaker: Martin Samuels, M.D. Topic: Voodoo Death Revisited. For more information, contact the Northeast Regional Office.

Franklin — Social. Wed., Jan. 28, 6 p.m. Location: Hope and Olive Restaurant, Greenfield. For more information, contact the West Central Regional Office.

Hampden — Winter District Meeting. Tues., Jan. 20, 6:30 p.m. Location: Clarion Hotel and Conference Center, West Springfield. Title: An Evening with Dr. John B. Herman, M.D., chair, Board of Registration in Medicine. Eligible for 1 AMA PRA Category 1 Credit™. For more information, contact Suzanne Skibinski at (413) 736-0661 or hdms@massmed.org.

Hampshire — Executive Committee Meeting. Wed., Jan. 14, 6 p.m. Location: Zen Restaurant, Northampton. For more information, contact the West Central Regional Office.

Plymouth — Executive Committee Meeting. Wed., Jan. 28, 6 p.m. Location: Southeast Regional Office, Lakeville. For more information, contact the Southeast Regional Office.

Suffolk — District Meeting. Thurs., Jan. 22, 6 p.m. Location: Trustees Room, Bulfinch Building, MGH. Speaker: Jeffrey Drazen, M.D., editor-in-chief of the *New England Journal of Medicine*. For more information, contact the Northeast Regional Office.

Worcester — Retail-Based Health Clinic Forum. Wed., Jan. 21, 5:30 p.m. Location: Mechanics Hall, Worcester. This program will provide an overview of retail-based clinics and their potential impact on patient safety, physician practices, and the future of primary care. For more information, contact Joyce Cariglia at (508) 753-1579.

Statewide News and Events

Arts, History, Humanism, and Culture Member Interest Network — Creative Writing Contest. Deadline for submissions is January 15, 2009. **Poetry Workshop.** Sat., Jan. 17, 10 a.m. to 12 p.m. Location: Mechanics Hall, Worcester. 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.

In Memoriam

The following deaths of MMS members were reported to the Society in October, November, and December 2008. We also note member deaths on the MMS website at www.massmed.org/memoriam.

Raymond D. Adams, M.D., 97; Chestnut Hill, MA; Duke University School of Medicine, 1936; died October 18, 2008. **Andre Bell, M.D.**, 49; Florence, MA; Medical College of Pennsylvania, 1987; died October 20, 2008. **Warren Bennett, M.D.**, 84; Baltimore, MD; Harvard Medical School, 1947; died November 18, 2008. **Daniel H. Clancy Jr., M.D.**, 89; Wellesley, MA; Tufts University School of Medicine, 1943; died November 2, 2008. **Robert E. Clancy, M.D.**, 82; Hingham, MA; Tufts University School of Medicine, 1948; died November 21, 2008. **Franklin H. Epstein, M.D.**, 84; Brookline, MA; Yale University School of Medicine, 1947; died November 5, 2008. **David W. Fagell, M.D.**, 76; Lynnfield, MA; University of Vermont College of Medicine, 1958; died October 23, 2008. **Sydney R. Gordon, M.D.**, age unknown; Wayland, MA; Tufts University School of Medicine, 1937; died June 2008. **William B. Havey Jr., M.D.**, 88; Leominster, MA; Tufts University School of Medicine, 1951; died October 13, 2008. **William L. Jenney, M.D.**, 87; New Bedford, MA; Yale University School of Medicine, 1945; died November 22, 2007. **Henry H. Lerner, M.D.**, 98; Coral Gables, FL; Boston University School of Medicine, 1934; died October 28, 2008. **Anthony Lovell, M.D.**, 68; Longmeadow, MA; Yale University School of Medicine, 1967; died November 15, 2008. **Robert N. Lundberg, M.D.**, 89; Gloucester, MA; Cornell University Medical College, 1944; died November 18, 2008. **Edward S. Murphy, M.D.**, 88; Winchester, MA; Tufts University School of Medicine, 1944; died October 20, 2008. **John D. Nicholson, M.D.**, 84; Clinton, MA; Tufts University School of Medicine, 1953; died October 12, 2008. **Terence J. O'Toole, M.D.**, 70; Brockton, MA; University of Ottawa Faculty of Medicine, 1963; died October 18, 2008. **R. Anthony Pavone, M.D.**, 98; Los Angeles, CA; Tufts University School of Medicine, 1936; died July 10, 2008. **Henry Pendergrass, M.D.**, age unknown; Gladwyne, PA; University of Pennsylvania School of Medicine, 1952; date of death unknown. **Fawzi A. Pualwan, M.D.**, 82; Spencer, MA; Vanderbilt University School of Medicine, 1951; died November 15, 2008. **Julius B. Richmond, M.D.**, 91; Chestnut Hill, MA; University of Illinois College of Medicine, 1939; died July 27, 2008. **Daniel M. Swan, M.D.**, 98; Quincy, MA; University of Rochester School of Medicine, 1935; died November 8, 2008. **Herbert A. Tuck, M.D.**, age unknown; Fitchburg, MA; Tufts University School of Medicine, 1938; date of death unknown. **John E. Yelle, M.D.**, 89; Holyoke, MA; Boston University School of Medicine, 1945; died November 16, 2008.

AMA Interim Meeting Inspired by Life of Dr. Ron Davis

During a deeply emotional Interim Meeting opening session on Saturday, November 8, the AMA House of Delegates remembered the life of the association's immediate past president, Ronald M. Davis, M.D., who passed away earlier that week after a nine-month fight against pancreatic cancer. Physicians paid a final tribute to Dr. Davis, with Speaker Jeremy A. Lazarus, M.D., reading a letter that Dr. Davis wrote to the House before he died (www.ama-assn.org/ama1/pub/upload/mm/475/rondavis.pdf). Next, AMA board chair and MMS past president Joseph M. Heyman, M.D., introduced a poignant video tribute to Dr. Davis that included his stirring speech in June during the AMA Annual Meeting.

Later, AMA President Nancy H. Nielsen, M.D., Ph.D., urged physicians to continue to stand together despite the increased challenges the medical profession will face in the coming months — looming cuts to Medicare physician payments, a worsening economy, the rising rate of unemployment, and 46 million uninsured Americans. These are a few reasons the stakes have risen.

Dr. Nielsen pointed to cost as the central theme of the health care debate. "It is high time we do something about it," Dr. Nielsen said of the nation's broken health care system. That "something" she characterized as "fundamental change — for ourselves, for our patients, for our nation." Dr. Nielsen challenged physicians to advocate for comparative effectiveness research and to develop appropriate measures of care.

Dr. Nielsen also encouraged the physician community to return to the core values that brought them to medicine in the first place: serving humanity with humility, self-awareness, and a commitment to excellence. "I believe we can and should have the best health care system in the world," Dr. Nielsen concluded. "I believe that we have the talent and dedication to build that health care system. I believe we have the courage to do it now."

To read more about the 2008 AMA Interim Meeting, go to www.ama-assn.org/ama/pub/category/16552.html. **VS**

— Michele Boutin

Nominations for Senior Volunteer Physician of the Year Due Jan. 7

For the thirteenth time, this spring the MMS will honor a Senior Volunteer Physician of the Year. Candidates for this award are nominated by their peers and selected by the Committee on Senior Volunteer Physicians. The award recipient will be honored at the annual awards luncheon during the Society's Annual Meeting in May (see box below).

Eligible nominees must be MMS members 60 years of age or older who have

demonstrated a commitment to volunteerism and dedication to sharing their experience and medical expertise. The committee will consider volunteer activities conducted in Massachusetts only.

The deadline for submitting nominations is Wednesday, January 7, 2009.

To nominate a physician for this award, contact Erin Tally at (800) 322-2303, ext. 7413, or etally@mms.org. **VS**



SAVE THE DATE!

2009 MMS Annual Meeting

May 7–10, 2009

Seaport Hotel and World Trade Center, Boston

Thursday, May 7

- House of Delegates
- Annual Awards Luncheon
- Ethics Forum

Friday, May 8

- House of Delegates (continued)
- President's Reception and Dinner
- Member Art Exhibit

Saturday, May 9

- Annual Education Program
- Shattuck Lecture
- International Medical Graduates Reception
- Annual Banquet and Entertainment

More information to come!



MASSACHUSETTS MEDICAL SOCIETY

EVERY PHYSICIAN MATTERS, EACH PATIENT COUNTS.

WHAT'S ON THE WEB?

► State of the State Conference

Speakers include JudyAnn Bigby, M.D., Susan Dentzer, Elliott Fisher, and a panel discussion.

www.massmed.org/stateofstate08

► Post-Election Health Policy: Impact on Physicians

Slide presentation by MMS President Bruce Auerbach, M.D., at a recent meeting of New England Society of Health Care Strategy

www.massmed.org/forum

► Online Practice Calculators

The MMS Physician Practice Resource Center provides online tools for calculating employee time worked and employee leaves.

www.massmed.org/pprc

WWW.MASSMED.ORG

Defensive Medicine

continued from page 1

of its kind, with nearly 900 physicians in eight specialties (anesthesiology, emergency medicine, family medicine, internal medicine, general surgery, neurosurgery, orthopedics, and obstetrics/gynecology) taking part between November 2007 and April 2008.

Surveyed doctors were asked about their use of seven tests and procedures — plain film X-rays, CT scans, MRIs, ultrasounds, laboratory testing, specialty referrals and consultations, and hospital admissions. The results showed that 83 percent of those surveyed practiced defensive medicine — and that an average of 18 to 28 percent of all tests, procedures, referrals, and consultations were ordered for defensive reasons. Thirteen (13) percent of hospitalizations also resulted from defensive practices, the survey showed.

Nationwide, the study noted, “Some estimates report that the practice of defensive medicine costs the American health care system in excess of \$100 billion annually.”

Doctors Mistrust Liability System

“Physicians practice defensive medicine because they don’t trust the medical liability system,” said Alan Woodward, M.D., vice chair of the MMS Committee on Pro-

fessional Liability and a past MMS president. “This survey should provide a strong impetus for fundamental liability reform. Reducing defensive medicine in Massachusetts could dramatically reduce costs and at the same time improve patient safety, access to care, and quality of care.”

President-Elect Barack Obama and others who support health care reform nationally have said much the same thing and have offered proposals to revamp the professional liability system as part of their overall reform agendas (see related story on page 1).

Dr. Sethi and his fellow researcher, Robert H. Aseltine Jr., Ph.D., of the Institute for Public Health Research at the University of Connecticut Health Center, said they believe the actual cost of defensive medicine is “significantly higher” than their survey quantified. That’s largely because the survey did not include tests and diagnostic procedures ordered by physicians in other specialties or ask about certain other defensive medicine practices, such as ordering unnecessary prescriptions.

Beyond Cost to Access

In addition to the most obvious and costly practices already mentioned, a more subtle form of defensive medicine — physicians avoiding high-risk procedures

and/or high-risk patients — results in reduced patient access to care.

The MMS survey found that 38 percent of participating physicians reported they reduced the number of high-risk services they performed, with orthopedic surgeons (55 percent), obstetricians/gynecologists (54 percent), and general surgeons (48 percent) reporting the highest frequency of this. “Because of the malpractice environment, many specialists have closed their practices, stopped performing high-risk procedures, or reduced their care of high-risk patients,” Dr. Woodward said. “As a result, many smaller communities have little or no access to medical specialists.”

Dr. Woodward added that patient safety issues also arise because of defensive medicine. These include the risk of medically unnecessary radiation exposure and possible severe allergic reactions to contrast dyes used in diagnostic imaging. Also, the number of Caesarean births and the attendant risk of surgery-related complications have increased as a result of liability concerns.

To view the complete report, go to www.massmed.org/defensivemedicine. **VS**

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.

Live CME Activities

Go to www.massmed.org/cme/events.

2009 Health Policy Forum:

Physicians Effecting Change

January 30, 8:30 a.m.–5:30 p.m.

MMS headquarters, Waltham.

Jointly sponsored by the MMS and Brandeis University. 7.5 Credits (RM)

4th Annual Women’s Cardiac

Health Conference: Heart Healthy

Strategies to Empower Your Patients

February 6, 8:30 a.m.–3:15 p.m.

MMS headquarters, Waltham.

Sponsored by the MMS and its Committee on Women in Medicine, in collaboration with the American Heart Association and the Institute of Lifestyle Medicine.

5.5 Credits (3.25 RM)

Chronic Disease Management: Critical to the Quality and Cost Equation

March 6, 8:30 a.m.–12:30 p.m.

MMS headquarters, Waltham.

Sponsored by the MMS and the

New England Journal of Medicine.

4.25 Credits (RM)

Disaster and Primary Care:

How to Protect Your Patients

and Your Practice

March 31, 6:30–9:00 p.m. MMS

headquarters, Waltham. Sponsored

by the MMS in collaboration with

the Massachusetts Department of Public Health.

2.5 Credits (RM)

Online CME Activities

Go to www.massmed.org/cme.

NEW 15 Risk Management CME

Courses Developed from the

National E-Prescribing Conference

1 or 2 Credits. Go to www.massmed.org/cme/cms_eprescribing.

Massachusetts Medical Law Report

Quarterly Risk Management

CME Series

New E-Prescribing Regulations

Applauded by Doctors, Lawyers

1.0 Credit (RM)

NEW How to E-mail Patients without

Worrying about Liability

1.0 Credit (RM)

Reducing Errors in Patient Handoffs

1.0 Credit (RM)

Dealing with Difficult Patients

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)

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

Electronic Prescribing Education

2.5 Credits (RM)

Unmasking Depression in Primary

Care Practice

4.5 Credits (RM)

Save the Dates

March 12, 2009

E-Prescribing Conference

April 29, 2009

5th Annual Public Health

Leadership Forum

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.