

THE GREEN MOUNTAIN PHYSICIAN

A PUBLICATION OF THE VERMONT MEDICAL SOCIETY

"Not for ourselves do we labor"

July/August
2010

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Contact Us

PO Box 1457

Montpelier, VT 05601

800-640-8767 or 223-7898

Fax 802-223-1201

Online at:

www.vtmd.org

"Our medical society has been diligent over the years to work on all fronts to advocate for Vermont physicians and their patients, and we will continue in the future to do all we can to preserve this most fundamental relationship in our professional lives."

*Robert Tortolani, M.D.
VMS President*



FROM THE PRESIDENT'S DESK

By Robert Tortolani, M.D.

I hope you are all enjoying your summer and particularly that you are having some leisure time to provide balance in your otherwise hectic professional lives. Whatever else is said about the summer of 2010 in Vermont, there's no question it's the hottest we've had in many years!

We had, as usual, excellent participation during the brainstorming retreat in Randolph in late June. Our staff is currently organizing the ideas generated into a series of resolutions, which after further consideration by our council, will be presented to the membership at our annual meeting in Manchester, Nov. 5-6. I hope many of you will be able to attend what I hope will be a fine meeting.

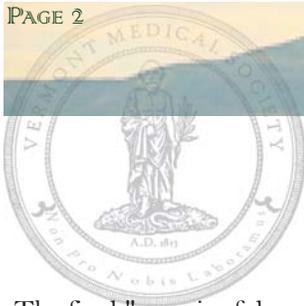
As I sit here writing this on the first day of August, I'm reminded that the season is about to change. During the last two days, it's been getting into the 40s at night and it's actually seemed a bit cold for the first time in two to three months.

Change is also very apparent in medicine. As a matter of fact, I think I've seen more changes in the last five years than I had seen in the previous 20 in terms of how we are delivering medical care in our community. While our community hospital, Brattleboro Memorial Hospital, remains the hub of medical care in our community, as your hospital does in yours, things are definitely changing.

The quality of care at night in our hospital has been enhanced greatly by our night hospitalist service, as has the education and professional satisfaction of our night nurses, not to mention the sleep quality of those of us in the community who provide inpatient care to our patients! Furthermore, our patient's hospital stays seem briefer than ever and our discharge planners and nurses are challenged by the rapid turnover. Finally, we are seeing more of our physicians choosing to be hospital employed in order to reduce administrative burdens and provide more financial security. Fortunately, our hospital has been there to help support practices that choose to make this change.

While some changes are good for us and our patients, one thing that I do not want to see change is the physician/patient relationship. This relationship is an essential element of our

Continued on Page 3



“MEANINGFUL USE” FINAL RULE FOR EHR INCENTIVE PROGRAM ISSUED

The final "meaningful use" rule for electronic medical record adoption was issued by Centers for Medicare and Medicaid Services (CMS) on July 13, and it provides Vermont physicians and hospitals some flexibility in meeting certain objectives to qualify for the federal Medicare or Medicaid incentives. CMS also issued a final rule the same day outlining the standards and criteria EMR vendors need to follow for their products to become certified for meaningful use.

David Blumenthal, M.D. (*pictured right*), the national health information technology coordinator, will be the keynote speaker at the Sept. 8th annual meeting of the Vermont Information Technology Leaders in South Burlington (see related story on pg. 4). Dr. Blumenthal has also agreed to attend the VMS Council Meeting being held on September 7th over Vermont Interactive Television and he will be available beginning at 8:00 p.m. to take questions and answers regarding the meaningful use criteria. VMS Council Meetings are open to all VMS members. For more information on available sites contact Stephanie Winters at swinters@vtmd.org.



The CMS rule divides the 25 meaningful use objectives into two categories: a core group of 15 objectives that physicians and hospitals must meet, and a "menu set" of 10 procedures from which they can choose any five to defer in 2011-12, the first round of the incentive program. CMS also softened some requirements to make them easier to achieve.

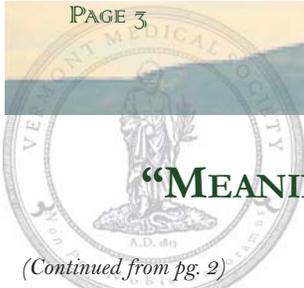
Each objective has an accompanying measure to determine if a physician has met the goal. For example, one core objective – that a physician use an EMR to conduct computerized physician order entry for medication orders – requires that more than 30 percent of a doctor's patients taking at least one medication have at least one drug ordered through CPOE. The meaningful use regulations specify only the objectives physician and hospital EMRs must achieve in payment years 2011 and 2012. Additional objectives will be added in future years.

The American Recovery and Reinvestment Act of 2009 created incentive payments of up to \$44,000 under Medicare, or up to \$63,750 under Medicaid to physicians who achieve meaningful use of certified electronic health record (HER) systems within a certain timeframe. The Medicare incentive payments are greater for those practices that adopt EHRs in 2011 or 2012.

As stated earlier, for the first round of Medicare and Medicaid EMR bonuses in 2011-12, physicians must meet the below 15 core objectives and at least five of 10 of the below "menu set" items. Each objective has a measure to determine if an EMR was used to perform the function for an appropriate number of opportunities:

Core set (must meet all)

- Record patient demographics;
- Record vital signs/chart changes;
- Maintain current and active diagnoses;
- Maintain active medication list;
- Maintain active allergy list;
- Record adult smoking status;
- Provide patient clinical summaries;
- Provide electronic health information copy on demand;
- Generate and transmit prescriptions electronically;
- Use computerized physician order entry for drug orders;
- Implement drug-drug/drug-allergy interaction checks;
- Be capable of electronic clinical information exchange;
- Implement one clinical decision support rule;
- Protect patient data privacy and security; and
- Report clinical quality measures to CMS or states.



“MEANINGFUL USE” FINAL RULE ISSUED

(Continued from pg. 2)

Menu set (can defer up to five for 2011-12)

- Implement drug formulary checks;
- Incorporate clinical lab test results;
- Generate patient lists by condition;
- Identify patient-specific education resources;
- Perform medication reconciliation between care settings;
- Provide summary of care for transferred patients;
- Submit electronic immunization data to registries;
- Submit electronic epidemiology data to public health agencies;
- Send care reminders to patients; and
- Provide timely patient electronic access to health information.

According to CMS, the agency will begin to make meaningful use incentive payments for EHRs to eligible physicians and hospitals as early as May 2011. Officials stated that CMS will open registration for the incentive program in January, and physicians and other healthcare providers must verify that they have demonstrated meaningful use of certified EHRs for 90 days. Eligible hospitals and physicians must have a national provider identifier (NPI) and be enrolled in the CMS Provider Enrollment, Chain and Ownership System (PECOS) to participate in the incentive program, and most providers also need to have an active user account in the National Plan and Provider Enumeration System (NPPES). The Office of the National Coordinator is in the process of establishing a temporary EHR certification program and hopes to have multiple organizations ready to certify EHR products shortly.

For more information, please go to: <https://www.cms.gov/EHRIncentivePrograms/>

PRESIDENTS' DESK

(cont'd from pg. 1) ability to help our patient through whatever health challenge he or she faces. It also provides the most satisfaction in our professional lives. Last year, the president of the Rhode Island Medical Society, an internist, said she loved what happens in her exam room but hated all the rest of her professional existence. Recent surveys of our membership reflect a similar feeling.

We must constantly work to preserve the quality of this most important interaction. We, and our patients, deserve to have an adequate time to communicate with each other. We need to reduce the demands on our time, which interfere with time spent with our patients, and be reimbursed appropriately for this time. A more subtle erosion of the physician/patient relationship is that which occurs when a physician's feelings toward his or her patient can be undermined by the great emotional price of a malpractice suit.

Our medical society has been diligent over the years to work on all fronts to advocate for Vermont physicians and their patients, and we will continue in the future to do all we can to preserve this most fundamental relationship in our professional lives.

Sincerely,


Robert Tortolani, M.D.
 Family Physician
 Brattleboro, Vt.



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NATIONAL HEALTH IT COORDINATOR TO KEYNOTE VITL SUMMIT

David Blumenthal, M.D., the national coordinator for health information technology, will be the keynote speaker at the VITL Summit '10 conference on Wednesday, Sept. 8, at the Sheraton Burlington in Burlington, Vt.

In his role as the national coordinator, Dr. Blumenthal is charged with building an interoperable, private and secure nationwide health information system and supporting the widespread, meaningful use of health IT.

After his keynote address, Dr. Blumenthal will participate in a panel discussion about how Vermont health care professionals can achieve meaningful use of electronic health records systems and how physicians can qualify for federal incentive payments.

In addition to Dr. Blumenthal's keynote address and panel discussion, VITL Summit '10 will also offer numerous health IT breakout sessions, such as:

- How Hospitals Can and Are Helping Physicians with Health IT;
- The Medical Home, Quality Reporting and Health IT;
- EHR Budgeting for Small Practices;
- Meaningful Use for Vermont Hospital and their Physician Practices;
- The Ins and Outs of Health Information Exchange; and
- Strategies for Small Practices to Achieve Meaningful Use.

The American Academy of Family Physicians will credit attendees with up to 4.75 CME credits.

The conference's admission fee is \$69 (with a group discount of \$10 per registrant available when three or more members attend) and the registration deadline is Aug. 31. For the conference agenda and more information, visit: <http://vitl.net/vitl-summit>.

VERMONT INTERNIST NAMED PRESIDENT-ELECT OF THE AMERICAN COLLEGE OF PHYSICIANS



Fletcher Allen Health Care's Virginia Hood, M.D., was recently elected president-elect of the American College of Physicians (ACP). Dr. Hood will assume the presidency of ACP, the nation's second-largest physician organization, in April 2011.

Dr. Hood is a professor of medicine at the University of Vermont College of Medicine. She is an attending physician and Chair of the Residents' Research and Scholarly Activity Committee at Fletcher Allen. She is also a consulting physician for Central Vermont Medical Center.

"I am both honored and challenged by being given this opportunity to represent the American College of Physicians, an organization whose mission is to promote excellence and professionalism in the practice of medicine through education and advocacy for the benefit of our patients," said Dr. Hood. "One area of particular interest to me is ensuring that all internists work together for the common good of our patients and our profession. Internists specialize in the prevention, detection, and treatment of illness in adults. Together we have an extraordinary opportunity to promote policies and practices that can profoundly influence the health and well being of the country."

Dr. Hood was elected to the ACP Board of Regents in 2005 and re-elected in 2008 and has served in an advisory capacity to the State of Vermont's health care programs as a member of the Drug Utilization Review Board in the Office of Vermont Health Care Access (Medicaid).

POLICY PRIORITIES DISCUSSED DURING ANNUAL PLANNING RETREAT

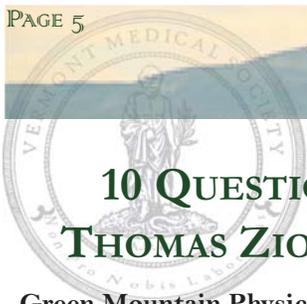
On June 19th, the Vermont Medical Society held its annual planning retreat at the Three Stallion Inn in Randolph, Vt. The retreat served as a health care policy brainstorming session, with its outcomes to be used to determine the society's policy priorities for the upcoming year.

Six themes emerged from the session:

- Ensuring patient access to health care;
- Preserving the physician/patient relationship;
- Protecting physicians from unfunded mandates;
- Enacting tort reform;
- Encouraging physician leadership in the health care community; and
- Ensuring patient confidentiality protections in health IT initiatives.

Following the meeting, VMS staff was tasked with crafting draft resolutions and forwarding them to the VMS executive council for its review and approval.

Resolutions that are approved by the council will be put to a vote of the full VMS membership at the annual meeting on Nov. 6, at the Equinox Hotel in Manchester, Vt.



10 QUESTIONS WITH..... THOMAS ZIOBROWSKI, M.D.

Green Mountain Physician: Where do you practice and how long have you been practicing there?

Dr. Thomas Ziobrowski: I have practiced general internal medicine in St. Johnsbury since September 1978, several months after completing my residency in internal medicine at Pennsylvania Hospital in Philadelphia.

GMP: What got you interested in a career in medicine?

Dr. Ziobrowski: Although I think I always considered medicine an option because my father was an urologist, it wasn't until midway through college that I decided to go to medical school. Besides the satisfaction of being in a helping profession I think the wide options of practice, research or administration are what really appealed to me.

GMP: North Counties Health Care is one of three Blueprint pilot projects in the state. How has being part of the Blueprint changed the way you provide care to your patients?

Dr. Ziobrowski: Being part of the Blueprint has added resources to support the enviable cooperation between different services that have been present in our area for years. I am not sure how much of these supports to attribute to the Blueprint or to other aspects of my parent organization, Northern Counties Health Centers. Having a mental health professional and chronic care nurse on site feels like a big advantage to me; how much it affects outcomes I am not yet sure. Northeastern Vermont Regional Hospital's community programs and support of a diabetes educator, as well as the Area on Aging and Caledonia Home Health and Hospice all work together to get patients what they need, making it easier for me to concentrate on my piece. I think the Blueprint gives my office a framework to track the population we serve and help pick up what we otherwise would miss.

GMP: Is having a community health team in your area that includes nurse care managers, behavioral health specialists, health coaches, community health workers and public health specialist helpful to you and your patients with chronic conditions?

Dr. Ziobrowski: The community health team is helpful for all sorts of patients, not just ones with the specific chronic conditions that are the focus today (hypertension, diabetes, and asthma).

GMP: Is having an EHR and access to a registry like Docsite helpful in tracking and improving care for patients with chronic conditions?

Dr. Ziobrowski: Having an EHR has its advantages and disadvantages. It is great for searching through different sorts of information and accessing colleague's notes. I feel particularly fortunate to be able to access information from my office, the hospital, and DHMC easily. I haven't had much experience with Docsite yet. We have noticed a lot of mistaken information, but I gather that is improving, whether enough to trust it yet or not I am not sure. There will always be delays in data entry and mistakes, so as with any kind of measurement, you have to have a way to estimate the accuracy of anything there. Dealing with getting information into a registry or for that matter with IT issues such as an EHR or Physician Order Entry necessarily distracts you from patient care and carries some risk.

GMP: Do you think the Blueprint has the potential to lower emergency department use and certain hospital admissions?

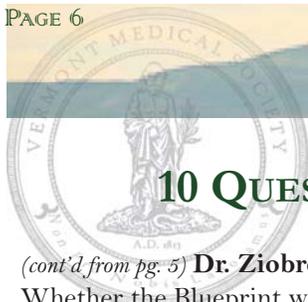
BRUMSTED NAMED FAHC CHIEF MEDICAL OFFICER



John Brumsted, M.D., has added the role of Chief Medical Officer (CMO), to his duties as Chief Quality Officer at Fletcher Allen Health Care. As CMO, Dr. Brumsted will continue to oversee quality and patient safety, accreditation and regulatory efforts, case management, medical ethics, community health improvement and Medical Staff functions. He will also be responsible for meeting the clinical and operational data requirements for the organization.

Dr. Brumsted, the immediate past president of VMS, will also be responsible for regional care delivery system innovation. This work includes spreading the Blueprint medical home model and integrating care management protocols in the emerging PRISM Regional system and among other providers in our region.

In both these roles, Dr. Brumsted will work closely with Faculty Practice President Paul Taheri, M.D. Dr. Taheri will continue to lead all aspects of the Faculty Practice and oversee the Network Development department and its functions, while Dr. Brumsted will work with the medical staff leadership as the point person for global medical staff issues and the



10 QUESTIONS WITH.....

(cont'd from pg. 5) **Dr. Ziobrowski:**

Whether the Blueprint will lower ER use and hospital admissions remains to be seen. Just the process of overseeing the transitions between hospital and outpatient follow-up ought to reduce errors in medications.

GMP: Would you recommend participation in the Blueprint to physicians in other parts of Vermont?

Dr. Ziobrowski: I am not familiar with other physicians' situations, particularly as to the cost of implementing an EHR and/or the Blueprint. I do believe that the additional staff can be helpful but a physician in private practice likely could not afford them.



GMP: How do you relax and unwind?

Dr. Ziobrowski: I have many different interests and am not really expert at any of them. I am always happy to learn something new. For the past two years I have volunteered in locating vernal pools for a project from the Vermont Center for Ecostudies, which gets me out in the woods, off trails with a goal. I like to stop and look at tiny things in the outdoors. I have been playing duets on classical guitar with a musician friend. I have sung with a small local chorus the Pumpkin Hill Singers for twenty odd years. I enjoy working on our 20 acres, in conjunction with the state Wildlife Habitat Improvement Project, and just keeping the drive plowed and the trails mowed on my tractor is an outlet.

GMP: Regarding how medicine is practiced, what is the biggest difference between now and when you entered the profession?

Dr. Ziobrowski: The biggest difference between now and when I started practicing in St. Johnsbury is the increased isolation from peers. When I began, there were three practices that cared for inpatients on two med-surg floors at NVRH. I made rounds together with my associate three days each week, as did the other practices. In a rural setting without a lot of subspecialists I believe the cross fertilization between different physicians was very important. Now the inpatient services are smaller, so many do not ever come to the hospital; virtually every physician is employed so there is more administrative focus on cost and no one makes rounds together. Moreover, half the physicians in town do not practice at the hospital and we have a core group of seven providing hospitalist services. There are two major consequences: when any of us are working at the hospital, we are alone and the hospital medical staff organization is no longer a focal point for physicians to get together, and nothing has replaced it.

GMP: Why are you a member of the Vermont Medical Society?

Dr. Ziobrowski: When I started out in Vermont, I had to join the Society in order to get malpractice insurance. I currently see VMS as a link to other physicians in an increasingly fragmented medical community and as a way to support the efforts of folks like Madeleine Mongan and Paul Harrington to advocate on behalf of physicians but also for the best interests of citizens of Vermont.

THE IMPORTANCE OF SPIROMETRY IN DIAGNOSING COPD

Blue Cross and Blue Shield of Vermont wishes to engage Vermont Medical Society members in a state-wide effort to increase spirometry testing when diagnosing (and managing) patients who may have chronic obstructive pulmonary disease (COPD). Currently, COPD is the fourth leading cause of death and disability in the U.S., with over 12 million Americans currently diagnosed with the disease, and an estimated 12 million additional sufferers who aren't even aware they have it. Many of the milder forms of COPD can be very difficult to detect and diagnose, *especially early on in the course of the disease when patients tend to minimize their symptoms.*

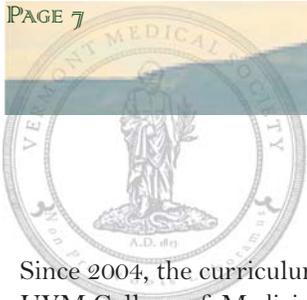
Spirometry

- Spirometry is an inexpensive and cost-effective diagnostic tool. Diagnostic spirometers can cost about \$2,000, and office spirometers typically cost under \$800 and require even less testing time than diagnostic models;
- In 2007, the total annual estimated cost of COPD was \$42.6 billion, including almost \$26.7 billion in direct health care expenditures and \$16 billion in indirect morbidity and mortality costs; and
- Spirometry testing is generally reimbursable and includes CPT codes 94010, 94014-94016, 94060, 94070, 94375, 94620.

In an effort to ameliorate the long-term consequences of COPD and other respiratory conditions among our members, BCBSVT recently formed a respiratory conditions improvement team. The team includes a medical director, nurse, data analyst and quality improvement project manager. They work with internal and external partners to address barriers to optimal health in members with respiratory conditions. One of the team's partnerships involves a certified respiratory therapist. The respiratory therapist is available for a free, hands-on spirometry training for physicians and their staff. Please contact the BCBS-VT Quality Improvement department at qualityimprovement@bcbsvt.com for more information. Note that ten or more providers must be present for each training session.

For more information on COPD, please visit the Global Initiative for Chronic Obstructive Lung Disease (GOLD) website at www.goldcopd.org.

Information for this article was adapted from NCQA's "The State of Health Care Quality: Value, Variation and Vulnerable Populations," 2009.



UVM MED STUDENTS ANALYZE EFFECT OF CLIMATE CHANGE ON DISEASE IN VERMONT

Since 2004, the curriculum for second-year students at the UVM College of Medicine has included a requirement to conduct public health projects that address health needs identified by local community agencies and emphasize physicians' role in improving population health. Directed by Jan K. Carney, MD MPH, Associate Dean for Public Health, in partnership with the United Way of Chittenden County Volunteer Center, the projects are designed to help UVM College of Medicine students become better physicians by learning the challenges of improving public health.

The following are the first in a series of occasional articles that will feature some of these projects and the students working on them.

Warming Climate Changes Vermont Disease

One of the projects conducted by members of the class of 2011 was an analysis of the effect of climate change on disease in Vermont. The objective of the study was to assess Vermont's risk for experiencing an increase in vector-borne disease (VBD) and how the risk correlates with the state's documented climate change.

The students looked at climatologic data, including data from the U.S. Geological Survey's NOAA Satellite Information Service, which demonstrates a measurable increase in Vermont's average annual temperature and precipitation over the past 112 years. This data also reflects an observed increase of 1.16 inches of annual precipitation in Vermont over the same time period. These changes in temperature and precipitation have the potential to prompt the migration of non-endemic flora and fauna into new environments. The introduction of non-native species can present foreign disease to a novel population. This phenomenon, specifically with vector borne diseases (VBD), has already been reported elsewhere in the United States.

This project was an initial step toward the ultimate goal of anticipating the appearance of VBD in Vermont and promoting preventive behaviors before the VBD becomes endemic. Working with professors at the UVM College of Medicine and scientists from the Vermont Department of Health, the students compiled scientific literature regarding climate change and Vermont's weather patterns.

Temperature projections were modeled to generate predictions of Vermont's future climate to the year 2020. Additional investigation documented current vector habitats and disease life-cycles and analyzed individual threats for movement to Vermont.

Evidence from the data assembled by the students links Vermont's climate change and the introduction of Lyme disease. Lyme disease did not exist in Vermont 20 years

ago, but is now prevalent in the state. The incidence of Lyme is predicted to increase as winters become milder and summers become longer.

The precedent set by the migration of Lyme disease into Vermont was used as a model to create a list of other vector-borne diseases that could be seen in Vermont in the near future. Recent migration patterns of other vectors carrying VBD largely unseen in Vermont although appearing in neighboring states have shown a correlation with rising temperatures. The VBDs with potential to migrate to Vermont include West Nile Virus (WNV), Rocky Mountain Spotted Fever (RMSF), Hantavirus, Eastern Equine Encephalitis, other mosquito-borne encephalitides, and possibly even Malaria.

Steven Perrins, UVM COM 2011, a member of the group of students that worked on this project noted, "One of the things I did not realize when we started this project was the lack of awareness of Lyme Disease and vector borne illness among both physicians and the public. Of course many general practitioners do have Lyme disease on their differential diagnoses, but many infected people do not know the signs and symptoms of Lyme Disease until they have been infected chronically over many months/years."

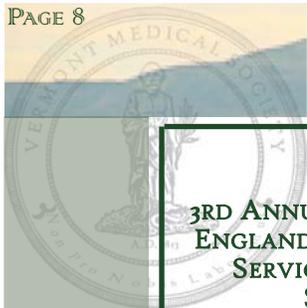
To help formulate professional and public educational strategies to address these emerging infectious diseases, the students condensed information that could be distributed to local physicians and the general public to raise awareness of how to prevent the spread of diseases by mosquitoes, ticks and mice. These educational materials included lists of natural and chemical repellants for ticks and mosquitoes such as essential oils and EPA-registered repellants. Links to CDC and EPA websites were also included for additional information.

The study concluded that climate change has already instigated the invasion of new insect species transporting pathogenic disease into Vermont. Human cases of WNV, RMSF, Hantavirus, Eastern Equine Encephalitis, and other mosquito-borne encephalitides, and possibly Malaria are expected to emerge and increase in Vermont with warmer temperatures in the near future.

To view the student-produced poster related to this project, visit <http://www.vtmd.org/VDH-EnvironmentalHealth2009.pdf>.

Class of 2011 students Elizabeth Baker, Matthew Meyer, Asya Mu'Min, Lindsay Oliver, Daniel Oppenheimer, Steven Perrins and Whitney Young worked on this project with Jan Carney, M.D. M.P.H. as their faculty mentor and William Bress, PhD. and Razelle Hoffman-Contois as community faculty from the Vermont Department of Health.

CONFERENCES



3RD ANNUAL NORTHERN NEW ENGLAND RURAL EMERGENCY SERVICES AND TRAUMA SYMPOSIUM

September 13, 2010
DHMC
Lebanon, NH

For more information call 603-653-1531 or go to the website at <http://ccehs.dartmouth-hitchcock.org>

MAKING WAVES IN PEDIATRIC CRITICAL CARE

September 17, 2010
DHMC
Lebanon, NH

For more information call 603-653-1531 or go to the website at <http://ccehs.dartmouth-hitchcock.org>

WHAT'S NEW IN PSYCHIATRY? For Non-Psychiatric Physicians and Nurses

November 5, 2010
DHMC - Auditorium G
Lebanon, NH

For more information call 603-653-1531 or go to the website at <http://ccehs.dartmouth-hitchcock.org>

VITL SUMMIT '10 CONFERENCE

September 8, 2010
Sheraton Hotel and Conference Center
Burlington VT

For more information go to <http://vitl.net/vitl-summit>.

HEALTH CARE QUALITY CONFERENCE

September 24, 2010
Sheraton Hotel and Conference Center
Burlington VT

For more information call 802-656-2292 or go to the website at <http://cme.uvm.edu>.

Save the Date!

November 6, 2010
Equinox Hotel, Manchester, Vt.

Vermont Medical Society 197th Annual Meeting

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