What Does the Federal Sunshine Act Mean for Massachusetts Physicians?

Mass. Law and New Federal Act Have Similar Goals

**BY VICKI RITTERBAND**

The federal Physician Payments Sunshine Act has now been in effect for several months. What does it mean for the average Massachusetts physician?

Under the Sunshine Act, part of the Affordable Care Act, the news rules are as follows: manufacturers of drugs, devices, biologicals, or medical supplies that participate in federal health care programs must report to the Centers for Medicare and Medicaid Services (CMS) any payments or “transfers of value” to physicians. Those transfers include consulting and speaker fees, food, beverages, entertainment, travel, and lodging. Additionally, manufacturers and group purchasing organizations must disclose direct and indirect ownership and investment interests held by physicians and close family members. There are no gift bans or limits to the value of gifts that individuals can accept.

Exemptions to the federal reporting rule include educational materials and items used directly with patients; payments of less than $10 (unless the cumulative amount for an individual physician exceeds $100 per year); and samples intended for patient use. Manufacturers do not have to track items such as pens, notepads, or meals that are provided at large-scale events, so Massachusetts physicians will not see signs admonishing them to refrain from eating bagels — a common sight at conferences before the state’s 2008 gift ban and disclosure act was relaxed.

Physicians don’t have to do any reporting; however in January 2014, CMS will launch an online portal for physicians to sign up to receive alerts when their financial disclosures are ready for review and correction.

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**HIPAA Changes Now in Effect**

**Resources Available at www.massmed.org/HIPAA**

**BY LIZ ROVER BAILEY, ESQ.**

The final omnibus rule from Health and Human Services (HHS) implementing changes to the Health Insurance Portability and Accountability Act (HIPAA) became effective September 23, 2013. Please review the content below to confirm that you have done these things; if you have not, contact the MMS’s Physician Practice Resource Center or an attorney for help and guidance in achieving compliance. Such a process will include the following:

- You should have reviewed a list of your vendors and contractors to determine which ones are now considered business associates even if they were not before.

- The final rule broadened the definition of “business

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**BY ERICA NOONAN**

In the past 18 months, a new approach to handling adverse medical events has made strides in Massachusetts, with six pilot sites now participating in a program called Communication, Apology, and Resolution (CARe).

The program, based on an approach pioneered by the University of Michigan and formerly called Disclosure, Apology, and Offer (DA&O), continues to gain supporters, said Alan Woodward, M.D., past president of the MMS and chair of its Committee on Professional Liability.

The current system of handling medical malpractice cases — which take on average more than five years if the case has to wind through the court system — takes “a terrible toll” on both patients and providers, said Dr. Woodward.

The CARe approach involves four components: open and ongoing communication with the patient; investigation and safety system improvement; appropriate apology; and resolution, including offer of compensation, if warranted.

“If we are successful, it will indeed become the standard way that the next generation of clinicians approach patient safety and event resolution.”

— Kenneth Sands, M.D., Beth Israel Deaconess Medical Center

“All we are talking about is doing what is morally and ethically correct, and what you would want done if you or a family member was harmed,” Dr. Woodward said.

“A Culture of Secrecy”

Historically, Dr. Woodward said, physicians and health systems have worked under a system with “perverse incentives and forces, as well as a culture of secrecy and finger-pointing.” Change will take time.

“The current system created a culture of secrecy, so we failed to communicate and learn from our mistakes. That was counterproductive to our well-being as physicians,” Dr. Woodward said, pointing to escalated rates of divorce, depression, and suicide among physicians named in a malpractice lawsuit.

Using a 2010 grant from the Agency for Healthcare Research and Quality given to the MMS and Beth Israel Deaconess Medical Center (BIDMC), a wide variety of stakeholders — including physicians, hospital administrators, malpractice attorneys, patient groups, and insurers — were interviewed about barriers to implementing CARe statewide.

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**CARe Approach Continues to Gain Ground**

**Communication, Apology, and Resolution for Adverse Medical Events**

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ACA and Physicians: What You Need to Know

Earlier this month, the nation’s health care exchanges — a centerpiece of the Affordable Care Act (ACA) — opened for business.

In Massachusetts, we’ve had something similar in the Health Connector since 2006, but in its transition to a federal health care exchange, there will be differences for physicians, patients, and employers.

To comply with the law, physicians and practices must provide written notice to all employees, even those who work part-time, of the health coverage options available to them through the exchange.

On the MMS website, you’ll find more information about your obligations under the law, as well as model language from the U.S. Department of Labor you can use to notify your employees. You can also direct your employees to the Massachusetts Health Connector website at www.masshealthconnector.org.

Other changes are afoot, and they are particularly important to independent medical practices. In this issue of Vital Signs, you will find articles outlining what physicians should know about the new federal Sunshine Act, and changes to HIPAA compliance regulations.

The legal and regulatory health care landscape is changing faster than any of us expected, and the MMS intends to offer extra resources and support that practices will need.

On Page 3 you will find a re-introduction to our Physician Practice Resource Center, the resources it has to offer independent practices, and something new — the launch of the monthly Practice Pulse e-newsletter, free to all MMS members. We hope you’ll take advantage of it.

Sunshine Act continued from page 1

At some time between April and August 2014, physicians' personal reports will be ready to review. They have 45 days for review and another 15 days to resolve any disputes before the information is made public.

The majority of the information in the disclosure reports will be available on a public, searchable website.

How to Ensure Your Report Is Accurate

If you have reason to expect that you may show up in the reports, the AMA suggests you take several steps to ensure accurate reporting. They include:

- If you have a National Provider Identifier (NPI) number, make sure that the information in the NPI number is current because it will be used by manufacturers to confirm they have identified you correctly.
- You want to guard against being assigned payments made to another doctor — something that could happen especially if you have a common name.
- Make sure that financial and conflict-of-interest disclosures required by your employer or other entities that provide your funding are updated regularly. These entities may compare their information to what is posted on the public website.
- Learn what financial transfers and ownership interest must be reported. Understand what exemptions apply and when indirect transfers (those not made directly to a physician) are reportable.
- Ask industry representatives to allow you to review reportable transfers before they report them to catch errors early.

Along with the CMS portal, the Massachusetts Department of Public Health’s website also reports data required under the state law. Since 2009, the DPH has posted several types of reports about the transfer of value between manufacturers and physicians and institutions, including the top spenders and recipients as well as the general category of value transfer, e.g., “grants/education gifts or “compensation for bona fide services.”

Public Access to Information

Massachusetts law and the federal Sunshine Act have similar goals: providing the public with information about the financial interactions between physicians and the industry. Where the two laws overlap, the more stringent one applies. Does the federal law alter anything in the Massachusetts law? “There has been no indication that the state plans to change its reporting program in light of the new federal law,” according to MMS General Counsel Charles Alagero.

For some physicians though, there will be new considerations. “If you think, for example, that you’re going to be speaking at many events and accrue a lot of speakers’ fees, then you should consider familiarizing yourself with the nature of the data that is being reported and then tracking your payments,” said Alagero.

“But remember that the onus of complying with the new law is on the drug and medical devices industries.”

More resources on the Sunshine Act are available at www.massmed.org/sunshine.

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Your Two Cents

Vital Signs welcomes letters to the editor. Letters should be 200 words or fewer, and all are subject to editing. Send to the MMS Department of Communications, 860 Winter Street, Waltham, MA 02451-1411; vitalsigns@mms.org; or fax to (781) 642-0976.
Physician Practice Resource Center: Adding Value and Creating Change

At the PPRC, our goal is to ensure that physicians have the information, support, and resources needed to maintain a thriving practice. Our staff has hands-on experience and deep knowledge of complex issues facing the practice environment. You can count on us to be there, watching out for what impacts you, keeping you informed, and advocating on your behalf.

Practice Consultation Services
The PPRC’s Practice Help Center is a place you can bring your practice questions and problems and have them addressed and worked on to help you reach a resolution. When you contact us, we are here to listen, respond, and help. For example, the Practice Help Center recently received a call from a practice seeking resources, information, and direction on how to prepare for ICD-10. Our staff talked with the practice about the next steps that could be implemented based on its unique practice environment and provided documents and videos in order to arm the practice with the information necessary to get it on the path toward preparation.

New Resources
Our knowledgeable staff stays on top of emerging trends and systematic changes, such as ICD-10, HIPAA, model employment contracts and staff bylaws, in order to inform and prepare physicians. In an effort to continue to provide important, timely information to physicians, the PPRC is happy to expand our communication through our newly created Practice Pulse newsletter. The newsletter is designed to keep you current and aware of key things that will impact your practice and provide you with links to valuable resources, upcoming education programs, and tips to help you focus on what matters most.

Contact the Practice Help Center at (781) 434-7702 or pprc@mms.org.

HIPAA Changes
continued from page 1

• associate* to include an entity that “creates, receives, maintains, or transmits” protected health information (PHI) for a covered entity.
• You should have revised your agreements with your business associates to reflect that they may now be directly liable for a failure to comply with certain HIPAA requirements. If a business associate agreement (BAA) was already in place as of January 25, 2013, and is not renewed or amended, you will have until September 23, 2014, to revise it. HHS notes, though, that “[r]eliance on this sample may not be sufficient for compliance with State law, and does not replace consultation with a lawyer or [discussions] between the parties to the contract.”
• The requirements for which business associates may be directly liable, including those relating to:
  – HHS’s investigation of complaints
  – Implementing safeguards to protect PHI
  – Minimum necessary disclosures of PHI
  – Permitted, required, and prohibited uses and disclosures of PHI
• You should have revised your notice of privacy practices (NPP) to reflect new requirements, and made the new NPP available to all patients. The NPP must now include:
  – A description of the uses of PHI that will not require patient authorization
  – A description of the uses of PHI that will require patient authorization
  – A statement that the patient may opt out of fundraising communications (if applicable)
  – A statement that, if the patient so requests, you will not share information related to care for which the patient paid in full and out-of-pocket, other than as required by law or to care for the patient
  – A statement that you are required to notify individuals of a breach of their PHI
  – If you are a health plan that uses or discloses PHI for underwriting, a statement that you will not use or disclose genetic information for underwriting purposes
• The secretary of HHS no longer has discretion about whether to investigate a complaint. He or she must investigate a complaint against a covered entity or a business associate, and must conduct a compliance review if it appears that a HIPAA violation has resulted from willful neglect. It is important to note that the final rule makes covered entities liable for the acts and omissions of their business associates, whether or not a proper BAA is in place. It is therefore important to not only revise your BAA, but also to choose your vendors and contractors with care, so that you trust they will abide by the terms of the BAA. VS

Visit www.massmed.org/HIPAA for more information and resources, including a HIPAA toolkit and sample templates for physician use.

Fun Facts about the Physician Fact Book
The 2013 Physician Fact Book is now available to MMS members. Some highlights:

• The percentage of Massachusetts physicians considered specialists has increased significantly, from 46.96% in 2012 to 62.47% in 2013.
• While more than 60% of physicians in Massachusetts are male, the percentage of female physicians in the state has slowly been climbing at a rate of about 1% per year over the past five years.
• In 2013, Massachusetts had nearly 200 more physicians per 100,000 people than the United States, on average.

See the complete 2013 MMS Physician Fact Book at www.massmed.org/factbook.
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MMS and Alliance Tobacco Poster Contest Winners Honored at State House

Entry Period for 2014 Contest Open through Feb. 14, 2014

The MMS recently celebrated the 12 student winners of the MMS and Alliance 19th Annual Anti-Tobacco Poster Contest. In his remarks to the children, their families, and legislators, MMS President Ronald Dunlap, M.D., said, “As we all know, children establish good health habits at an early age. It’s also true that the younger you start smoking, the harder it is to quit.” Tobacco is the leading cause of preventable disease, disability, and death in Massachusetts and in the nation, he said. “Although we have accomplished much in the fight to reduce the number of deaths attributed to smoking, we can and must do more,” calling children “important allies” in the fight against tobacco use.

The entry period for next year’s contest has begun and will continue through February 14, 2014. Kits, including a 2014 calendar developed from last year’s winning entries, will be mailed in early November to elementary schools, pediatricians, and family physicians across Massachusetts. Artists submitting the 12 winning posters will be invited, with their families, physicians, and legislators, to a ceremony at the Massachusetts State House. They will receive a $50 gift certificate and will be recognized on the MMS website and in news releases sent to local media outlets.

In a small number of those cases, it was determined that there was significant harm to the patient and it was unclear whether reasonable care was provided. Those cases are currently undergoing a more complete evaluation and there has been full communication with the patient and/or family, said Dr. Sands. “We have had a good response from physicians, administrators, and patients who have somehow been a part of the program, he said. “Clinicians, after some initial trepidation, find that it feels like the natural and ethical way to approach an adverse event.”

CARe and strategies for facilitating adoption

The program’s Roadmap to Reform was released in spring of 2012, and a few months later, the Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI) was formed. MACRMI’s CARe model is currently being piloted at BIDMC, Beth Israel Deaconess Hospital-Milton, Beth Israel Deaconess Hospital-Needham, Baystate Medical Center, Baystate Mary Lane Hospital, and Baystate Franklin Medical Center. According to Kenneth Sands, M.D., senior vice president for health care quality at BIDMC, the pilot program is going well and about 90 cases have been assessed since December 2012.

In recent months, other states have sought advice from Massachusetts about starting similar programs. “Based on our and others’ progress, many states are now interested in implementing this kind of approach,” said Dr. Woodward. MACRMI members hope that doctors — especially ones in training and new to the profession — will begin to view adverse medical events through a new lens.

“Other States Looking to Massachusetts”

Hopeful-for federal funding to support the pilot site implementation did not materialize, so MACRMI successfully solicited support from a broad coalition, including all of the state’s major health and liability insurers. State legislation, which applies to all providers in the Commonwealth, cleared the way for CARe provisions that went into effect in November 2012. The legislation included a six-month prelitigation resolution period, sharing all pertinent medical records, strong apology protections, and guidelines for full disclosure of significant medical injury.

State reporting requirements to the Board of Registration in Medicine have been changed to clarify obligations under CARe and efforts are underway at the federal level to do the same. In recent months, other states have sought advice from Massachusetts about starting similar programs.

For more information on the CARe program and the MACRMI coalition, or to request a presentation at your institution, contact Melinda Van Niel at (617) 667-7155 or visit www.macrmi.info.
STATE UPDATE

Q & A with BRM Chair Candace Lapidus Sloane, M.D.

Can you comment on the work the Board is doing to create regulations that will implement or amend this law in a responsible manner?

Dr. Sloane: The Massachusetts Legislature was following the requirements of the federal statute regarding electronic medical records. It is a matter of great importance to the improved care of patients, and the Board has been actively engaged in discussions with all concerned stakeholders.

The Board will endeavor to implement the requirements of “displaying skills” in EMRs within the framework of all the existing CME demands on physicians already in place. We are focused not only on preventing the disenfranchisement of certain categories of physicians, but also on our mission to provide broad access to uninterrupted quality medical care for patients. We will try and mitigate the burden as best we can while obeying the spirit and letter of the law.

MMS: The Board is finally at full strength with seven members serving after a number of vacancies have been filled. How sharp do you feel the learning curve is for new members and what are the tough issues?

Dr. Sloane: I am fortunate to lead a Board of intelligent, experienced, and diligent volunteer members. The governor and the secretary have appointed people of substance and insight. With the help of our superb interim executive director and her staff, we are approaching full speed in our deliberations and decisions. We are well up the curve.

MMS: As allied health professions expand their roles through legislative action and regulations from other boards, how do you see the Board of Medicine of the future interacting with other boards and professions engaging in procedures and practices that have traditionally been the practice of medicine?

Dr. Sloane: It is important to recognize that our Board, its sister boards, and the DPH share the mission to help to ensure that all patients have access to and receive the highest quality health care. For this reason, the various Massachusetts boards should interact early, informally, and openly about issues of shared concern.

I am a traditionalist. My guiding credo is to do what is best for the safety of the patient population of the Commonwealth. I believe physicians should provide the level and type of care, be it procedures or consultations, best performed by a doctor. The Board will always cooperate with all the boards of HHS to find the optimal mix of responsibility assignments for each of the health care professions.

“My guiding credo is to do what is best for the safety of the patient population of the Commonwealth.”

— William Ryder, Esq

FEDERAL UPDATE

Keeping Our Eye on Reform in the Midst of Capitol Hill Chaos

MMS Officials Believe 2013 Offers Best Opportunity to Eliminate SGR

The acrimony and discord in Congress over the Affordable Care Act, which led to the recent federal shutdown, has been tremendously frustrating to all of us who work in federal health care advocacy.

Yet this is the political environment in which we as a physicians’ organization will continue to advocate for those health care reforms critical to Massachusetts patients.

We expect that legislation to repeal and replace the Sustainable Growth Rate (SGR) for Medicare physician payments will be debated by the end of this year. Legislation emerged from a House committee that includes some of the main issues advocated by the AMA and many of the national medical and state organizations — a period of stability for Medicare payments, direct physician involvement in developing new quality reporting requirements, and flexibility and choice for physician practices.

But some proposed legislation to reform SGR includes a number of troublesome provisions, including a lack of provisions to address how small, rural, and retiring physician practices will keep up with the new requirements that are envisioned. Nor does it reconcile the myriad of existing requirements and demands on physicians’ practices with the new ones proposed as part of the reforms.

An even bigger issue confronting those hoping to eliminate the SGR permanently will be how to pay for the new plan. In the past Congress has decreased funds for others, including hospitals, to stop the pending Medicare physicians’ payments cuts. Many of these groups have already announced their opposition to this approach again, which is of no surprise.

The MMS continues to believe that 2013 presents us the best opportunity we have seen to date to eliminate the SGR. The Congressional Budget Office this year scored the cost of eliminating the current program at about $130 billion, which is about $100 billion less than previous years.

And yet the challenges, both in terms of the political environment and the fiscal realities, will require an unparalleled advocacy effort from physicians, patients, and the health care community.

We will, as always, keep you posted on our progress.

— Alex Calcagno
The New Medicine: “I Didn’t Go to Provider School!”

As physicians’ roles continue to change due to a multitude of forces beyond our control, this month Gary Chinman, M.D., a Physician Health Services (PHS) associate director, shares with us some telling reports from the front lines of Massachusetts health care in 2013. (These anecdotal reports are heavily disguised and de-identified.) Amid this change, our professional identities continue to be challenged. We need to do our best to develop patience, resilience, and flexibility; otherwise, frustration, stress, and burnout ensue. This is a very tall order in the face of mounting pressures and growing demands. PHS can assist in identifying resources that may be helpful, so please do not hesitate to give us a call.

— PHS Director Steve Adelman, M.D.

“When I’m with my patients I love what I do. We talk to each other; really talk. I love that connection.”

Christine, a dermatologist in her late 40s, was detailing the joys and stressors of her work, and how the latter contribute to her drinking. Her family recently found her passed out on the kitchen floor. “And the EMR gets right in the way of that. The EMR is turning me into a technician that types. I hate it.”

On another occasion I spoke to a gastroenterologist who was “completely fed up” with what she thought was passive-aggressive behavior by the OR nurses. When the nursing ringleader said something discourteous, the GI doc shot back with a comment that provoked a formal complaint and a general investigation into the GI doc’s status at the hospital.

Our health care delivery system is undergoing rapid, unprecedented change not seen since Abraham Flexner’s 1910 report, which among other seismic changes, prompted half the medical schools in the country to close. Untied contractual entities, e.g., ACOs, are sweeping the country and bringing capitation with them. Many doctors are selling or closing their private practices to become employees of large corporate networks. Patients are being assigned to patient-centered medical homes where much of the care is delivered by non-M.D.s who cost less. Insurance companies increasingly dictate what treatment can be administered through the mechanism of “pre-authorizations.” And through all of this, the role of the physician is changing dramatically. No longer the boss, the doctor is rapidly becoming just another member of a team and is often lumped in with other “providers,” e.g., advanced practice nurse practitioners, physician assistants, pharmacists, which prompted one internist to make the complaint: “I didn’t go to provider school!”

The opportunities for which many of us chose medicine (i.e., to be professionally autonomous, to control our career destiny, to be in charge, have automatic respect, and manage our reimbursements), are eroding. In fact, some of the personal values and character traits that were esteemed by school admission staff 30 years ago are now often seen as problematic. In other words, the way many doctors see themselves and define their identity is now clashing with the systems in which these doctors work.

These issues cause tremendous stress, often visible as the kind of behavior that brings docs to PHS. Sufficiently severe stress, particularly that which truly threatens our self-esteem, can disturb our emotional homeostasis, to which we can respond with behaviors to self-soothe or to confront the perceived threat. The former behaviors can include the use of illicit substances and the latter can include angry verbal retaliation. Both are common reasons physicians are referred to PHS and both can be viewed as symptoms of an underlying problem: a troubled work culture.

Some physicians welcome this new culture and others simply accept it and make the personal changes required to enable their survival or prosperity. For multiple reasons, other physicians can’t navigate these changes well, leading to problematic behavior. However, the skills and wisdom of these struggling docs are still critically invaluable to the overall system. They deserve our compassion and respect as we help them find their place in this new medical world.

For more information about Physician Health Services, visit www.physicianhealth.org or call (781) 434-7404.
Recruit a Colleague or Group

As the health care delivery model evolves, the Society is working harder than ever to ensure that our efforts reflect the collective voice of individual physicians and groups of physicians. We would like to remind our members about the Society’s Recruit Your Colleague rewards opportunity.

We encourage our individual members to recruit a physician colleague or group of colleagues to join the MMS and earn up to a $250 bonus, potentially a 30 percent discount on annual state medical society dues, and well-deserved recognition at the 2014 MMS Annual Meeting.

MMS membership includes DocbookMD, a HIPAA-compliant, secure messaging application for mobile devices designed by and for physicians (includes Android, iPhone, iPad, and iPod touch), a FREE subscription to the New England Journal of Medicine newsletters, and up to 50 percent discounts on clinical, practical, and Board-required continuing medical education (CME).

For more information, please contact info@massmed.org or call (800) 322-2303, ext. 7311.

Women in Medicine: Competition, Collaboration, and Team Leadership

The Women’s Leadership Forum, titled “Women in Medicine: Competition, Collaboration, and Team Leadership” was held Sept. 26 at MMS headquarters. Pictured from left to right are: MMS Past President Alice A. Coombs, M.D.; Cynthia M. Sacco, M.D.; MMS Committee on Women in Medicine Chair Shakti Sabharwal, M.D.; 2013 Woman Physician Leadership Awardee Marianne E. Felice, M.D.; Najmosama Nikrui, M.D.; MMS Past President Lynda M. Young, M.D.; Helen E. Caijias, M.D.; and Patricia R. Felcak, M.D.

Norfolk South — “Smoking: Don’t Go There,” 15th Annual Smokeout Program. Nov. 18 to 22. Location: Elementary and middle schools on the South Shore.

Southeast Regional Caucus. Thurs., Nov. 21, 6:00 p.m. Dinner; 6:30 p.m. Meeting. Location: LeBaron Hills Country Club, Lakeville. The delegates from Barnstable, Bristol North, Bristol South, Norfolk South, and Plymouth district medical societies will meet to review and discuss the resolutions prior to IM13. For more information, contact Southeast Regional Office.

Suffolk — Delegates Meeting. Wed., Nov. 20, 6:00 p.m. Location: East Garden Room, Massachusetts General Hospital, Boston. Resolution Review. For more information, contact the Northeast Regional Office.

Worcester — Fall District Meeting. Wed., Nov. 13, 5:30 p.m. Location: Beechwood Hotel, Worcester. Dinner includes annual award ceremony and scholarship awards presentations. For more information, contact Joyce Cariglia at (508) 753-1579 or wdms@massmed.org.

Norfolk South — Delegates Meeting. Thurs., Nov. 21, 6:00 p.m. Location: MMS headquarters, Waltham. Resolution Review. For more information, contact Northeast Regional Office.
MMS SPONSORED AND JOINTLY SPONSORED CME ACTIVITIES

LIVE CME ACTIVITIES
Go to www.massmed.org/calendar. Unless otherwise noted, event location is MMS headquarters, Waltham.

How to Thrive in the Changing Health Care Environment
Thurs., Nov. 7, 2013, 5:30 to 8:45 p.m.

The Impact of Genomic Testing on the Treatment of Lung Cancer
Thurs., Nov. 7, 2013, 5:30 to 8:30 p.m.
Hilton Boston-Dedham

Using Data Wisely Webinar
Wed., Nov. 20, 2013, noon to 1:00 p.m.

Annual Oration — The Imperative of Patient Engagement in the Era of Health Care Reform and Practice Transformation (at the MMS Interim Meeting)
Fri., Dec. 6, 2013, 2:00 to 3:00 p.m.

Ethics Forum — Ethical issues in Accountable Care Organizations (at the MMS Interim Meeting)
Fri., Dec. 6, 2013, 3:30 to 5:30 p.m.

ONLINE CME ACTIVITIES
Go to www.massmed.org/cme.

Risk Management CME
End-of-Life Care
- End-of-Life Care (3 modules)
  -- Ethics and End-of-Life Care
  -- Advance Care Planning
  -- Communication and Conflict Resolution in End-of-Life Care
- The Importance of Discussing End-of-Life Care with Patients
- Legal Advisor: Advance Directives

Pain Management
- Opioid Prescribing, Risk Management of Opioid Therapy, and the Opioid Abuse Epidemic (6 Modules)
- Legal Advisor: Identifying Potential Drug Dependence and Preventing Abuse
- Managing Risk When Prescribing Narcotic Painkillers for Patients

Other Risk Management CME
- Guide to Accountable Care Organizations: What Physicians Need to Know
- HIPAA 2.0: What’s New in the New Rules?
- Cancer Screening Guidelines (3 modules)

LIVE CME ACTIVITIES
Go to www.massmed.org/calendar. Unless otherwise noted, event location is MMS headquarters, Waltham.

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  -- Advance Care Planning
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- The Importance of Discussing End-of-Life Care with Patients
- Legal Advisor: Advance Directives

Pain Management
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- Legal Advisor: Identifying Potential Drug Dependence and Preventing Abuse
- Managing Risk When Prescribing Narcotic Painkillers for Patients

Other Risk Management CME
- Guide to Accountable Care Organizations: What Physicians Need to Know
- HIPAA 2.0: What’s New in the New Rules?
- Cancer Screening Guidelines (3 modules)

TO REGISTER FOR ANY OF THESE ACTIVITIES,
CALL (800) 843-6356.

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

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