SNM Board of Directors
2008 Mid-Winter Meeting

February 16, 2008
6:00 – 10:00pm
Terrace Room
Saturday, February 16, 2008
SNM Board of Directors Meeting

1. Opening Schedule
   A. Commencement: 6:00pm
   B. Cocktail Reception: 6:30pm
   C. Dinner: 7:45pm

2. Commencement
   A. Welcome and Call to Order, Alexander J. B. McEwan, MD, President
   B. Establishment of a Quorum, Alexander J. B. McEwan, MD, President
   C. Approval of Agenda and Standing Rules, Alexander J. B. McEwan, MD, President
      1) ACTION: Approval of Agenda
      2) ACTION: Approval of Standing Rules

3. Secretary/Treasurer's Report, Richard B. Noto, MD

4. SNMTS President's Report, David Gilmore, MS, CNMT, NCT, RT(N)

5. Agenda Topics
   A. Finance Committee Report - Paul H. Murphy, PhD
      1) Review Audit Report
      2) ACTION: Approval audit report
   B. PET Center of Excellence Report, Homer Macapinlac, MD
      1) PET CEO Utilization Task Force
         a) Task Force Report
         b) Action Plan
         c) PET Task Force Roster
      2) PET CEO Other Activities
   C. MI Center of Excellence
      1) Molecular Imaging Center of Excellence Report, Martin Pomper, MD
      2) Report on MI Fundraising Update, Peter S. Conti, MD, PhD
   D. World Molecular Imaging Conference (WMIC), Henry F. VanBrocklin, PhD and Homer Macapinlac, MD
   E. Coding and Reimbursement – HOPPS Update, Gary L. Dillehay, MD
   F. Health Care Policy and Practice, Warren R. Janowtiz, MD, JD
      1) Physician Quality Reporting Initiative (PQRI), Robert E. Henkin, MD
      2) Committee Recommendations
   J. Outreach, Alexander J. B. McEwan, MD
1) Public Relations, *Alexander J. B. McEwan, MD and Michael Wm. Schick, Porter Novelli*

   1) Helping SNM Tell Its Story of Serving Humanity
      (SNM Communications Project)

   2) Spreading the Word About MI and PET
      (Molecular Imaging Consumer Awareness Project)

   2) Clinical Trials
   3) Pharma
   4) Other Societies

6. New Business

7. Cocktail Reception (7:30pm)

8. Dinner (7:45pm)

9. Adjournment
Commencement
Welcome and Call to Order
Establishment of Quorum
Approval of Agenda and Standing Rules
ACTION ITEM: Approval of Meeting Agenda

SUBMITTED BY: Alexander J. B. McEwan, MD

PROPOSED RESOLUTION: Resolved, that the meeting agenda for the February 15, 2008 Board of Director’s Meeting be adopted.

FINANCIAL IMPACT: N/A

BACKGROUND: Robert’s Rules of Order (current issue) provide that it is customary to adapt an agenda for each session in organizations that meet less than quarterly. An Agenda requires a two-thirds vote (or unanimous consent) in order to be changed.

<table>
<thead>
<tr>
<th>ACTION</th>
<th>DATE (year-mo-day)</th>
<th>AYES</th>
<th>NAYS</th>
<th>Unanimous</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adopted</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defeated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revised</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
RESOLUTION FORM
SNM Board of Directors
February 16, 2008

ACTION ITEM: Approval of Board of Directors Standing Rules

SUBMITTED BY: Alexander J. B. McEwan, MD

PROPOSED RESOLUTION: Resolved, that the standing rules of the Board of Directors stated below be adopted for this meeting:

- Raise hand to be recognized
- Those that have not yet spoken will get priority
- Limit discussion on any one topic to thirty (30) minutes unless voted on by the Board with majority vote approving to extend discussion.

FINANCIAL IMPACT: N/A

BACKGROUND: N/A

ACTION: ADOPTED ___ DEFEATED ___ OTHER ___

<table>
<thead>
<tr>
<th>ACTION</th>
<th>DATE (year-mo-day)</th>
<th>AYES</th>
<th>NAYS</th>
<th>Unanimous</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adopted</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defeated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revised</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Secretary/Treasurer’s Report
SNMTS President’s Report
David Gilmore, MS, CNMT, NCT, RT(N)
The technologist section is continuing to develop new programs and move forward with several initiatives in the New Year. Technologists will need to be competent in PET/CT and SPECT/CT fusion imaging in the very near future, in PET/MR within a few years, and in radioimmunotherapy as research and protocols develop. The SNMTS has approved a professional entry-level curriculum outlined as the educational foundation for individuals entering the field of nuclear medicine technology. The SNMTS Educator's Task Force has been increasing outreach efforts, creating presentations to use at chapter and local meetings to discuss the new curriculum and entry-level education.

During the November, RSNA meeting, SNMTS Leadership met with an ACR Delegate to discuss the ACR’s concerns with the advanced practitioner. On January 17, 2008, the SNM Board of Directors approved the new name, “Nuclear Medicine Advanced Associate.” The SNMTS leadership has notified ACR of this name and is requesting comments until the first of March, at which, if no comments are received, the SNMTS will moved forward using “Nuclear Medicine Advanced Associate,” as the official name of the advanced program. The final competencies and curriculum will be approved this year, paving the way for colleges and universities to start the master’s program for advance practice.

During the European Association of Nuclear Medicine (EANM) meeting in October, I met with EANM Technologist leadership regarding future international collaboration. The EANM Technologists and the SNMTS will begin developing co-sponsored sessions for the 2009 Annual SNM and EANM Meetings’. Additionally, the SNMTS was invited to participate in “Tech Tips,” a unique series of books, first developed by the EANM technologists, serve as a quick reference to various procedures and guidelines. The SNMTS will continue to research this opportunity over the next several months.

New this year, the SNMTS Executive Board has made a concerted effort to hold monthly conference calls to ensure that action items are voted on in a more efficient manner. This change has not only affect the Executive Board, but the SNMTS Committees as well. Committee chairs have been more engaged than ever; holding conference calls throughout the year to ensure consistent forward movement with policies, programs, curriculums, and awards. Additionally, the Mid-Winter Meeting governance schedule was shortened by one day for technologists, due to the on-going work of the committees throughout the year. This will continue with the Annual Meeting, with SNMTS committee meetings beginning on the Thursday prior to the Annual Meeting.

Five new technologist award categories were approved to cover travel expenses for technologists’ first-time oral presentations at the annual meeting, completion of a bachelor's
degree, enrollment in an advanced practitioner program, student travel, and clinical advancement to gain the appropriate education in additional modalities (such as CT, MRI, etc.).

We are working on developing marketing messages and a recruitment campaign targeted at those in emerging technologies, advanced imaging modalities, and molecular imaging and therapy. To grow our membership, we need to grow and attract technologists early in their career. SNMTS voted to extend the free trial student program for up to 24 months and allow student members to receive free registration to our annual meetings. We also welcome related non-nuclear imaging professionals to join the Technologist Section.

Now more than ever we need to become united to move the SNMTS forward and position the SNMTS to be the leader in molecular imaging, while maintaining focus on our current state of nuclear medicine!

Respectfully submitted,

David Gilmore, MS, CNMT, NCT, RT(R)(N)
SNMTS President
Agenda Topics
Finance Committee – Audit Report
RESOLUTION FORM
SNM Board of Directors
February 16, 2008

ACTION ITEM: Approval of audit report.

SUBMITTED BY: SNM Audit Subcommittee

PROPOSED RESOLUTION:
Be it resolved that, the SNM Board of Directors accept The Society of Nuclear Medicine, Inc. audited Financial Report for September 30, 2007, as audited by McGladrey & Pullen.

FINANCIAL IMPACT: N/A

BACKGROUND:
The chair of the audit subcommittee met with the audit firm prior to the beginning of the audit fieldwork. The subcommittee met with the audit firm after the completion of the audit fieldwork and prior to the issuance of the audited financial reports. There were no audit findings, no audit adjustments, and no passed audit adjustments. The subcommittee voted unanimously to recommend acceptance of the audited financial report.

ACTION: ADOPTED ___ DEFEATED ___ OTHER ___

<table>
<thead>
<tr>
<th>ACTION</th>
<th>DATE (year-mo-day)</th>
<th>AYES</th>
<th>NAYS</th>
<th>Unanimous</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adopted</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defeated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revised</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Independent Auditor’s Report

To the Board of Directors
The Society of Nuclear Medicine, Inc.
Reston, Virginia

We have audited the accompanying statement of financial position of The Society of Nuclear Medicine, Inc. (the Society) as of September 30, 2007, and the related statements of activities and cash flows for the year then ended. These financial statements are the responsibility of the Society’s management. Our responsibility is to express an opinion on these financial statements based on our audit. The prior year summarized comparative financial information has been derived from the Society’s 2006 financial statements and, in our report dated November 24, 2006, we expressed an unqualified opinion on those statements.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the 2007 financial statements referred to above present fairly, in all material respects, the financial position of the Society as of September 30, 2007, and the changes in its net assets and its cash flows for the year then ended, in conformity with accounting principles generally accepted in the United States of America.

Vienna, Virginia
February __, 2008

DRAFT
<table>
<thead>
<tr>
<th>Contents</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Auditor's Report On The Financial Statements</td>
<td>1</td>
</tr>
<tr>
<td>Financial Statements</td>
<td></td>
</tr>
<tr>
<td>Statement Of Financial Position</td>
<td>2</td>
</tr>
<tr>
<td>Statement Of Activities</td>
<td>3</td>
</tr>
<tr>
<td>Statement Of Cash Flows</td>
<td>4</td>
</tr>
<tr>
<td>Notes To Financial Statements</td>
<td>5-10</td>
</tr>
<tr>
<td>Independent Auditor's Report On The Supplementary Information</td>
<td>11</td>
</tr>
<tr>
<td>Supplementary Information</td>
<td></td>
</tr>
<tr>
<td>Schedule Of Natural Expenses</td>
<td>12</td>
</tr>
<tr>
<td>Details Of Statement Of Activities</td>
<td>13</td>
</tr>
</tbody>
</table>
The Society Of Nuclear Medicine, Inc.

Statement Of Financial Position
September 30, 2007 (With Comparative Totals For 2006)

<table>
<thead>
<tr>
<th>Assets</th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$206,730</td>
<td>$202,736</td>
</tr>
<tr>
<td>Accounts receivable, net</td>
<td>462,853</td>
<td>480,241</td>
</tr>
<tr>
<td>Contributions receivable</td>
<td>860,000</td>
<td>-</td>
</tr>
<tr>
<td>Inventory, net</td>
<td>118,573</td>
<td>104,090</td>
</tr>
<tr>
<td>Prepaid expenses and other assets</td>
<td>319,331</td>
<td>337,642</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>1,967,487</td>
<td>1,124,709</td>
</tr>
<tr>
<td>Deposits</td>
<td>59,900</td>
<td>33,124</td>
</tr>
<tr>
<td>Investments</td>
<td>4,004,476</td>
<td>3,518,586</td>
</tr>
<tr>
<td>Property and Equipment, net</td>
<td>2,597,595</td>
<td>2,606,905</td>
</tr>
<tr>
<td>Contributions receivable, net</td>
<td>1,601,347</td>
<td>-</td>
</tr>
<tr>
<td><strong>$ 10,230,805</strong></td>
<td><strong>$ 7,283,324</strong></td>
<td></td>
</tr>
</tbody>
</table>

| Liabilities And Net Assets          |            |            |
| **Current Liabilities**             |            |            |
| Accounts payable and accrued expenses| $893,629  | $781,793   |
| Deferred revenue                    | 687,071    | 986,336    |
| Line of credit                      | -          | 125,000    |
| Due to affiliates                   | 138,666    | 67,729     |
| **Total current liabilities**       | 1,719,366  | 1,960,858  |

Commitments and Contingencies

Net Assets

Unrestricted:
- Undesignated: 1,443,075 1,457,208
- Designated: 4,133,147 3,697,427

Temporarily restricted: 5,576,222 5,154,635

Temporarily restricted: 2,935,217 167,831

**$ 10,230,805** **$ 7,283,324**

See Notes To Financial Statements.
The Society Of Nuclear Medicine, Inc.

Statement Of Activities
Year Ended September 30, 2007 (With Comparative Totals For 2006)

<table>
<thead>
<tr>
<th></th>
<th>Unrestricted</th>
<th></th>
<th></th>
<th>Temporarily</th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Undesignated</td>
<td>Designated</td>
<td>Restricted</td>
<td>Total</td>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Revenue and support:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meetings</td>
<td>$3,821,117</td>
<td>$-</td>
<td>$-</td>
<td>$3,821,117</td>
<td>$3,780,933</td>
<td></td>
</tr>
<tr>
<td>Leadership</td>
<td>31,349</td>
<td></td>
<td>3,451,147</td>
<td>3,482,496</td>
<td>27,000</td>
<td></td>
</tr>
<tr>
<td>Communications</td>
<td>2,394,242</td>
<td></td>
<td></td>
<td>2,394,242</td>
<td>2,096,983</td>
<td></td>
</tr>
<tr>
<td>Membership</td>
<td>2,079,304</td>
<td></td>
<td></td>
<td>2,079,304</td>
<td>2,013,774</td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>754,742</td>
<td></td>
<td></td>
<td>754,742</td>
<td>869,782</td>
<td></td>
</tr>
<tr>
<td>Councils</td>
<td>-</td>
<td>77,565</td>
<td></td>
<td>77,565</td>
<td>51,112</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>47,942</td>
<td></td>
<td></td>
<td>47,942</td>
<td>90,658</td>
<td></td>
</tr>
<tr>
<td>Bank interest - Operations</td>
<td>42,887</td>
<td></td>
<td></td>
<td>42,887</td>
<td>30,296</td>
<td></td>
</tr>
<tr>
<td>Center of excellence</td>
<td>40,604</td>
<td></td>
<td></td>
<td>40,604</td>
<td>37,005</td>
<td></td>
</tr>
<tr>
<td>Grants and awards</td>
<td>20,000</td>
<td></td>
<td></td>
<td>20,000</td>
<td>188,120</td>
<td></td>
</tr>
<tr>
<td>Net assets released from restrictions</td>
<td>683,761</td>
<td>- (683,761)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Total revenue and support</td>
<td>9,915,728</td>
<td>77,565</td>
<td>2,767,386</td>
<td>12,760,679</td>
<td>9,185,663</td>
<td></td>
</tr>
</tbody>
</table>

Expenses:

Program services:

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>2,514,551</td>
<td></td>
<td></td>
<td>2,514,551</td>
<td>2,529,760</td>
<td></td>
</tr>
<tr>
<td>Meetings</td>
<td>1,629,808</td>
<td></td>
<td>1,629,808</td>
<td>1,739,754</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>1,545,601</td>
<td></td>
<td>1,545,601</td>
<td>1,763,197</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership</td>
<td>1,375,904</td>
<td></td>
<td>1,375,904</td>
<td>1,312,396</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Molecular Imaging Campaign</td>
<td>525,972</td>
<td></td>
<td></td>
<td>525,972</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants and awards</td>
<td>134,290</td>
<td></td>
<td>134,290</td>
<td>171,737</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Policy and Regulatory Affairs</td>
<td>111,802</td>
<td></td>
<td>111,802</td>
<td>227,076</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Councils</td>
<td>-</td>
<td>64,908</td>
<td></td>
<td>64,905</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Center of excellence</td>
<td>10,905</td>
<td></td>
<td></td>
<td>10,905</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support services:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative</td>
<td>647,535</td>
<td></td>
<td></td>
<td>647,535</td>
<td>599,051</td>
<td></td>
</tr>
<tr>
<td>Finance</td>
<td>521,794</td>
<td>20,395</td>
<td></td>
<td>542,189</td>
<td>496,373</td>
<td></td>
</tr>
<tr>
<td>Information services</td>
<td>464,438</td>
<td></td>
<td></td>
<td>464,438</td>
<td>398,651</td>
<td></td>
</tr>
<tr>
<td>Membership</td>
<td>332,929</td>
<td></td>
<td></td>
<td>332,929</td>
<td>328,591</td>
<td></td>
</tr>
<tr>
<td>Development</td>
<td>115,592</td>
<td></td>
<td></td>
<td>115,592</td>
<td>119,216</td>
<td></td>
</tr>
<tr>
<td>Total expenses</td>
<td>9,931,121</td>
<td>85,303</td>
<td></td>
<td>10,016,424</td>
<td>9,754,367</td>
<td></td>
</tr>
</tbody>
</table>

Change in net assets before interest and dividends and market value adjustment on investments

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrealized (loss) gain on investments</td>
<td>-</td>
<td>(78,789)</td>
<td>-</td>
<td>(78,789)</td>
<td>150,901</td>
<td></td>
</tr>
<tr>
<td>Realized gain (loss) on investments</td>
<td>-</td>
<td>387,454</td>
<td>-</td>
<td>387,454</td>
<td>(350)</td>
<td></td>
</tr>
<tr>
<td>Interest and dividends - Investments</td>
<td>-</td>
<td>136,053</td>
<td>-</td>
<td>136,053</td>
<td>113,657</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-</td>
<td>444,718</td>
<td>264,208</td>
</tr>
</tbody>
</table>

Change in net assets before interfund transfers

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(15,393)</td>
<td>436,980</td>
<td>2,767,386</td>
<td>3,188,973</td>
<td>(304,496)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Interfund transfers

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1,260</td>
<td>(1,260)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Change in net assets

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(14,133)</td>
<td>435,720</td>
<td>2,767,386</td>
<td>3,188,973</td>
<td>(304,496)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Net assets:

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning</td>
<td>1,457,208</td>
<td>3,697,427</td>
<td>167,831</td>
<td>5,322,466</td>
<td>5,626,962</td>
<td></td>
</tr>
<tr>
<td>Ending</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Net assets: $1,443,075 $4,133,147 $2,935,217 $8,511,439 $5,322,466

See Notes To Financial Statements.
The Society Of Nuclear Medicine, Inc.

Statement Of Cash Flows
September 30, 2007 (With Comparative Totals For 2006)

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash Flows From Operating Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in net assets</td>
<td>$3,188,973</td>
<td>$(304,496)</td>
</tr>
<tr>
<td>Adjustments to reconcile change in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>net assets to net cash provided by</td>
<td></td>
<td></td>
</tr>
<tr>
<td>operating activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>264,496</td>
<td>214,758</td>
</tr>
<tr>
<td>Loss on disposal of property and</td>
<td>75</td>
<td>2,835</td>
</tr>
<tr>
<td>equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discount on contributions receivable</td>
<td>113,653</td>
<td>-</td>
</tr>
<tr>
<td>Realized and unrealized (gain) on</td>
<td>(308,665)</td>
<td>(150,551)</td>
</tr>
<tr>
<td>investments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in assets and liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Increase) decrease in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts receivable, net</td>
<td>17,388</td>
<td>80,818</td>
</tr>
<tr>
<td>Contributions receivable</td>
<td>(2,575,000)</td>
<td>-</td>
</tr>
<tr>
<td>Inventory, net</td>
<td>(14,483)</td>
<td>(3,140)</td>
</tr>
<tr>
<td>Prepaid expenses and other assets</td>
<td>18,311</td>
<td>1,209</td>
</tr>
<tr>
<td>Deposits</td>
<td>(26,776)</td>
<td>3,134</td>
</tr>
<tr>
<td>Increase (decrease) in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued</td>
<td>111,836</td>
<td>(80,111)</td>
</tr>
<tr>
<td>expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>(299,265)</td>
<td>325,988</td>
</tr>
<tr>
<td>Due to affiliates</td>
<td>70,937</td>
<td>61,571</td>
</tr>
<tr>
<td>**Net cash provided by operating</td>
<td>561,480</td>
<td>152,015</td>
</tr>
<tr>
<td>activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Flows From Investing Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of building improvements,</td>
<td>(255,261)</td>
<td>(393,204)</td>
</tr>
<tr>
<td>furniture and equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds from sales of investments</td>
<td>1,458,338</td>
<td>343,906</td>
</tr>
<tr>
<td>Purchases of investments</td>
<td>(1,635,563)</td>
<td>(352,560)</td>
</tr>
<tr>
<td>**Net cash (used in) investing</td>
<td>(432,486)</td>
<td>(401,858)</td>
</tr>
<tr>
<td>activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Flows From Financing Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net (repayments) borrowings on line</td>
<td>(125,000)</td>
<td>125,000</td>
</tr>
<tr>
<td>of credit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Net cash (used in) provided by</td>
<td>(125,000)</td>
<td>125,000</td>
</tr>
<tr>
<td>financing activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Net increase (decrease) in cash</td>
<td>3,994</td>
<td>(124,843)</td>
</tr>
<tr>
<td>and cash equivalents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash And Cash Equivalents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beginning</td>
<td>202,736</td>
<td>327,579</td>
</tr>
<tr>
<td>Ending</td>
<td>206,730</td>
<td>202,736</td>
</tr>
<tr>
<td><strong>$</strong></td>
<td><strong>206,730</strong></td>
<td><strong>202,736</strong></td>
</tr>
<tr>
<td>Supplementary Disclosure Of Cash Flow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash payments for interest</td>
<td>$283</td>
<td>$1,394</td>
</tr>
</tbody>
</table>

See Notes To Financial Statements.
Notes To Financial Statements

Note 1. Nature Of Activities And Significant Accounting Policies

Nature of activities: The Society of Nuclear Medicine, Inc. (the Society) was incorporated in the state of Washington in 1954 and is dedicated to demonstrating the value of nuclear medicine through excellence in the education, research, and clinical practices of the discipline. The Society is a multidisciplinary organization of over 17,000 physicians, physicists, chemists, radiopharmacists, technologists, and others interested in the diagnostic and therapeutic use of radiopharmaceuticals.

The Society is related to The Society of Nuclear Medicine Education and Research Foundation (the Foundation) as both organizations share common board members. Although related, control and economic interest do not exist; and therefore, the Foundation’s financial statements are not consolidated with the Society's.

A summary of the Society’s significant accounting policies follows:

Basis of accounting: The Society prepares its financial statements on the accrual basis of accounting, whereby revenue is recognized when earned and expenses are recognized when incurred.

Basis of presentation: The financial statement presentation follows the recommendations of the Financial Accounting Standards Board in its Statement of Financial Accounting Standards (SFAS) No. 117, Financial Statements of Not-for-Profit Organizations. Under SFAS No. 117, the Society is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets. There are no permanently restricted net assets at September 30, 2007.

Cash and cash equivalents: For the purposes of reporting cash flows, the Society considers all highly liquid investments purchased with a maturity of three months or less, other than those held as part of the Society’s long-term investments, to be cash and cash equivalents.

Financial risk: The Society maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The Society has not experienced any losses in such accounts. The Society believes it is not exposed to any significant credit risk on cash.

The Society invests in a professionally managed portfolio that contains corporate obligations, U.S. Treasury and Agency notes, mutual funds and common shares of publicly traded companies. Such investments are exposed to various risks such as market and credit. Due to the level of risk associated with such investments, and the level of uncertainty related to change in the value of such investments, it is at least reasonably possible that changes in risks in the near term would materially affect investment balances and the amounts reported in the financial statements.

Receivables: Receivables are carried at original invoice amounts less an estimate made for doubtful receivables based on a review of all outstanding amounts on a monthly basis. Management determines the allowance for doubtful accounts by identifying troubled accounts and by using historical experience applied to an aging of accounts. Receivables are written off when deemed uncollectible. Recoveries of receivables previously written off are recorded when received. The provision for doubtful accounts, based on management’s evaluation of the collectibility of receivables, is $39,428 at September 30, 2007.

Inventory: Inventory consists of publications held for resale and is valued at the lower of cost (first-in, first-out method) or market. The provision for obsolescence is based on management’s evaluation of the salability of inventory. The provision for obsolescence is $14,000 at September 30, 2007.
The Society Of Nuclear Medicine, Inc.

Notes To Financial Statements

Note 1. Nature Of Activities And Significant Accounting Policies (Continued)

Investments: Investments with readily determinable fair values are reflected at fair market value. To adjust the carrying value of these investments, the change in fair market value is charged or credited to current operations in the statement of activities.

Property and equipment: Acquisitions of property and equipment greater than $1,000 are recorded at cost and depreciated using the straight-line method over their estimated useful lives of 3 to 39 years.

Valuation of long-lived assets: The Society accounts for the valuation of long-lived assets under Statement of Financial Accounting Standards (SFAS) No. 144, Accounting for the Impairment or Disposal of Long-Lived Assets. SFAS No. 144 requires that long-lived assets and certain identifiable intangible assets be reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of long-lived assets is measured by a comparison of the carrying amount of the asset to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the estimated fair value of the assets. Assets to be disposed of are reportable at the lower of the carrying amount or fair value, less costs to sell.

Income taxes: The Society is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. Income from nonexempt functions is subject to income taxes to the extent that the revenue exceeds related costs. No net income was taxable in 2007; accordingly, no provision has been made for either federal or state income taxes in the accompanying financial statements.

Revenue recognition: Membership dues are recognized ratably over the applicable membership period to which they apply. Revenue received for dues which relate to subsequent years has been reflected as deferred revenue.

Subscription revenue is recognized ratably over the applicable subscription period to which it applies. Revenue received for subscriptions which relate to subsequent years has been reflected as deferred revenue.

Meeting revenue is recognized at the time of the event and amounts received in advance are recorded as deferred revenue.

Publication revenue is recognized upon shipment of the material.

Contributions are recorded as a receivable when a verifiable promise to give is received. All promises to give are recorded as a temporarily restricted net asset. As promises to give are actually collected and all restrictions are met, the contributions are transferred to unrestricted support. The Society’s promises to give are generally receivable over an extended period of time and are discounted at a rate of 2% per annum. The allowance for doubtful promises to give is based on management’s experience. Management expects all promises to give to be fully collectible, consequently, no allowance has been recorded at September 30, 2007.

Net assets: A summary of the Society’s net assets and any restrictions or designations thereon are as follows:

Temporarily restricted net assets: Temporarily restricted net assets result from contributions whose use is limited by donor-imposed stipulations that either expire by passage of time or can be fulfilled and removed by actions of the Society pursuant to these stipulations. Net assets may be restricted for various purposes, such as use in future periods or used for specified purposes.
The Society Of Nuclear Medicine, Inc.

Notes To Financial Statements

Note 1. Nature Of Activities And Significant Accounting Policies (Continued)

Unrestricted net assets: Unrestricted net assets are the net assets that are neither permanently restricted nor temporarily restricted by donor-imposed restrictions.

Undesignated: Undesignated net assets account for the general operations of the Society.

Designated: The Board of Directors has designated a portion of unrestricted net assets for the following purposes:

Council activities: Designated net assets that represent the cumulative change in net assets of the Society’s council activities.

Capital reserve: Designated net assets that were established, in accordance with resolutions of the Board of Directors, for the purpose of maintaining in reserve six months of the immediately succeeding year’s operating expense, which includes depreciation expense.

Functional allocations of expenses: The costs of providing various programs and other activities have been summarized on a functional basis in the statement of activities. Accordingly, certain costs have been allocated among the programs and supporting services benefited. Certain management and staff expenses have been allocated to programs on the basis of time spent. Other expenses have been allocated to programs on a percentage basis.

Estimates: The preparation of the financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Prior year information: The financial statements include certain prior year summarized comparative information in total but not by net asset class. Such information does not include sufficient detail to constitute a presentation in conformity with accounting principles generally accepted in the United States of America. Accordingly, such information should be read in conjunction with the Society’s financial statements for the year ended September 30, 2006, from which the summarized information was derived.

Reclassifications: Certain items in the 2006 financial statements have been reclassified to conform with the 2007 financial statement presentation. Their reclassifications had no effect on the previously reported change in net assets.
The Society Of Nuclear Medicine, Inc.

Notes To Financial Statements

Note 2. Contributions Receivable

Contributions receivable represent unconditional promise to give by donors. Current contributions receivable are expected to be collected during the next year and are recorded at net realizable value. Long-term contributions receivable are expected to be collected over the next several fiscal years. Contributions that are expected to be collected after one year are discounted at 2% per annum and reflected in the financial statements at their net present value.

The following are the contributions receivable at September 30, 2007:

<table>
<thead>
<tr>
<th>Less than one year</th>
<th>$ 860,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two to five years (net of discount of $113,653)</td>
<td>1,601,347</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 2,461,347</strong></td>
</tr>
</tbody>
</table>

In addition, the Society has been informed of a conditional promise to give totaling $400,000. Future payments are contingent upon the donor obtaining required annual management approvals. No amounts for conditional promises to give are included in the financial statements.

Note 3. Investments

The Society’s investments consist of the following at September 30, 2007:

| Common stocks | $ 1,313,624 |
| Mututal funds | 1,166,174 |
| U.S. Treasury and Agency notes | 1,006,716 |
| Corporate bonds | 470,094 |
| Money market | 47,868 |
| **Total** | **$ 4,004,476** |

The following schedule summarizes the investment return for the year ended September 30, 2007:

| Interest and dividends - Investments, net of investment expense of $20,395 | $ 115,658 |
| Net realized and unrealized gains | 308,665 |
| **Total** | **$ 424,323** |
The Society Of Nuclear Medicine, Inc.

Notes To Financial Statements

Note 4. Property And Equipment
Property and equipment and accumulated depreciation consist of the following at September 30, 2007:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>$ 402,264</td>
</tr>
<tr>
<td>Building and improvements</td>
<td>2,664,571</td>
</tr>
<tr>
<td>Furniture and equipment</td>
<td>1,343,100</td>
</tr>
<tr>
<td></td>
<td>4,409,935</td>
</tr>
<tr>
<td>Less: Accumulated depreciation</td>
<td>(1,812,340)</td>
</tr>
<tr>
<td></td>
<td>$ 2,597,595</td>
</tr>
</tbody>
</table>

Depreciation and amortization expense was $264,496 for the year ended September 30, 2007.

Note 5. Line Of Credit
The Society has a $1,000,000 line of credit with Branch Banking and Trust. There were no amounts due under the line of credit as of September 30, 2007. Bank advances carry an interest rate equal to the current 30-day London Interbank Offered Rate (LIBOR) plus 250 basis points (8.22% at September 30, 2007). The line renews automatically each year.

Note 6. Retirement Plans
The Society has a defined contribution plan under Internal Revenue Code Section 401(k) and a dormant Section 457 plan. Eligible employees can voluntarily contribute part of their salary to the defined contribution plan. The 401(k) plan includes a discretionary employer contribution provision. Retirement expense for the year ended September 30, 2007, was $266,750.

Note 7. Board Designated And Temporarily Restricted Net Assets
The Board of Directors has designated a portion of the unrestricted net assets to be used for council activities and capital reserves. The following is a summary of the activities related to these designated amounts during the year ended September 30, 2007:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital reserve</td>
<td>$ 3,624,808</td>
<td>$ 424,323</td>
<td>-</td>
<td>$ 4,049,131</td>
</tr>
<tr>
<td>Council activities</td>
<td>72,619</td>
<td>12,657</td>
<td>(1,260)</td>
<td>84,016</td>
</tr>
<tr>
<td></td>
<td>$ 3,697,427</td>
<td>$ 436,980</td>
<td>(1,260)</td>
<td>$ 4,133,147</td>
</tr>
</tbody>
</table>
The Society Of Nuclear Medicine, Inc.

Notes To Financial Statements

Note 7. Board Designated And Temporarily Restricted Net Assets (continued)

The Society has temporarily restricted net assets at September 30, 2007. A portion of these net assets was released from restriction during fiscal year 2007, by incurring expenses satisfying the restricted purpose. The following is a summary of the temporarily restricted activities for the year ended September 30, 2007:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Friends Program</td>
<td>$147,831</td>
<td>$</td>
<td>$ (56,289)</td>
<td>$91,542</td>
</tr>
<tr>
<td>Self-Study Workbook on Oncology,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Mallinckrodt Educational Programs</td>
<td>10,000</td>
<td>-</td>
<td>-</td>
<td>10,000</td>
</tr>
<tr>
<td>Molecular Imaging Campaign</td>
<td>10,000</td>
<td>3,311,347</td>
<td>(525,972)</td>
<td>2,795,375</td>
</tr>
<tr>
<td>Grants and awards programs</td>
<td>-</td>
<td>139,800</td>
<td>(101,500)</td>
<td>38,300</td>
</tr>
<tr>
<td></td>
<td>$167,831</td>
<td>$3,451,147</td>
<td>$ (683,761)</td>
<td>$2,935,217</td>
</tr>
</tbody>
</table>

Included in the temporarily restricted net assets of the Molecular Imaging Campaign is $2,461,347 (net of discount) of contributions receivable.

Note 8. Commitments

The Society has contracted with hotels for convention and hotel space for conferences and meetings to be held beginning in fiscal year 2008 and ending in fiscal year 2013. In the event the Society cancels or reduces its contracted room nights, the Society may be liable for cancellation fees for all rooms that the hotel will not be able to resell.
Independent Auditor’s Report On The Supplementary Information

To the Board of Directors
The Society of Nuclear Medicine, Inc.
Reston, Virginia

Our audit was made for the purpose of forming an opinion on the basic financial statements taken as a whole. The supplementary information which follows is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information for the year ended September 30, 2007, has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the financial statements taken as a whole. The comparative information for the year ended September 30, 2006, was previously audited by us, and in our report dated November 24, 2006, we expressed an unqualified opinion on such information in relation to the basic financial statements taken as a whole.

Vienna, Virginia
February __, 2008

DRAFT
The Society Of Nuclear Medicine, Inc.

Schedule Of Natural Expenses
Year Ended September 30, 2007 (With Comparative Totals For 2006)

<table>
<thead>
<tr>
<th>Item</th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$3,467,193</td>
<td>$3,127,883</td>
</tr>
<tr>
<td>Printing</td>
<td>1,004,270</td>
<td>1,003,222</td>
</tr>
<tr>
<td>Fringe benefits and payroll taxes</td>
<td>915,705</td>
<td>917,433</td>
</tr>
<tr>
<td>Travel</td>
<td>620,438</td>
<td>687,663</td>
</tr>
<tr>
<td>Meeting expense</td>
<td>595,626</td>
<td>666,915</td>
</tr>
<tr>
<td>Consultants</td>
<td>571,900</td>
<td>582,931</td>
</tr>
<tr>
<td>Service contractors</td>
<td>518,788</td>
<td>431,406</td>
</tr>
<tr>
<td>Postage and mailing</td>
<td>465,928</td>
<td>404,140</td>
</tr>
<tr>
<td>Office expense</td>
<td>415,538</td>
<td>384,243</td>
</tr>
<tr>
<td>Honoraria</td>
<td>359,175</td>
<td>453,607</td>
</tr>
<tr>
<td>Equipment rental</td>
<td>331,407</td>
<td>275,524</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>264,496</td>
<td>214,758</td>
</tr>
<tr>
<td>Grants</td>
<td>184,268</td>
<td>217,537</td>
</tr>
<tr>
<td>Bank fees</td>
<td>154,724</td>
<td>122,126</td>
</tr>
<tr>
<td>Other</td>
<td>67,703</td>
<td>110,252</td>
</tr>
<tr>
<td>Advertising and promotions</td>
<td>48,796</td>
<td>85,363</td>
</tr>
<tr>
<td>Telephone</td>
<td>30,186</td>
<td>67,970</td>
</tr>
<tr>
<td>Interest</td>
<td>283</td>
<td>1,394</td>
</tr>
</tbody>
</table>

$10,016,424  $9,754,367
The Society Of Nuclear Medicine, Inc.

**Details Of Statement Of Activities**

**Year Ended September 30, 2007 (With Comparative Totals For 2006)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrestricted net assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meetings</td>
<td>$3,821,117</td>
<td>$3,780,933</td>
<td>$3,479,357</td>
<td>$3,427,468</td>
<td>$341,760</td>
<td>$353,465</td>
</tr>
<tr>
<td>Communications</td>
<td>2,394,242</td>
<td>2,096,983</td>
<td>2,032,800</td>
<td>1,751,445</td>
<td>361,442</td>
<td>345,538</td>
</tr>
<tr>
<td>Membership</td>
<td>2,079,304</td>
<td>2,013,774</td>
<td>1,213,748</td>
<td>1,240,121</td>
<td>865,556</td>
<td>773,653</td>
</tr>
<tr>
<td>Professional</td>
<td>754,742</td>
<td>869,782</td>
<td>617,727</td>
<td>647,659</td>
<td>137,015</td>
<td>222,123</td>
</tr>
<tr>
<td>Councils</td>
<td>77,565</td>
<td>51,112</td>
<td>77,565</td>
<td>51,112</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>47,942</td>
<td>90,658</td>
<td>47,942</td>
<td>90,658</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bank interest - Operations</td>
<td>42,667</td>
<td>30,296</td>
<td>42,667</td>
<td>30,296</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Center of excellence</td>
<td>40,604</td>
<td>37,005</td>
<td>40,604</td>
<td>37,005</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Leadership</td>
<td>31,349</td>
<td>17,000</td>
<td>28,889</td>
<td>17,000</td>
<td>2,460</td>
<td>-</td>
</tr>
<tr>
<td>Grants and awards</td>
<td>20,000</td>
<td>188,120</td>
<td>20,000</td>
<td>143,120</td>
<td>-</td>
<td>45,000</td>
</tr>
<tr>
<td>Net assets released from restrictions</td>
<td>683,761</td>
<td>75,842</td>
<td>627,472</td>
<td>75,475</td>
<td>56,289</td>
<td>367</td>
</tr>
<tr>
<td>Total unrestricted revenue and support</td>
<td>9,933,293</td>
<td>9,251,505</td>
<td>8,228,771</td>
<td>7,511,359</td>
<td>1,764,522</td>
<td>1,740,146</td>
</tr>
<tr>
<td>Expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program services:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communications</td>
<td>2,514,551</td>
<td>2,529,760</td>
<td>2,323,408</td>
<td>2,331,559</td>
<td>191,143</td>
<td>198,201</td>
</tr>
<tr>
<td>Meetings</td>
<td>1,629,808</td>
<td>1,739,754</td>
<td>1,609,627</td>
<td>1,715,047</td>
<td>20,181</td>
<td>24,707</td>
</tr>
<tr>
<td>Professional</td>
<td>1,545,601</td>
<td>1,763,197</td>
<td>1,471,933</td>
<td>1,600,277</td>
<td>73,668</td>
<td>162,920</td>
</tr>
<tr>
<td>Leadership</td>
<td>1,375,904</td>
<td>1,312,396</td>
<td>882,832</td>
<td>869,332</td>
<td>493,072</td>
<td>443,064</td>
</tr>
<tr>
<td>Molecular Imaging Campaign</td>
<td>525,972</td>
<td>-</td>
<td>525,972</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Grants and awards</td>
<td>134,290</td>
<td>171,737</td>
<td>121,500</td>
<td>126,370</td>
<td>12,790</td>
<td>45,367</td>
</tr>
<tr>
<td>Health Policy and Regulatory Affairs</td>
<td>111,802</td>
<td>227,076</td>
<td>111,796</td>
<td>225,667</td>
<td>6</td>
<td>1,409</td>
</tr>
<tr>
<td>Councils</td>
<td>64,908</td>
<td>58,055</td>
<td>64,908</td>
<td>58,055</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Center of excellence</td>
<td>10,905</td>
<td>10,510</td>
<td>10,905</td>
<td>10,510</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Support services:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative</td>
<td>647,535</td>
<td>599,051</td>
<td>647,535</td>
<td>599,051</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Finance</td>
<td>542,189</td>
<td>496,373</td>
<td>542,035</td>
<td>494,489</td>
<td>154</td>
<td>1,884</td>
</tr>
<tr>
<td>Information services</td>
<td>464,438</td>
<td>398,651</td>
<td>464,438</td>
<td>398,651</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Membership</td>
<td>332,929</td>
<td>328,591</td>
<td>328,522</td>
<td>327,252</td>
<td>4,407</td>
<td>1,339</td>
</tr>
<tr>
<td>Development</td>
<td>115,592</td>
<td>119,216</td>
<td>66,169</td>
<td>73,295</td>
<td>49,423</td>
<td>45,921</td>
</tr>
<tr>
<td>Management fee</td>
<td>-</td>
<td>-</td>
<td>(593,207)</td>
<td>(985,100)</td>
<td>95,207</td>
<td>985,100</td>
</tr>
<tr>
<td>Total expenses</td>
<td>10,016,425</td>
<td>9,754,367</td>
<td>8,218,373</td>
<td>7,844,455</td>
<td>1,798,051</td>
<td>1,909,912</td>
</tr>
<tr>
<td>Change in net assets before interest and dividends and market value adjustment on investments</td>
<td>(23,131)</td>
<td>(502,862)</td>
<td>10,398</td>
<td>(333,096)</td>
<td>(33,529)</td>
<td>(169,766)</td>
</tr>
<tr>
<td>Unrealized gain (loss) on investments</td>
<td>(78,789)</td>
<td>150,901</td>
<td>(78,789)</td>
<td>150,901</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Realized (loss) gain on investments</td>
<td>387,454</td>
<td>(350)</td>
<td>387,454</td>
<td>(350)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Interest and dividends - Investments</td>
<td>136,053</td>
<td>113,657</td>
<td>136,053</td>
<td>113,657</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Change in net assets before interest and dividends and market value adjustment on investments</td>
<td>444,718</td>
<td>264,208</td>
<td>444,718</td>
<td>264,208</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Change in unrestricted net assets</td>
<td>421,587</td>
<td>(238,654)</td>
<td>455,116</td>
<td>(88,888)</td>
<td>(33,529)</td>
<td>(169,766)</td>
</tr>
<tr>
<td>Temporarily restricted net assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions</td>
<td>3,451,147</td>
<td>10,000</td>
<td>3,451,147</td>
<td>10,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net assets released from restrictions</td>
<td>(683,761)</td>
<td>(75,842)</td>
<td>(627,472)</td>
<td>(75,475)</td>
<td>(56,289)</td>
<td>(367)</td>
</tr>
<tr>
<td>Change in temporarily restricted net assets</td>
<td>2,767,386</td>
<td>(65,842)</td>
<td>2,823,675</td>
<td>(65,475)</td>
<td>(56,289)</td>
<td>(367)</td>
</tr>
<tr>
<td>Change in net assets</td>
<td>$3,188,973</td>
<td>$304,496</td>
<td>$3,278,791</td>
<td>$134,363</td>
<td>$89,818</td>
<td>$170,133</td>
</tr>
</tbody>
</table>
The PET Utilization Task Force was created by the PET Center of Excellence in November 2007 to develop a plan to address the recent decrease in PET/CT utilization. Dr. Homer Macapinlac was named Chair of the Task Force with assistance from Dr. George Segall. The activities of the task force are currently being funded by the Molecular Imaging Center of Excellence ($55,000) and the PET Center of Excellence ($30,000), totaling $85,000. The task force is comprised of physicians, technologists, and industry representatives. The members of the task force were selected by the PET Center of Excellence Board of Directors with input from the SNM Leadership.

The task force has been charged with: identifying the factors responsible for the penetration and growth of PET/CT in oncology, cardiology, and neurology; identifying the opportunities and threats regarding PET/CT utilization; and developing short-term goals and long-range plans to increase PET/CT utilization.

The first face-to-face meeting of the task force was January 15 in Chicago, IL, with over 25 individuals in attendance. Background information was gathered for the meeting and can now be found on the PET CEO webpage (once you log-on to the website). Susan Wallace, MD served as the facilitator with discussion centering around referring physician needs and interpreting physician needs. From this meeting a list of short-term and long-term goals were developed (see attached).

Several working groups have been identified and potential chairs have been contacted to begin working towards these goals: survey referring physicians to understand current state and validate assumptions; provide clinical education to improve accuracy and quality of PET/CT Services that are being provided; change Practice Guidelines to include PET/CT (update response criteria); design and Initiate studies to demonstrate cost-effectiveness & outcomes; convince ASCO to initiate a PET/CT awareness campaign (joint effort w/ SNM); design & initiate evidence based studies to justify PET/CT studies; and document Clinical Best-Practices and Develop Information Sharing Method(s).

The task force has been working diligently over the past several months to develop this plan and will continue working over the next year to ensure that momentum does not stop. We hope that this task force will prove successful in identifying the factors responsible for the penetration and growth of PET/CT in oncology, cardiology, and neurology and identifying the opportunities and threats regarding PET/CT utilization.
PET Utilization Task Force
Action Plan
January 15, 2008
<table>
<thead>
<tr>
<th>FOCUS AREA</th>
<th>GOALS</th>
<th>CHAMPIONS</th>
<th>YEAR 1</th>
<th>YEARS 2-3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REFERRING PHYSICIANS</strong></td>
<td>• Identify needs that are/are not being met</td>
<td>Macapinlac Peller</td>
<td>• Develop and distribute survey related to current satisfaction level of the PET/CT services they are receiving and to identify specific quality issues. Also include broader questions related to reasons why they refer today (or not). Be sure to investigate details related to reports (what they like, what they don't like, what they want). • Summarize data and develop an action plan to meet needs • Discuss action plan with other professional groups, such as ASCO, to enlist their cooperation and help</td>
<td>• Provide education for administrators to support investments in improved quality of services • Develop and distribute materials that referring physicians can use for patients • Provide resources to help with authorization of services by third party payors • Meet other needs identified in survey</td>
</tr>
<tr>
<td><strong>PRACTICE GUIDELINES</strong></td>
<td>• Develop clinical practice guidelines to ensure appropriate utilization and proper performance of PET/CT • Develop a summary of best practices to supplement practice guidelines</td>
<td>Segall Fletcher Delbelke</td>
<td>• Collect and review existing practice guidelines • Distribute, revise, develop guidelines for oncology, neurology, and cardiology • Develop educational materials describing best practices • Develop educational activities (on-line, meetings)</td>
<td>• Distribute/publish guidelines and best practices • Implement nation-wide educational activities • Work with ASCO, ASTRO, NCCN and other professional groups to ensure appropriate utilization of PET/CT in practice guidelines</td>
</tr>
<tr>
<td><strong>NUCLEAR MEDICINE PHYSICIANS AND RADIOLOGISTS</strong></td>
<td>• Identify the educational need of physicians and technologists who perform and interpret PET/CT • Develop a report template to standardize reporting and improve quality</td>
<td>Shreve Rohren</td>
<td>• Develop programs to educate Nuclear Medicine physicians to interpret CT, and Radiologists to interpret PET • Provide education for physicians on the needs of referring physicians and elements of a good report • Develop report template</td>
<td>• Implement nation-wide educational activities Develop self tutorial for elements of a good report • Develop clinical support team to do on-site evaluation, consultation, and training</td>
</tr>
<tr>
<td><strong>RESEARCH</strong></td>
<td>• Identify research priorities • Develop standardized research methodology that will facilitate aggregation of data • Collect data on cost-effectiveness of PET/CT</td>
<td>Graham</td>
<td>• Identify research needs and list priorities • Create an electronic library of studies on the cost-effectiveness of PET/CT • Identify programs within SNM that could provide financial support for research in areas identified as high priority • Identify individuals/sites for research</td>
<td>• Develop standardized research methodology • Provide financial support for research in high-priority areas</td>
</tr>
<tr>
<td>Need</td>
<td>Impact on Increasing Referrals (H, M, L)</td>
<td>Solution Availability Today (H, M, L)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>--------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good reports - short, precise, accurate, interpreter’s competence as consultant</td>
<td>H</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide evidence based studies to justify PET/CT studies</td>
<td>H</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Update response criteria to include PET response (change guidelines)</td>
<td>H</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical management pathways for under utilized indications</td>
<td>H</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Survey why oncologists don’t refer; create panel to investigate what they need</td>
<td>H</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASCO driving PET/CT awareness campaign</td>
<td>H</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broad coverage by CMS and private payers</td>
<td>H</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>one call to schedule; for reimbursement issues</td>
<td>H</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cost effectiveness data &amp; outcome tracking</td>
<td>H</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy pre-authorization process (full burden on referring physician office)</td>
<td>H</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>easy pathway to web based info</td>
<td>H</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Info on how PET can make their job easier</td>
<td>H</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased cooperations between societies for coverage</td>
<td>H</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What do I do with this information? How does this change patient management? -</td>
<td>H</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>stratify patient into correct treatment plan</td>
<td>H</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>tumor board marketing tools</td>
<td>H</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>quality PET/CT imaging (protocol, patient prep)</td>
<td>H</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>understand reimbursed indications</td>
<td>H</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>patient risk vs benefit</td>
<td>H</td>
<td>H</td>
<td></td>
<td></td>
</tr>
<tr>
<td>clinical protocols</td>
<td>H</td>
<td>H</td>
<td></td>
<td></td>
</tr>
<tr>
<td>positive patient experiences</td>
<td>H</td>
<td>H</td>
<td></td>
<td></td>
</tr>
<tr>
<td>response to patient advocacy groups</td>
<td>H</td>
<td>H</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PET/CT vs. other modality options</td>
<td>H</td>
<td>H</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reach patients in order to impact PET/CT scans</td>
<td>M</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CME from an oncology society &amp; endorsements; web resources for referring MDs</td>
<td>M</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>promote patient safety</td>
<td>M</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>one stop shop - PET optimized CT (Full PET &amp; Full diagnostic CT read) - simple scheduling for patient &amp; integrated report</td>
<td>M</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>data on which patient types are appropriate for PET</td>
<td>M</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient FAQ and reference guide</td>
<td>M</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>response to patient demand</td>
<td>M</td>
<td>H</td>
<td></td>
<td></td>
</tr>
<tr>
<td>support of administrators</td>
<td>M</td>
<td>H</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-tumor metabolic maps</td>
<td>L</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>identify biomarker presence or absence</td>
<td>L</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dosimetry for RIT</td>
<td>L</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>improve PACS systems so they view images properly</td>
<td>L</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>improve CD ROMs so outside studies can be viewed properly</td>
<td>L</td>
<td>L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PET practice guidelines</td>
<td>L</td>
<td>M</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Interpreting Physician Needs Prioritization

<table>
<thead>
<tr>
<th>Need</th>
<th>Impact on Increasing Referrals (H, M, L)</th>
<th>Solution Availability Today (H, M, L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- standard templates &amp; structured reporting</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- improved software for image viewing</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- historical information (prior studies)</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- timely</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- do they answer the clinical question?</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- provide images with reports</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- CME</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- measure the service provided</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- tele medicine - friendly reports for remote interpretation</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- cross-train nucs to read CT &amp; rads to read PET</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- SNM provides fast track training for CT</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- education on referring MD needs</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- faster analysis of PET studies</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- train residents &amp; fellows in radiology &amp; nuc med</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- educate office staff &amp; support group surrounding practice</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>Competency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- certification or proof; accreditation</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- incentive to improve quality</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- quality assurance programs</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- review quality of scans &amp; reports included in equipment sale</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>Improved Communication between referring and interpreting MDs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- improved relations with med onc, rad onc &amp; surgeons</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- education tools on how to work with payors for coverage</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- administrator’s education to support investments in quality of PET center</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>Improved Education Materials for Interpreting MDs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- electronic library of PET/CT information</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- marketing materials - how to sell PET</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- standard procedures</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>- material to provide patients and referring MDs</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td>Greater confidence in reimbursement stability</td>
<td>H</td>
<td>M</td>
</tr>
<tr>
<td>Better / Faster computers and software programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Fee = work load</td>
<td>H</td>
<td>M</td>
</tr>
<tr>
<td>When do I order a follow-up exam?</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>New radiopharmaceuticals</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Bring Preceptorships &amp; Education to them so they do not need to leave practice</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Better understanding of pre-authorization process</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Help with turf war - Radiology vs. CT department</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Access to expert for over-reads &amp; protocol</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Payment for CT portion of PET/CT</td>
<td>M</td>
<td>M</td>
</tr>
</tbody>
</table>
**Referring Physicians**

- **Good reports - short, precise, accurate, Interpreter Competence as consultant**
  - Broad survey referring physicians (medical oncologists) related to current satisfaction level and to identify specific
  - Need to identify an incentive to get referrers to respond to the broad survey.
  - ASCO focus group to get deeper understanding of the survey results.
- **Survey why oncologists don't refer; create panel to investigate what they need**
  (see above survey)
- **ASCO driving PET/CT awareness campaign (joint effort w/ SNM)**
  - Identify PUTF member to sit on Advocacy task force and communicate needs of PUTF to that group for actions.
- **Easy pre-authorization process (full burden on referring physician office)**
  - Education
    - education on referring MD needs
    - train residents & fellows in radiology & nuc med / education office staff & support group surrounding practice
  - **Improved Communication between referring and interpreting MDs**
    - administrator's education to support investments in quality of PET center

**Practice Guidelines**

- **Update response criteria to include PET/CT (change guidelines)**
  - Survey ACRIN, SWOG, RTOG, ACSOG, NCI to identify existing studies (get from Barry Siegel?)
- **Clinical management pathways for under utilized indications**
  - Approach NCCN to modify guidelines for the 'Big 5' - start w/ breast
- **ASCO driving PET/CT awareness campaign (joint effort w/ SNM)**
  - Identify PUTF member to sit on Advocacy task force and communicate needs of PUTF to that group for actions.
- **Quality Reporting**
  - practice guideline to be approved by SNM and published in JNM
  - Overall report quality - standardized templates & structured reporting, improved software for image viewing - faster analysis, historical information, answer clinical questions, provide images with reports, CME, measure the service provided, tele-medicine friendly reports for remote interpretation
  - Gather: ICANL elements for reporting, ACR standards, any software solutions? etc.
  - - get data from NOPR to see common mistakes and missing elements
  - - go to sites who already have templates that work - MD Anderson
  - - incorporate needs of the referring MD
  - **Improved Education Materials for Interpreting MDs**
  - Standard Procedures (See Quality Reporting)

- **Simply referral process: e.g. one call to schedule; for reimbursement issues**
  - Create best-practice sharing task force / sub-committee
  - SNM sanctioned how-to brochures/website
  - Ideally, develop nation-wide clinical support team,
  - Consider reverse fellowship program
### Nuclear Medicine Physicians and Radiologists

**Quality Reporting**
Build into MOC process ABR & ABNM joint effort - create society sponsored performance improvement module satisfying part 4 requirements - *(separate SNM task force looking for projects)*

**Education**
cross-train nucs to read CT & rads to read PET - PET review course for those techs taking the PET Boards how to be a better PET Champion fast track training for CT - Weekend PET/CT certification program sanctioned by SNM for radiologists to meet requirements - sample curriculum; does demand exist? How will it be marketed?

**Competency**
already part of MOC; PET/CT competency module (accreditation, incentive to improve quality, quality assurance programs, review quality of scans & reports include in equipment sales)

**Improved Communication between referring and interpreting MDs**
education tools (how to work with payors) quality & grow speakers' bureau

### Cost effectiveness data & outcome tracking

**Define and initiate NOPR2**
Consider retrospective study Data mining for current NOPR Cost effectiveness prospective study

**Easy pathway to web based info**

**Research**
fast track training for CT - Weekend PET/CT certification program sanctioned by SNM for radiologists to meet requirements - sample curriculum; does demand exist? How will it be marketed? faster analysis of PET studies via software developments

**Improved Education Materials for Interpreting MDs**
Electronic Library of PET/CT Information (centrally located)

**Payment for CT portion of PET/CT**

### Good reports - short, precise, accurate, Interpreter Competence as consultant
Structure a small study to validate that perception of report really does improve when the new report standards are implemented. Measure current state Measure improved state

**Design & initiate evidence based on studies to justify PET/CT studies**

**Update response criteria to include PET/CT (change guidelines)**
Complete Meta Study Meta analysis of existing guidelines by indication (start with Breast? Mankoff?) Integrate into already planned studies

**ASCO driving PET/CT awareness campaign (joint effort w/ SNM)**

### Miscellaneous

**Produce joint white papers**

**Quality Reporting**
SNM certification for CT - certifying documentation and not competency; would need to be brought up to board incorporate into new software releases or industry distribution channels build into NOPR2
<table>
<thead>
<tr>
<th>Action (What)</th>
<th>Articulate a clear deliverable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improved Communication between referring and interpreting MDs</strong></td>
<td>- improve relations with med onc, rad onc &amp; surgeons</td>
</tr>
<tr>
<td></td>
<td>- technology based communications?</td>
</tr>
<tr>
<td><strong>Improved Education Materials for Interpreting MDs</strong></td>
<td>- how do we promote awareness? - MI site for patients &amp; referring MDs (see as a PET/CT resource, not solely an SNM resource)</td>
</tr>
</tbody>
</table>


Members of the PET Utilization Task Force Committee:

Facilitator (1):
Dr. Sue Wallace

Industry (15):
Ms. Lynn Bender (Cardinal Health)
Ms. Teri Blomker (Siemens Medical Solutions USA)
Mr. Jim Cavanaugh (Philips)
Ms. Michelle Emsdorff (IBA Molecular)
Dr. Richard Frank (GE Healthcare)
Mr. Bob Kovac (Bracco Diagnostics, Inc.)
Ms. Jenny Lynch (Cardinal Health)
Ms. Kim McDaniel (Bracco Diagnostics, Inc.)
Ms. Sue Minerch (Siemens Medical Solutions USA)
Dr. Ron Petrocelli (Siemens Medical Solutions USA)
Mr. Anwer Rizvi (IBA Molecular)
Mr. Scott Schubert (GE Healthcare)
Ms. Tamar Thompson (Bracco Diagnostics, Inc.)
Dr. Thom Tulip (Bristol-Myers Squibb Medical Imaging)
Mr. Peter Webner (IBA Molecular)

Physicians (14):
Dr. Harry Agress (Hackensack University Medical Center)
Dr. Robert Atcher (Los Alamos National Lab)
Dr. Jacqueline Brunetti (Holy Name Hospital)
Dr. Michael Graham (University of Iowa)
Dr. Warren Janowitz (Baptist Hospital of Miami)
Dr. Michael Kipper (Scripps Mercy Hospital)
Dr. Homer Macapinlac (M.D. Anderson Cancer Center)
Dr. David Mankoff (University of Washington Medical Center)
Dr. Alexander McEwan (Cross Cancer Institute)
Dr. Patrick Peller (Mayo Clinic Rochester, MN)
Dr. Eric Rohren (U. T. M. D. Anderson Cancer Center)
Dr. George Segall (VA Medical Center)
Dr. Paul Shreve (PET Medical Imaging Center)
Dr. Jack Ziffer (Baptist Hospital of Miami)

Technologist (1):
Mr. Paul Christian (Huntsman Cancer Institute, U of Utah)

Consultant (1):
Ms. Joanne Lockwood

SNM (3):
Virginia Pappas, CEO
Nikki Wenzel, Associate Director, Leadership Services
Cara Hinman, Program Manager, Leadership Services

Total Members: 35
Molecular Imaging Center of Excellence Report
Martin Pomper, MD
Committee Charges for 2007-2008:

The goals for the following four years of the Molecular Imaging Center of Excellence (MICoE) are to:

- Provide indispensable resources for education, knowledge exchange, training, and networking (education, communications)
- Advocate for molecular imaging and therapy (advocacy)
- Educate and promote collaboration with referring physicians and patient groups (outreach and communications)
- Support innovations in translational research (translational issues)
- Position molecular medicine as an essential tool in providing the highest standards of patient care around the world.

As you are aware, these are the same goals identified in the SNM Strategic Plan. MICoE has had the lead for implementing the goals in conjunction with existing SNM staff, Committees, Councils, and the PET Center.

Current Working Objectives/Goals (please reference Strategic Plan):

A1. Objective: Position SNM as a central education and research repository for molecular imaging and therapy.
A2. Objective: Create awards, grants and fellowships for individuals interested in molecular imaging.
A3. Objective: Develop fellowship and residency curricula.
A4. Objective: Attract and address diversified educational needs of nuclear medicine and molecular imaging practitioners.
A7. Objective: Complete and implement an internal communications plan to communicate to members and member groups that the society is their indispensable resource for molecular imaging.
B1. Objective: Take a proactive role advocating for reimbursement and research funding.
C1: Objective: Create outreach program aimed at referring physicians, patient groups, federal agencies, regulators and general public.
D1: Objective: Define translational research from bench to bedside – research to practice.
D3. Develop research program to assist new investigators in the field of molecular imaging.
D7. Objective: Assure the viability of MI through the development of techniques that meet a clinical need and that are reimbursable.
D5. Objective: Develop standardized imaging protocols, outcome measures and the role of biomarkers in clinical trials.
E1. Objective: Develop an integrated strategic marketing plan to position SNM as the recognized leader in molecular imaging initiatives.
F. Objective: SNM will attract researchers, technologists and laboratory technicians involved in molecular imaging as members.

Progress of Charge/Objectives/Goals to Date:

In the past year, the MICoE has made remarkable progress toward its ambitious goals. To build our capacity to achieve these goals, we have developed an infrastructure that includes a staff of three working at SNM headquarters, set up a governance and committee structure for the Center that includes diverse membership, held elections, and are reaching out to the wider molecular imaging and therapeutic communities. We launched a
program that provides not only free membership to all SNM members, but a free trial membership in the MICoE to anyone (including non-SNM members) with an interest in MI.

The 2007-2008 Board of Directors election brought several changes. Lily Wu, MD, PhD from UCLA was elected to her first 3 year term, Scott Holbrook, B.S., CNMT from Precision Nuclear, previously an ex-officio member of the board, was elected to a 3 year term, and Craig Levin, MD, PhD from Stanford University was reelected to a 3 year term. Michael Graham, MD, PhD from the University of Iowa was appointed as the new liaison to the SNM Board. Although Todd Peterson, PhD and George Sgorous, PhD left the Board, they continue to serve the Center in several capacities. In addition, a new nominating committee, consisting of Mathew L. Thakur, PhD (chair), Al Sinusas, Craig Levin, Ben Tsui, and Julie Sutcliffe will be developing the slate of candidates for the next election.

Communications
Getting the word out was our first order of business this year. We launched a monthly MI Update column in Newsline last February, and in December JNM began a series of short review articles called Focus on Molecular Imaging. A new Web site, www.molecularimagingcenter.org was launched last summer; we expect it to become one of the primary ways we will provide “indispensable resources for education, knowledge exchange, training, and networking.” We also launched a quarterly newsletter, MI Gateway that is distributed to the entire SNM membership with every third issue of JNM. Another resource that will be indispensable to anyone who wants to keep up with the expanding MI field is our monthly e-mail service to MICoE members. It includes a list of the most recent research in MI as well as other news of interest.

We knew that to move forward in a new field, it was essential to first agree on a definition of molecular imaging that would guide our actions. In the June Molecular Imaging Update (J Nucl Med. 2007;48:18N–21N), David Mankoff, chair of the Definitions Task Force, provided a definition that has made the decision-making process far clearer. Here is the short version:

Molecular imaging is the visualization, characterization, and measurement of biological processes at the molecular and cellular levels in humans and other living systems. Molecular imaging typically includes two- or three-dimensional imaging as well as quantification over time. The techniques used include radiotracer imaging/nuclear medicine, MRI, MRS, optical imaging, ultrasound, and others.

Our new public relations firm will be developing a “lay-person’s” version of this definition.

Looking forward, a JNM supplement on MI is in the works, as is a series of brochures on the practical benefits of MI. Our new speaker’s bureau is accepting applications from both speakers and organizations seeking speakers. Speakers have been funded to attend four chapter meetings thus far.

In 2007 we took MI on the road with a presentation designed to inform industry partners about our activities and the funding opportunities that were available to them through the MI Bench to Bedside campaign.

We have hired a new global public relations firm and will be intensifying our media campaign. As part of this effort, a “rapid action response” team is being developed to respond to timely issues, such as the recent isotope shortages, through op-ed editorials and media contacts. SNM recently launched a new e-mail news service to bring a daily dose of news on molecular imaging and other medical and governmental issues that affect our profession.

Advocacy
Advocacy is an important part of our mission. In addition to ongoing meetings with key legislators and federal officials, advocacy efforts last year featured a new element—Capitol Hill Day, held during our annual meeting in Washington, DC. SNM also ran a full-page ad in Roll Call, the Capitol Hill newspaper, to underline the case for more funding for basic nuclear medicine research, which was supported by the 2007 National Academy of Sciences report on the state of the science in nuclear medicine.

Outreach
Through the hard work of many MICoE members, we have worked to develop or strengthen strategic partnerships and collaborations, not only with other imaging societies but with organizations such as the American Society for Therapeutic Radiology and Oncology, the American Society of Clinical Oncology, the Radiation Therapy Oncology Group, the American Chemical Society, the American Academy of Neurology, and the American Heart Association. We have begun patient outreach activities and will continue our efforts to build partnerships with patient advocacy groups in the coming year.
Education
The educational activities at SNM mid-winter and annual meetings are expanding their focus on molecular imaging. At last June’s Annual Meeting, SNM hosted the first Molecular Imaging Gateway, a gauntlet of educational exhibits lining the corridor leading to the exhibit hall. Our next annual meeting, in New Orleans this June, will repeat the Gateway exhibits and will feature new molecular imaging educational and abstract tracts.

We are also supporting the education and training of the molecular medicine practitioners of the future through a series of new and expanded grants to residents and researchers.

Last fall, the MICoE Education Task Force submitted formal recommendations to the nuclear medicine residency review committee (RRC) for curriculum revisions that include increased emphasis on basic science topics such as molecular and cell biology and molecular imaging agents. While our task force includes several program directors, both SNM and the nuclear medicine RRC have solicited comments from a wider group of program directors through a survey, and will continue to outreach to this important group. Although curriculum change is a multi-year process, we are now working to identify specific resources in each of these new areas, including on-line courses, workshops, and articles.

Translational/Other Activities
Our third MI summit will be held this month immediately following the SNM Mid-Winter Educational Symposium. Experts from industry, academia, and practice have been invited to Molecular Imaging: The Future of Modern Medicine, where they will focus on how to move molecular imaging techniques into mainstream medicine. “Translational medicine” is a major theme in all of our activities. Last June we held an action planning retreat for some of the most promising technologies. Recommendations from that retreat are being prepared for publication, and we are planning a series of future retreats and advocacy activities to encourage the process of translating our science into techniques with practical benefit to patients.
Corporate Fundraising

- Corporate gifts and pledges total $4,140,000 as of February 4, 2007.

- Our Honor Roll of Donors includes:
  - Corporate Circle ($500,000 +):
    - GE Healthcare
    - Bristol-Myers Squibb Medical Imaging
    - IBA Molecular
    - Siemens Medical Solutions USA
    - Covidien (formerly Tyco Healthcare/Mallinckrodt)
Corporate Honor Roll

– Corporate Visionary (250,000 to $499,999):
  • Cardinal Health
  • Philips
  • MDS Nordion
  • Bracco Diagnostics
Corporate Honor Roll

– Corporate Contributor ($50,000 to $99,999):
  • Molecular Insight
  • Mediso Medical Imaging Systems

– Corporate Friend ($5,000 to $49,999):
  • FlouroPharma
  • Digirad
More to Come…

• Decisions are pending in all giving levels with 3 companies.
• 133 companies have been contacted for participation.
• Scheduling for discovery calls with major pharmaceutical companies is ongoing.
The Education and Research Foundation of SNM

• The ERF is responsible for seeking individual support for the campaign. Their goal is to secure member participation.

• They intend to raise $500,000 for the Campaign over five years.

• $136,241 in gifts/pledges has been raised as of December 31, 2007.

• There are two major gift requests totaling $30,000 under consideration now.

• Regional dinners are being planned to secure major donor support from our top 30 prospects. There will be two such meetings this week.
Gifts and Pledges from corporate and individual donors combined total $4,276,241 of our $5,000,000 goal to date.
World Molecular Imaging Conference
SNM & World Molecular Imaging Conference (WMIC)

Below are the arrangements with the WMIC organizers concerning SNM’s participation in the WMIC.

1. SNM will co-organize a clinical PET session at WMIC.
2. Representing the SNM on the WMIC Program Committee will be Homer Macapinlac and Henry Van Brocklin (likely).
3. Homer and Henry will work with the appropriate representatives of the WMIC steering and program committees in developing the session.
4. The SNM will reimburse all travel-related costs for co-organized session.*
5. The SNM will cover the cost of room rental and AV for the co-organized session**
6. The SNM will be recognized as the session co-organizer in primary meeting materials.
7. The SNM will be recognized on the WMIC website with logo (and perhaps other marketing literature) and brief verbiage regarding the session (as it develops)

* The WMIC Steering Committee has authorized the following reimbursement guidelines:
  1. Up to $500 for European travel plus three nights hotel
  2. Up to $1,500 for Asian and American travel plus three nights hotel
  3. No honorarium

** SNM would pay actual costs for room rental and audio-visual (AV) estimated at $1,000 room rental and $1,000 AV.
Coding and Reimbursement
Health Care Policy and Practice
Physician Quality Reporting Initiative (PQRI)
Background

In June 2007 SNM President Sandy McEwan created a working group to develop measures for the AMA Physician's Consortium on Quality. In order to understand the progress this group has made, it is necessary to describe the process that must be undertaken to produce a physician quality measure. There were numerous lessons learned during this process, which can be applied to future measures and some lessons, which may affect future guideline development within the SNM.

The AMA Physician Consortium has a very well structured process it follows in creating quality measures. This process involves selection of a procedure that can be measured with reference to physician performance, followed by the constitution of the multispecialty working group to develop a framework for the measure. As part of this procedure there are two co-chairs for development of each procedure. One of the co-chairs comes from the lead organization, which is in this case the SNM and the other is an expert in the methodology of quality measure development. We were very fortunate to draw Dr. Paul Wallner, a well-known radiation oncologist as the co-chair expert in methodology. Dr. Wallner proved invaluable in assisting in the development of the measures to date.

Once the measure is developed to the satisfaction of the working group it is posted for public comment. Following public comment the measures is reviewed once again by the working group in light of the public comments and modifications are made as necessary. The format for quality measures is not flexible. The same format must be followed by all medical specialties. In addition, the quality measures format is based on a single physician-patient interaction in a traditional setting. The process is not well designed for a diagnostic only procedure or specialty. It is expected that the procedure chosen will be based on an analysis of gaps in care from prior studies. The structure of quality measure is usually derived from practice guidelines developed by the organization. Since our guidelines address predominantly technical issues rather than physician performance we encountered problems with lack of specification as to how our physicians are expected to perform. Additional criteria that must be satisfied are that the majority of practitioners within the specialty must perform this procedure, and the procedure should have a significant financial impact.

The initial request by the SNM was to develop procedures related to cardiac imaging. This request was denied because there are already too many cardiac physician quality measures. Consideration was given to developing a quality measure based on thyroid imaging. However, when analyzed the volume of thyroid imaging today is relatively small and its dollar impact is quite low. No studies have been performed in nuclear medicine to demonstrate where gaps in care exist. After analysis, two procedures that appeared to fulfill the criteria for high-volume high dollar impact were identified. These were perfusion lung imaging and bone scanning. Because of political issues surrounding
perfusion lung imaging it was elected to use the bone scan as the model procedure.

Bone scanning was accepted by the Consortium as a procedure and a call was put out to all medical specialties to nominate individuals to serve on working group. It had been hoped that we would be able to recruit physicians from orthopedics, oncology, radiology, and pediatrics for service. In fact, only radiology responded nominating a member for the working group. AMA called on a retired oncologist to serve on the working group as well. In addition, several AMA consultants were tasked with assisting the working group. In late August of 2007 the working group met in Chicago at which time four potential physician quality measures were developed. Subsequently, the working group went on to further define the conditions of these measures and to describe how they might be employed. The draft measures were circulated to several quality groups as well as the AMA consultants. Review by the quality groups and AMA consultants indicated that at least two of the measures would not be tenable based on implementation problems. Generally, CPT codes, both level I and level II are employed for the quality measures. Two of the measures were dropped because of the difficulty in developing descriptive CPT level to codes and envisioned difficulty in processing of data for those measures. The surviving measures were further refined. These measures required the interpreting physician for bone scans to indicate whether or not comparison was made to other imaging procedures at the time of interpretation. Successful completion of this measure would require the physician to code 80% of the procedures he or she performs as having been compared or not having been compared. The second measure that survived involves a communication standard requiring physicians interpreting bone scans to directly notify the referring physician if in the opinion of the nuclear medicine physician the bone scan contains a finding that might result in a pathologic or imminent fracture.

Current Status

At the present time, the measures are awaiting a presentation to the meeting of the Consortium on February 29, 2008 in Washington, DC. Dr. Robert Henkin will present the measures to date to the Consortium as the workgroup chair from the lead organization. If the Consortium of votes to accept these two measures there are two further steps. These steps involve presentation to outside quality organizations, which must review and accept or reject these measures. We expect this to be a difficult session as purely diagnostic measures have been infrequently reviewed by the quality organizations. The measures developed by radiology today are rather limited and involve specific measurements in certain clinical settings. These measures, incidentally, were not developed directly by radiology. Radiology currently has submitted several measures that they have developed that are parallel in process to what our measures are. If the quality groups approve our measures they will be presented to CMS for final review. Even if the Consortium and the quality groups approve the measures CMS still has the option to reject them for reimbursement. The region five CMS medical director was present during the initial meetings of the workgroup, however, and felt that we were on the right track. The earliest that these measures could be used by CMS for reimbursement would be calendar year 2009.
Lessons Learned

Perhaps the most important lesson we have learned in this process is that the nature of our guidelines do not lend themselves easily to development of physician quality measurements. If we intend to pursue this further we need to consider the development of specific physician guidelines. In addition, the absence of information on gaps in medical care makes selection of topics for quality management development very difficult. Some consideration needs to be given assessment of gaps in care delivered by nuclear medicine physicians.
Nuclear Medicine: Radionuclide Bone Imaging
Physician Performance Measurement Set

For Consortium Vote
February 29, 2008

Nuclear Medicine Work Group
Robert Henkin, MD, FACNP, FACR (Co-Chair) (Nuclear Medicine)
Paul Wallner, DO, FACR, FAOCR, FASTRO (Co-Chair) (Radiation Oncology)
Sue Abreu, MD, FACNP (Nuclear Medicine)
Terence Beven, MD, FACNP (Nuclear Medicine)
Gary L. Dillehay, MD, FACR, FACNP (Radiology & Nuclear Medicine)
Gregory A. Francken, MD (Diagnostic Radiology)
Mark Gebhardt, MD (Orthopedic Surgery)
Leonie Gordon, MD, FACNP (Nuclear Medicine)
Kenneth McKusick, MD, FACR, FACNP (Radiology & Nuclear Medicine)
Haydee Muse, MD (Health Plan representative, Internal Medicine & Pulmonary Medicine)
Henry D. Royal, MD, FACR, FACNP (Nuclear Medicine & Internal Medicine)
John Schneider, MD, PhD (Internal Medicine)
William G. Spies, MD, FACR (Radiology & Nuclear Medicine)
Amol M. Takalkar, MD, FACNP (Nuclear Medicine)
Robert Wagner, MDMD, MSMIS, FACNP (Nuclear Medicine)
Elizabeth Yung, MD (Radiology & Nuclear Medicine)

American Medical Association
Joseph Gave, MPH
Kendra Hanley, MS, CHE
Karen Kmetik, PhD
Shannon Sims, MD, PhD
Beth Tapper, MA

Centers for Medicare and Medicaid Service
Sue Nedza, MD, MBA, FACEP
Sylvia Publ, MBA, RHIA

Consortium Consultants
Rebecca Kresowik
Timothy Kresowik, MD

Society of Nuclear Medicine
Emily Gardner
Denise A. Merlino, MBA, CNMT, CPC

American College of Radiology
Carolyn R. MacFarlane, MS, CNMT
Judy McKenzie
Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians.

These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.

Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.

THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND

© 2007 American Medical Association. All Rights Reserved

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

THE SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.
Purpose of Measures:
These clinical performance measures, developed by the Society of Nuclear Medicine (SNM) and the Physician Consortium for Performance Improvement® (Consortium), and are designed for individual quality improvement. Unless otherwise indicated, the measures are also appropriate for accountability if appropriate methodological, statistical, and implementation rules are achieved.

Accountability Measures:
Measure #1: Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
Measure #2: Communication to Referring Physician of Patient’s Potential Risk for Fracture for All Patients Undergoing Bone Scintigraphy

Intended Audience and Patient Population:
These measures are designed for use by physicians and for calculating reporting or performance measurement at the individual physician level. When existing hospital-level or plan-level measures are available for the same measurement topics, the Consortium attempts to harmonize the measures to the extent feasible.

These measures are designed for Nuclear Medicine physicians, Radiologists and other physicians directing or performing the selected imaging examinations

The Consortium also encourages the use of these measures by eligible health professionals, where appropriate.

Measure Specifications
The Consortium seeks to specify measures for implementation using multiple data sources, including paper medical record, administrative (claims) data, and particular emphasis on Electronic Health Record Systems (EHRS). Draft specifications to report on these measures for Nuclear Medicine using administrative (claims) data are included in this document. We have identified codes for these measures, including ICD-9 and CPT (Evaluation & Management Codes, Category I and where Category II codes would apply). Specifications for additional data sources, including EHRS, will be fully developed at a later date. We welcome comments on the draft specifications included in addition to the measure language.

Measure Exclusions:
For process measures, the Consortium provides three categories of reasons for which a patient may be excluded from the denominator of an individual measure:

1. **Medical reasons**
   Includes:
   - not indicated (absence of organ/limb, already received/performd, other)
   - contraindicated (patient allergic history, potential adverse drug interaction, other)
   - intolerant

2. **Patient reasons**
   Includes:
   - patient declined
   - economic, social, or religious reasons
   - other patient reasons

3. **System reasons**
   Includes:
   - resources to perform the services not available
   - insurance coverage/payor-related limitations
   - other reasons attributable to health care delivery system

These measure exclusion categories are not available uniformly across all measures; for each measure, there must be a clear rationale to permit an exclusion for a medical, patient, or system reason. The exclusion of a patient may be reported by appending the appropriate modifier to the CPT Category II code designated for the measure:

- **Medical reasons**: modifier 1P
- **Patient reasons**: modifier 2P
- **System reasons**: modifier 3P

© 2007 American Medical Association. All Rights Reserved.
CPT® Copyright 2006 American Medical Association
Although this methodology does not require the external reporting of more detailed exclusion data, the Consortium recommends that physicians document the specific reasons for exclusion in patients' medical records for purposes of optimal patient management and audit-readiness. The Consortium also advocates the systematic review and analysis of each physician's exclusions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exclusion.

Please refer to documentation for each individual measure for information on the acceptable exclusion categories and the codes and modifiers to be used for reporting.

Measures #1-2 in the Nuclear Medicine measurement set are process measures.

For outcome measures, the Consortium specifically identifies all acceptable reasons for which a patient may be excluded from the denominator. Each specified reason is reportable with a CPT Category II code designated for that purpose.

There are no outcome measures in the Nuclear Medicine measurement set.

The Consortium continues to evaluate and likely will evolve its methodology for handling exclusions as it gains experience in the use of the measures. The Consortium welcomes comments on its exclusions methodology.

Data Capture and Measure Calculation
The Consortium intends for physicians to collect data on each patient eligible for a measure. Feedback on measures should be available to physicians by patient to facilitate patient management and in aggregate to identify opportunities for improvement across a physician's patient population.

Measure calculations will differ depending on whether a rate is being calculated for performance or reporting purposes.

The method of calculation for performance follows these steps: first, identify the patients (or reports) who meet the eligibility criteria for the denominator (PD); second, identify which of those patients (or reports) meet the numerator criteria (A); and third, for those patients (or reports) who do not meet the numerator criteria, determine whether an appropriate exclusion applies and subtract those patients from the denominator (C). (see examples below)

Note: For measure 1 in the Nuclear Medicine measurement set, the unit of measurement is the “final report”, rather than “patients”.

The methodology also enables implementers to calculate the rates of exclusions and to further analyze both low and high rates, as appropriate (see examples below).

The method of calculation for reporting differs. One program which currently focuses on reporting rates is the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI). Currently, under that program design, there will be a reporting denominator determined solely from claims data (CPT and ICD-9), which in some cases result in a reporting denominator that is much larger than the eligible population for the performance denominator. Additional components of the reporting denominator are explained below.

The components that make up the numerator for reporting include all patients/reports from the eligible population for which the physician has reported, including: the number of patients/reports who meet the numerator criteria (A), the number of patients/reports for whom valid exclusions apply (C) and also the number of patients/reports who do not meet the numerator criteria (D). These components, where applicable, are summed together to make up the inclusive reporting numerator. The calculation for reporting will be the reporting numerator divided by the reporting denominator. (see examples below).

Examples of calculations for reporting and performance are provided for each measure.

Calculation for Performance
For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator, Denominator, and Denominator Exclusions.
Numerator (A) Includes:
Number of patients/reports meeting numerator criteria

Performance Denominator (PD) Includes:
Number of patients/reports meeting criteria for denominator inclusion

Denominator Exclusions (C) Include:
Number of patients/reports with valid medical, patient or system exclusions (where applicable; will differ by measure)

Performance Calculation

\[
\frac{A \, (# \text{ of patients meeting numerator criteria})}{PD \, (# \text{ patients in denominator}) - C \, (# \text{ patients with valid denominator exclusions})}
\]

It is also possible to calculate the percentage of patients excluded overall, or excluded by medical, patient, or system reason where applicable:

Overall Exclusion Calculation

\[
\frac{C \, (# \text{ of patients with any valid exclusion})}{PD \, (# \text{ patients in denominator})}
\]

OR

Exclusion Calculation by Type

\[
\begin{align*}
C_1 \, (# \text{ patients with medical reason}) \\
PD \, (# \text{ patients in denominator})
\end{align*}
\]

\[
\begin{align*}
C_2 \, (# \text{ patients with patient reason}) \\
PD \, (# \text{ patients in denominator})
\end{align*}
\]

\[
\begin{align*}
C_3 \, (# \text{ patients with system reason}) \\
PD \, (# \text{ patients in denominator})
\end{align*}
\]

Calculation for Reporting
For reporting purposes, this measure is calculated by creating a fraction with the following components: Reporting Numerator and Reporting Denominator

Reporting Numerator includes each of the following components, where applicable. (There may be instances where there are no patients to include in A, C, D, or E).

A. Number of patients/reports meeting additional denominator criteria (for measures where true denominator cannot be determined through ICD-9 and CPT Category I coding alone) AND numerator criteria

C. Number of patients/reports with valid medical, patient or system exclusions (where applicable; will differ by measure)

D. Number of patients/reports not meeting numerator criteria and without a valid exclusion

E. All other patients/reports not meeting additional denominator criteria (for measures where true denominator cannot be determined through ICD-9 and CPT Category I coding alone)
**Reporting Denominator (RD) Includes:**
RD. Denominator criteria (identifiable through ICD-9 and CPT Category I coding)

**Reporting Calculation**

\[
\frac{A(\# \text{ of patients meeting additional denominator criteria AND numerator criteria}) + C(\# \text{ of patients with valid exclusions}) + D(\# \text{ of patients meeting additional denominator criteria NOT meeting numerator criteria}) + E(\# \text{ of patients not meeting additional denominator criteria})}{RD (\# \text{ of patients in denominator})}
\]
Measure #1: Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy

This measure may be used as an Accountability measure

Clinical Performance Measure

Numerator: Final reports that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT, etc.)

*Relevant imaging studies are defined as studies that correspond to the same anatomical region in question.

Denominator: All final reports for patients, regardless of age, undergoing bone scintigraphy

Denominator Exclusions: System reason for not documenting correlation with existing relevant imaging studies in final report (eg, no existing relevant imaging study available, patient did not have a previous relevant imaging study)

Measure: Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT) that were performed

The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

Bone scintigraphic abnormalities should be correlated with appropriate physical examination and imaging studies to ascertain that osseous or soft-tissue abnormalities, which might cause cord or other nerve compression or pathologic fracture in an extremity, are not present. (SNM, 2003).¹

Relevant radiographs and/or MR imaging of painful sites to exclude cord compression or severe lytic lesions which carry an increased risk of pathologic fracture, should be examined by the physician (SNM, 2003).¹

Rationale for the measure:
Radionuclide bone imaging plays an integral part in tumor staging and management; the majority of bone scans are performed in patients with a diagnosis of malignancy, especially carcinoma of the breast, prostate gland, and lung. This modality is extremely sensitive for detecting skeletal abnormalities, and numerous studies have confirmed that it is considerably more sensitive than conventional radiography for this purpose.² However, the specificity of bone scan abnormalities can be low since many other conditions may mimic tumor; therefore it is important that radionuclide bone scans are correlated with available, relevant imaging studies. Existing imaging studies that are available can help inform the diagnosis and treatment for the patient. Furthermore, correlation with existing radiographs is considered essential to insure that benign conditions are not interpreted as tumor. While there are no formal studies on variations in care in how often correlation with existing studies is not performed, there is significant anecdotal information from physicians practicing in the field that there is a gap in care and that correlation is not occurring frequently when images are available.

Literature suggests that as many as 30% of Radiology reports contain errors, regardless of the imaging modality, Radiologist's experience, or time spent in interpretation.³ Evidence has also suggested that Radiology reports are largely non-standardized and commonly incomplete, vague, untimely, and error-prone and may not serve the needs of referring physicians.⁴ Therefore, it is imperative that existing imaging reports be correlated with the Nuclear Medicine bone scintigraphy procedure to ensure proper diagnosis and appropriate patient treatment.

Data capture and calculations:

Calculation for Performance
For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator, Denominator.
Performance Numerator (A) Includes:
- Final reports that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.)

Performance Denominator (PD) Includes:
- All final reports for patients, regardless of age, undergoing bone scintigraphy

Denominator Exclusions (C) Include:
- System reason for not documenting correlation with existing relevant imaging studies in final report (e.g., no existing relevant imaging study available, patient did not have a previous imaging study)

Performance Calculation

\[
\frac{\text{A} \, (# \text{ of final reports meeting measure criteria})}{\text{PD} \, (# \text{ of final reports in denominator}) - \text{C} \, (# \text{ of final reports with valid denominator exclusions})}
\]

Components for this measure are defined as:

- **A**: # of final reports that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.)
- **PD**: # of final reports for patients, regardless of age, undergoing bone scintigraphy
- **C**: # of final reports with a system reason for not documenting correlation with existing relevant imaging studies (i.e., no existing relevant imaging study available)

**Calculation for Reporting**

For reporting purposes, this measure is calculated by creating a fraction with the following components: Reporting Numerator and Reporting Denominator.

**Reporting Numerator** includes each of the following instances:

A. Final reports that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.)

C. Final reports that do not include physician documentation of correlation with existing relevant imaging studies, but for whom there is a documented system reason for not doing so

D. Final reports that do not include physician documentation of correlation with existing relevant imaging studies and there is no documented system reason for not doing so

**Reporting Denominator (RD) Includes:**
- All final reports for patients, regardless of age, undergoing bone scintigraphy

**Reporting Calculation**

\[
\frac{\text{A} \, (# \text{ of final reports meeting numerator criteria}) + \text{C} \, (# \text{ of final reports with valid denominator exclusions}) + \text{D} \, (# \text{ of final reports NOT meeting numerator criteria})}{\text{RD} \, (# \text{ of final reports in denominator})}
\]

Components for this measure are defined as:
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td># of final reports that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT, etc.)</td>
</tr>
<tr>
<td>C</td>
<td># of final reports that do not include physician documentation of correlation with existing relevant imaging studies, but for whom there is a documented system reason for not doing so</td>
</tr>
<tr>
<td>D</td>
<td># of final reports that do not include physician documentation of correlation with existing relevant imaging studies, and there is no documented system reason for not doing so</td>
</tr>
<tr>
<td>RD</td>
<td># of final reports for patients, regardless of age, undergoing bone scintigraphy</td>
</tr>
</tbody>
</table>

**Measure Specifications – Measure #1: Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy**

Measure specifications for data sources other than administrative claims will be developed at a later date.

**A. Administrative claims data**

Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using codes recorded on claims or billing forms (electronic or paper). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.

(Note: The specifications listed below are those needed for performance calculation.)

**Denominator (Eligible Population):** All patients, regardless of age, receiving bone scintigraphy

- CPT® Procedure Codes: 78300, 78305, 78306, 78315, 78320

**Denominator Exclusion:** System reason for not documenting correlation with existing relevant imaging studies in final report (ie, no existing relevant imaging study available)

- Append modifier to CPT Category II code (in development): XXXXF-3P

**Numerator:** Final reports that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT, etc.)

- Report the CPT Category II code (in development) designated for this numerator: XXXXF

**B. Electronic Health Record System (in development)**

**C. Paper Medical Record (in development)**
**For Consortium Vote**  
**Nuclear Medicine-Radionuclide Bone Imaging**  

**Measure #2: Communication to Referring Physician of Patient’s Potential Risk for Fracture for All Patients Undergoing Bone Scintigraphy**

This measure may be used as an Accountability measure

<table>
<thead>
<tr>
<th>Clinical Performance Measure</th>
</tr>
</thead>
</table>
| **Numerator:** Patients with documentation of direct communication* to the referring physician within 24 hours of completion of the imaging study  

* Direct communication is defined as communication by the diagnostic imager or a designee to the treating or referring physician or his/her representative with confirmed receipt of the findings (either by fax confirmation, verbal communication, or certified letter)  

| **Denominator:** All patients, regardless of age, undergoing bone scintigraphy, considered to be potentially at risk for fracture in a weight-bearing site*  

*Examples of this would include: location of a lesion, new lesion in a weight-bearing region, increasing intensity and/or area of a previously noted lesion, etc.  

| **Denominator Exclusions:** Medical reason for not documenting direct communication* to the referring physician within 24 hours of completion of the imaging study (eg, previously reported prior lesion in same location with no evidence of progression or regression, negative scan)  

| **Measure:** Percentage of patients, regardless of age, undergoing bone scintigraphy considered to be potentially at risk for fracture in a weight-bearing site for whom there is documentation of direct communication to the referring physician within 24 hours of completion of the imaging study  

| The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:  

According to the SNM procedures guidelines for General Imaging, the reporting of specific findings that constitute “Direct Communication” should be employed when:  

- Findings likely to have a significant, immediate influence on patient care should be communicated to the requesting physician or an appropriate representative in a timely manner.  

- Actual or attempted communication should be documented as appropriate.  

- Significant discrepancies between an initial and final report should be promptly reconciled by direct communication (SNM, 2004)  

| **Rationale for the measure:**  

Physician communication of serious risk to patients with conditions such as bone metastases with lesions in weight bearing bones, occult fractures, injuries from child abuse or falls, is crucial to appropriate patient care. Quality of life after a fracture through a site of tumor in bone is markedly reduced. Many adverse patient outcomes can be prevented by communicating urgent findings with the referring physician. Literature suggests that as many as 30% of Radiology reports contain errors, regardless of the imaging modality, radiologist’s experience, or time spent in interpretation. A survey from the Physician Insurers Association of America (PIAA) demonstrated that “communication failure was the fourth most common primary allegation in malpractice lawsuits against US radiologists, and that 60% of communication-related claims resulted from failure to highlight an urgent or unexpected abnormal result.” Another study indicated that in 60% of the malpractice cases, the radiologists failed to directly contact the referring physician regarding urgent or significant unexpected findings; in 10% of cases, the written report was not issued in the appropriate time; and in 10% of cases, the report was sent to the wrong physician or patient. The Florida Radiological Society disclosed that 75% of claims against radiologists in 1997–99 stemmed from communication errors. The PIAA dealt with 243 communication-related radiology claims in 1994–2004 with a total indemnity liability of $16 million.  

The most common error cited has been the failure by a radiologist to directly contact the referring clinician about urgent, clinically significant, and unexpected findings. The 4 specific situations in which “direct contact” is required, according to the ACR’s standard for communication, are:
1. Findings requiring immediate medical intervention
2. Conclusions of the radiologist that differ from prior interpretations
3. Findings that suggest a likely worsening condition if not treated, and
4. Unclear findings that require direct follow-up

Data capture and calculations:

Calculation for **Performance**
For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator, Denominator, and Denominator Exclusions.

**Performance Numerator** (A) Includes:
- Patients with documentation of direct communication* to the referring physician within 24 hours of completion of the imaging study

**Performance Denominator** (PD) Includes:
- All patients, regardless of age, undergoing bone scintigraphy, considered to be potentially at risk for fracture in a weight-bearing site

**Denominator Exclusions** (C) Include:
- Medical reason for not documenting direct communication* to the referring physician within 24 hours of completion of the imaging study (eg, previously reported prior lesion in same location with no evidence of progression or regression)

**Performance Calculation**

\[
\text{A (\# of patients meeting numerator criteria)} \over \text{PD (\# of patients in denominator)} - \text{C (\# of patients with valid denominator exclusions)}
\]

Components for this measure are defined as:

<table>
<thead>
<tr>
<th></th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td># of patients with documentation of direct communication* to the referring</td>
</tr>
<tr>
<td></td>
<td>physician within 24 hours of completion of the imaging study</td>
</tr>
<tr>
<td>PD</td>
<td># of patients, regardless of age, undergoing bone scintigraphy, considered</td>
</tr>
<tr>
<td></td>
<td>to be potentially at risk for fracture in a weight-bearing site</td>
</tr>
<tr>
<td>C</td>
<td># of patients with a medical reason for not documenting direct communication* to the referring physician within 24 hours of completion of the imaging study (eg, previously reported prior lesion in same location with no evidence of progression or regression)</td>
</tr>
</tbody>
</table>

Calculation for **Reporting**
For reporting purposes, this measure is calculated by creating a fraction with the following components: Reporting Numerator and Reporting Denominator.

**Reporting Numerator** includes each of the following instances:

A. Patients with documentation of direct communication* to the referring physician within 24 hours of completion of the imaging study

C. Patients with no documentation of direct communication* to the referring physician within 24 hours of completion of the imaging study, but for whom there is a documented medical reason for not doing so

D. Patients with no documentation of direct communication* to the referring physician within 24 hours of completion of the imaging study and there is no documented medical reason for not doing so

E. Patients, regardless of age, undergoing bone scintigraphy, considered not to be at apparent risk for potential fracture in a weight-bearing site
bearing site or risk for potential fracture in a weight-bearing site is not determined

**Reporting Denominator (RD) Includes:**
- All patients, regardless of age, undergoing bone scintigraphy, considered to be potentially at risk for fracture in a weight-bearing site

**Reporting Calculation**

\[
A (\text{# of patients meeting additional denominator criteria AND meeting numerator criteria}) + C (\text{# of patients with valid denominator exclusions}) + D (\text{# of patients meeting additional denominator criteria NOT meeting numerator criteria}) + E (\text{# of patients not meeting additional denominator criteria})
\]

\[
\text{RD (\# of patients in denominator)}
\]

**Components for this measure are defined as:**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td># of patients with documentation of direct communication* to the referring physician within 24 hours of completion of the imaging study.</td>
</tr>
<tr>
<td>C</td>
<td># of patients with no documentation of direct communication* to the referring physician within 24 hours of completion of the imaging study but for whom there is a documented medical reason for not doing so</td>
</tr>
<tr>
<td>D</td>
<td># of patients with no documentation of direct communication* to the referring physician within 24 hours of completion of the imaging study, but for whom there is no documented medical reason for not doing so</td>
</tr>
<tr>
<td>E</td>
<td># of patients, regardless of age, undergoing bone scintigraphy, considered not to be at apparent risk for potential fracture in a weight-bearing site or risk for potential fracture in a weight-bearing site is not determined</td>
</tr>
<tr>
<td>RD</td>
<td># of patients, regardless of age, undergoing bone scintigraphy, considered to be potentially at risk for fracture in a weight-bearing site</td>
</tr>
</tbody>
</table>
Measure Specifications – *Measure #2: Communication to Referring Physician of Patient Risk for Potential Fracture For All Patients Undergoing Bone Scintigraphy*

Measure specifications for data sources other than administrative claims will be developed at a later date.

<table>
<thead>
<tr>
<th>A. Administrative claims data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using codes recorded on claims or billing forms (electronic or paper). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.</td>
</tr>
<tr>
<td>(Note: The specifications listed below are those needed for performance calculation.)</td>
</tr>
<tr>
<td><strong>Denominator (Eligible Population):</strong> All patients, regardless of age, undergoing bone scintigraphy, considered to be potentially at risk for fracture in a weight-bearing site</td>
</tr>
<tr>
<td>• CPT® Procedure Codes: 78300, 78305, 78306, 78315, 78320</td>
</tr>
<tr>
<td><strong>Denominator Exclusion:</strong> Medical reason for not documenting direct communication* to the referring physician within 24 hours of completion of the imaging study (eg, previously reported prior lesion in same location with no evidence of progression or regression)</td>
</tr>
<tr>
<td>• Append modifier to CPT Category II code (in development): XXXXF-1P</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients with documentation of direct communication* to the referring physician within 24 hours of completion of the imaging study</td>
</tr>
<tr>
<td>• Report the CPT Category II code (in development) designated for this numerator: XXXXF</td>
</tr>
</tbody>
</table>

| B. Electronic Health Record System (in development) |
| C. Paper Medical Record (in development) |
INFORMATION ON DEVELOPMENT METHODOLOGY FOR NON-RATED GUIDELINES

ACR Practice Guidelines and Technical Standards
Practice Guidelines describe recommended conduct in specific areas of clinical practice. They are based on analysis of current literature, expert opinion, open forum commentary, and informal consensus. Guidelines are not intended to be legal standards of care or conduct and may be modified as determined by individual circumstances and available resources.

Technical Standards describe technical parameters that are quantitative or measurable. They often include specific recommendations for patient management or equipment specifications or settings. Technical Standards are based on analysis of current literature, expert opinion, open forum commentary, and informal consensus. Technical Standards are intended to set a minimum level of acceptable technical parameters and equipment performance and may be modified as determined by individual circumstances and available resources.

SNM Procedure Guidelines
Procedure guidelines summarize scientific evidence and expert opinion regarding the performance of nuclear medicine procedures. In instances where there is little scientific evidence upon which to base procedure guidelines, expert opinion will be used in conjunction with available scientific data. The intent of a procedure guideline is to describe a procedure that will maximize the diagnostic information obtained, while minimizing the resources expended. Procedure guidelines are not intended to describe "cutting edge" or "state-of-the-art" procedures that may be under development at academic medical centers, nor are they intended to be advocacy statements. Procedure guidelines are also not intended to describe the minimally-acceptable procedure.

---


5 Parker, JA; Daube-Witherspoon ME; Graham, LS; Royal, HD; Todd-Pokropek, AE; Yester, ME. Procedure guideline for general imaging. Version 3.0. Reston (VA): Society of Nuclear Medicine; 2004

6 Physician Insurers Association of America, American College of Radiology. Practice standards claims survey. Physician Insurers Association of America; 1997; Rockville (MD).
## Nuclear Medicine Public Comment Report
December 2007

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Feedback Type</th>
<th>Comments</th>
<th>Suggested Response (for Work Group Discussion)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure #1: Correlation With Existing Imaging Studies For All Patients Receiving Bone Scintigraphy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Joseph Gave & Kendra Hanley (organization) | AMA PMAG (Performance Measures Advisory Group) | Support with modifications | 1. In Nuclear Medicine-Radionuclide Bone Imaging (NucMed) Measure #1: Correlation With Existing Imaging Studies for Patients Receiving Bone Scintigraphy, PMAG suggests further defining relevant imaging studies. The current definition, “Relevant imaging studies include studies that correspond to the same anatomical region” does not take into consideration situations where the bone is seen incidentally in other imaging studies. Would these instances where bone is seen incidentally in other imaging studies also be considered relevant studies?  
2. In Nuclear Medicine-Radionuclide Bone Imaging (NucMed) Measure #1: Correlation With Existing Imaging Studies for Patients Receiving Bone Scintigraphy, one of the examples listed in the system reason exclusion appear to belong in the medical exclusion category. PMAG suggests the measure exclusions and examples are reviewed by the workgroup and any examples listed are classified in the appropriate category.  
3. In Nuclear Medicine-Radionuclide Bone Imaging (NucMed) Measure #1: Correlation With Existing Imaging Studies for Patients Receiving Bone Scintigraphy, the rationale doesn’t seem to support the need for this measure. Is there additional information that could be added to strengthen the rationale? | 1. The Work Group will discuss further defining “relevant” imaging studies. The intent of the measure was to correlate only those previous studies that were in the same anatomical region with the expectation that when reports or scans are reviewed, the physician would document exactly what he/she reviewed on the report.  
2. Regarding the example that is listed for the system exclusion (patient did not have a previous imaging study), the Work Group will consider whether or not a medical exclusion should be added to accommodate this example.  
3. Staff will refine and modify the measure rationale so that it more accurately reflects the intent of the measure. |
| Robert Wagner, Loyola University | Support | Studies should be interpreted in the context of the reason for requiring the measure. | No response needed |
### Nuclear Medicine Public Comment Report
December 2007

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Feedback Type</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD (individual)</td>
<td>Nuclear Medicine</td>
<td></td>
<td>patient’s current clinical problem. As the bone scan is a very sensitive tool for evaluation of the cortical skeleton, it is often ordered when there is a finding noted on other studies. Correlation with other studies is useful to help clarify the pathology and answer the clinical question at hand.</td>
</tr>
<tr>
<td>Murray Becker, M.D. (individual)</td>
<td>ACR Nuclear Medicine Accreditation Committee</td>
<td>Support</td>
<td>I agree with measure. Correlation with existing imaging studies is crucial to proper interpretation of bone scintigraphy. I believe the proposed measure is clear, concise and will provide a meaningful measure of clinical outcome.</td>
</tr>
</tbody>
</table>

**Measure #2: Communication To Referring Physician Of Patient Risk For Potential Fracture For Patients Receiving Bone Scintigraphy**

| Joseph Gave & Kendra Hanley (organization) | AMA PMAG (Performance Measures Advisory Group) | Support with modifications | 1. In Nuclear Medicine-Radionuclide Bone Imaging (NucMed) Measure #2: Communication to Referring Physician of Patient Risk for Potential Fracture for All Patients Receiving Bone Scintigraphy, the current specifications create a broad denominator based solely on CPT procedure codes. The measure as it is currently modeled would require communication back to the referring physician for all patients undergoing this procedure. There were concerns voiced by several physicians on the PMAG about the volume of communication from the physician performing the imaging for patients whose scans are negative for risk of fracture. PMAG suggests two alternatives to limit the communication to patients who are at risk:  

a. Define the denominator to include patients “at risk” for fracture. CPT II codes could then be developed for the different “at risk” categories. Input would be needed from the workgroup to | 1. The Work Group spent considerable time discussing the issue of burden of measurement and attempted to minimize the burden, while still addressing the most crucial elements for reporting. The implementation and testing of these measures will provide a better understanding of the level of burden that will be placed on physicians and any needed measure modifications.  
a. Defining level of risk is a very subjective issue and cannot be categorized as such. The measure is intended to encompass those positive scans in weight-bearing sites that essentially contribute to patient risk. Adding additional |
<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Feedback Type</th>
<th>Comments</th>
<th>Suggested Response (for Work Group Discussion)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>define these categories. The current PCPI prostate cancer measures provide examples of this methodology (see prostate cancer measure “Adjuvant hormonal therapy for high-risk prostate cancer patients” and “inappropriate use of bone scan for staging low risk prostate cancer patients”. This approach provides a more accurate denominator.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b. The other option proposed by PMAG would require clearly defined specifications for exclusion criteria for cases that do not need to be communicated. An example would be medical exclusion (i.e., Scan is negative or scan wasn’t for metastatic disease or location of imaging study not one of risk).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. In Nuclear Medicine-Radionuclide Bone Imaging (NucMed) Measure #2: Communication to Referring Physician of Patient Risk for Potential Fracture For All Patients Receiving Bone Scintigraphy, the measure defines the following: Direct communication is defined as communication by the diagnostic imager or a designee to the treating or referring physician or his/her representative with confirmed receipt of the findings. PMAG suggests it would be useful to define “confirmed receipt” in addition to direct communication. PCPI staff can provide examples of definitions used for this element in other measurement sets.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>categories of risk in the denominator, then, would be difficult to accurately capture.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b. This approach is more widely supported than the above-mentioned suggestion. The Work Group will discuss adding an exclusion for when a scan is negative or when the patient is not at risk.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. The Work Group developed the definition of communication based on previously developed PCPI measures for communication (Radiology). The intent of direct communication is that the physician contact the referring physician’s office and provide documentation of how and with whom a message was left.</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Organization</td>
<td>Feedback Type</td>
<td>Comments</td>
<td>Suggested Response</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Huyen Tran</td>
<td>Albert Einstein Medical Center</td>
<td>Support with modifications</td>
<td>Denominator Exclusions (C) should also include all patients with bone scans without lesion at risk for potential fracture. If there is no bone scan lesion at risk for potential fracture, there is no medical indication to document direct communication to the referring physician. Mandating direct communication in this instance would be an overly bureaucratic burden without patient benefit. The overwhelming majority of bone scans do not show lesions at risk for potential fracture, so these patients will be a much larger number than A. &quot;Direct communication&quot; definition should also include activation of auditable, trace-able, verifiable electronic notification system such as Veriphy by Vocada.</td>
<td>The Work group will discuss adding an exclusion for when a scan is negative or when the patient is not at risk. The Work Group spent considerable time discussing the issue of physician burden in communicating. It is not the intent that the Nuclear Medicine physician always speak directly to the physician, but that there is documentation of how and with whom a message was left. The Work Group will consider adding electronic notification systems to the measure as an example of communication.</td>
</tr>
<tr>
<td>Elizabeth Yung MD</td>
<td>American College of Radiology</td>
<td>Support with modifications</td>
<td>Potential fracture is not a finding on bone scan. The defined numerator, patient risk for potential fracture is too vague, and not a finding. It is a subjective opinion of a risk for potential fracture, and because the outcome has not occurred, this is likely not to be elaborated in the report, and not likely to be communicated to the referring physician. This is especially true in light of the broad denominator which includes bone scans for all reasons, and all ages. As a performance measure, the numerator/denominator is likely to be extremely small, not a valid measure of performance, and not likely to address the 60% of communication-related problems.</td>
<td>Although risk of potential fracture is subjective, it is crucial to quality patient care that a physician evaluate that risk and appropriately communicate it to a referring physician.</td>
</tr>
</tbody>
</table>
### Nuclear Medicine Public Comment Report
#### December 2007

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Feedback Type</th>
<th>Comments</th>
<th>Suggested Response (for Work Group Discussion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richard Noto (individual)</td>
<td>Rhode Island Hospital</td>
<td>Does not support</td>
<td>The number of cases where direct communication regarding potential fracture is extremely small relative to the total number of bone scans. Almost all scans will fall into the &quot;C&quot; category where it is medically unnecessary to communicate directly regarding fracture risk. This measure may be very difficult to follow and quantify for this reason.</td>
<td>The Work Group developed this measure because of the importance of bone scintigraphy in patients with metastatic disease, occult fracture, etc. who may be at risk for pathological fracture. It is the belief of the Work Group that patient care will be improved through communication between physicians. Furthermore, morbidity is very high in this population as are the costs of care of a pathologic fracture. Catching these lesions before they fracture and administering prophylactic therapy to prevent a fracture represents a quality-of-life issue for the patient and a potentially large savings for the system.</td>
</tr>
<tr>
<td>Manuel L Brown, MD (individual)</td>
<td>Henry Ford Hospital</td>
<td>Does not support</td>
<td>This will be a small number of cases and therefore not a good measure</td>
<td>See comment above</td>
</tr>
<tr>
<td>Lea Anne Gardner, RN, PhD (organization)</td>
<td>American College of Physicians</td>
<td>Support with modifications</td>
<td>This measure is not clearly specified. The evidence based identifies a failure in communication in urgent or unexpected abnormal results, but this idea is not conveyed clearly in the title of the measure or the numerator. May we suggest the addition of a timeframe and mode of communication?</td>
<td>In the absence of standardized, evidence-based guidelines for Nuclear Medicine, the Work Group developed this measure to address failures in communication that occur in the imaging field. Although there is no direct evidence of a lack of communication for</td>
</tr>
</tbody>
</table>
patients with potential fracture, there was anecdotal evidence from the Work Group that there was a need for increased communication to convey urgent or unexpected results.

The Work Group discussed adding a timeframe for communication and although currently accepted standards for generating a report are within 24 hours of completion of a study, there is no clinical guideline that supports a timeframe. Without an accepted guideline, it was decided that a timeframe would be too arbitrary.

Robert Wagner, MD  
Loyola University Nuclear Medicine  
Support with modifications  
Whenever a significant finding is noted on an exam that may impact the immediate health of a patient, it makes sense to contact that patient’s ordering physician and notify them of the result. Intervention is then possible prior to potential complications of delay. On the downside, it is sometimes very difficult to contact the referring physician. Contact information may not be readily available or they may be out of town making this kind of communication difficult.

Joseph P. Drozda, Jr., M.D.  
Centene Corporation  
N/A  
Is a normal scan another denominator exclusion or is this measure saying that direct communication should occur regardless of fracture risk as assessed by bone scintigraphy?

As this measure is currently written, direct communication is intended to apply only to those cases where the physician believes that there is risk of fracture. For implementation
<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Feedback Type</th>
<th>Comments</th>
<th>Suggested Response (for Work Group Discussion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter Lund</td>
<td>PA Medical Society</td>
<td>Support</td>
<td>I agree</td>
<td>No response needed</td>
</tr>
<tr>
<td>Murray Becker, M.D.</td>
<td>ACR Nuclear Medicine Accreditation Committee</td>
<td>Support with modifications</td>
<td>I understand the rationale for this measure: improving communication regarding a potential fracture, most commonly of a weight bearing bone such as the hip, where an unexpected fracture could have grave consequences. However, I have reservations regarding using potential risk of fracture as a measure of clinical outcome with respect to bone scintigraphy. First, bone scintigraphy does not directly assess fracture risk. Rather it identifies suspicious locations of lesions. Then, anatomic imaging, either radiography or CT, is needed to assess the size/nature of the lesion. Second, the most at risk lesions, aggressive lytic lesions, may give a false negative on bone scintigraphy. I agree that assessing fracture risk is important and bone scintigraphy is a valuable tool in this assessment. I clearly feel it is my job to notify the referring clinician regarding fracture risk. But, I feel the process I use cannot be captured by the criteria and equations used in the formula. Honestly, I believe the criteria are vague, with respect to the thought process I use. A small sclerotic lesion in the hip has a completely different risk for a large aggressive lytic lesion. A low risk lesion may &quot;flair&quot; when they respond to therapy, but the given criteria requires a notification without</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The intent of this measure is to emphasize new or expanding lesions in any weight-bearing area and the need to communicate the presence of that lesion to the referring physician. If a scan is positive or equivocal in a weight-bearing area, the intent is for communication back to the referring physician.</td>
</tr>
<tr>
<td>Name</td>
<td>Organization</td>
<td>Feedback Type</td>
<td>Comments</td>
<td>Suggested Response (for Work Group Discussion)</td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
<td>---------------</td>
<td>----------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>taking any of these fractures into account.</td>
<td>diagnosis for a patient is not always on a report, so using diagnoses in general for these measures is problematic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not sure if I am articulating the process well but I guess my bottom line: my assessment for fracture risk and the decision to notify the clinician directly is complex, and not easily reflected by a simple fraction of phone calls I make.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>This should be contrasted by &quot;Measure 1&quot; above. Every bone scan should be correlated with other relevant imaging. I can look at the reports, calculate the fraction, and know if the nuclear medicine physician is doing a good job.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I would stick to more straight forward clinical scenarios, e.g. newly presenting metastases; newly progressing metastatic disease. In these cases, either the clinicians is called, which in my mind is correct, or not.</td>
<td></td>
</tr>
</tbody>
</table>

**General Comments**

Elizabeth Yung MD (organization)  
American College of Radiology  
Support with modifications  
It is not clear that the subjective opinion of risk for POTENTIAL fracture is a significant finding which may have an immediate influence on patient care. A recommendation for correlation with another imaging study (eg x-ray, CT or MRI) is more likely to be recommended if there is suspicion of potential fracture. Also including all bone scintigraphy and all ages in the denominator is too broad. The denominator exclusion of 'medical reason for not documenting direct communication' to the referring physician is not easily found.  
The intent of measure #1 was to focus on new or expanding lesions in any weight-bearing area and the need to communicate the presence of that lesion to the referring physician. The Work Group believes that communicating this risk will have a positive influence on patient care and thus reduce potential injury or harm to patients.  
The Work Group considered adding |
### Nuclear Medicine Public Comment Report
#### December 2007

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Feedback Type</th>
<th>Comments</th>
<th>Suggested Response (for Work Group Discussion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janet Leiker</td>
<td>American Academy of Family Physicians</td>
<td>Does not Support</td>
<td>This matter was discussed and is also the opinion of the ACR Commission on Nuclear Medicine which met on 11/25/07 at the RSNA in Chicago.</td>
<td>an age range to the measure, but decided that age inclusion for fracture risk was not an issue and that limiting the denominator population would not be beneficial. Although most cases would be in the adult population, a child with a metastatic tumor is just as much at risk as an elderly patient with metastatic colon cancer.</td>
</tr>
<tr>
<td>Richard Noto</td>
<td>Rhode Island Hospital</td>
<td>Support with modifications</td>
<td>These measures represent a low hurdle and should be presumed as the standard of care.</td>
<td>The Work Group believes that these measures represent measures of individual physician performance, and although there is limited information on gaps in care, anecdotal information the Work Group received from clinicians points towards an area for quality improvement.</td>
</tr>
<tr>
<td>Alice Scheff, MD</td>
<td>American College of Radiology</td>
<td>Support</td>
<td>Somewhat confusing for those of us not familiar with this process. Needs to be more concise for general distribution.</td>
<td>AMA staff will consider what additional information or background would be helpful to those not as familiar with the public comment process.</td>
</tr>
</tbody>
</table>

| Murray Becker, M.D.   | ACR Nuclear Medicine Accreditation Committee      | Support with modifications       | The boxes in which these comments are submitted are quite small...makes it difficult to write clearly.                                                                                                  | AMA staff will look into the layout of the website format for submitting comments.                                                                                                                                                                                |
| Alice Scheff, MD      | American College of Radiology                      | Support                         | Important patient care issues...should be part of all practices                                                                                                                                         | No response needed                                                                                                                                                                                                                                             |
The Measurement of Health Care Performance
A Primer from the CMSS

Supported by an unrestricted educational grant from the United Health Foundation
Physician Practice Measurement and Quality Improvement Primer

Introduction

Bruce E. Spivey, MD and Walter J. McDonald, MD

Over the past decade the issues of patient safety, quality improvement, outcome measures, practice measurement, efficiency, effectiveness, and the integrity and validity of physician performance have been widely discussed within and without medicine. The purpose of this primer is to create a common background of terminology, approaches, and rationale regarding physician practice measurement and quality improvement. The hope and expectation is that this will be of help to specialty societies, physician groups, and individual physicians in understanding the maze of rhetoric, as well as the rationale, for commitment to work in this area.

The rest of the document will include definitions, approaches, and even the “how to” for involvement of the physician community. As we approach any area that is new, controversial, and complex, we must remind ourselves why we should expend the time, energy, and money necessary to address quality measurement--basically we need to understand why quality measurement is important to physicians and their patients.

There are many, including those outside of medicine, who are clamoring for improvement in patient safety and who are demanding an explicit measurement of individual and system quality measures. This includes the public, payers, and certainly the government. Considerable emphasis on individual physician performance is being created by the Maintenance of Certification movement, as well as Maintenance of Licensure. The accreditors, certifiers, and educators are all emphasizing quality measurement. At the same time physicians are concerned about any measurement of cost without accompanying quality of care measures. Therefore, there are tremendous pressures and expectations to accurately measure individual physician (or a system of care) performance.

There is, however and most importantly, the perspective of the profession, which drives us in the same direction and should (and eventually must be) the primary compelling force in medicine’s commitment to quality measurement and performance assessment. In the document “Medical Professionalism in the New Millennium: A Physician Charter” (created by internal medicine and adopted by numerous medical specialties both in the United States and around the world) the statement is made that “professionalism is the basis of medicine’s contract with society.” The document contains three fundamental principles and ten professional responsibilities which describe the contract with society by physicians.

The fundamental principles are: 1) primacy of patient welfare; 2) patient autonomy; and 3) social justice and they are self-explanatory. The ten professional responsibilities all touch on aspects of quality of care, with five specifically addressing the responsibility of physicians to deal with quality of care. These are commitment to: professional competence; quality of care; access of care; scientific knowledge; and professional responsibilities (Other commitments are to: honesty with patients; patient confidentiality; appropriate relations with patients; just distribution of finite resources; and maintaining trust by managing conflicts of interest).

In addition to the inherent drive of individual professionalism, specialty societies must also commit to evaluate individual physician practice and efficiency, as it is in the best interest of their members to clearly establish quality measures within their specialty. The public expects it, the payers and the government are demanding it, and so it is natural for an organization to step up to provide these measures. If they do not show leadership, those less competent will.

Some pushback by individual physicians is inevitable given ambivalence about the process and even paranoia about the external pressures which have been created in this movement. This combined with an uncertainty of the process and a concern of being evaluated does lead to some resistance. Yet, the vast majority of physicians sense the responsibility of professionalism and realize the need to assure the public trust. They desire that it be done properly, and deep-down sense that it is both necessary and appropriate.

As some have said, the train has left the station. It is critical that we assure that the proper track is laid and that the direction of the train be appropriate for the sake of patients and their physicians.
The Measurement of Health Care Performance
A Primer for Physicians

This paper was developed by Katherine E. Garrett for the Council of Medical Specialty Societies with the support of a grant from the United Health Foundation. It is intended to be a “quick reference” guide to this multifaceted arena, and to support the ongoing work of Medical Specialty Societies to advance quality and continuous professional development.

It is the purpose of this order to ensure that health care programs administered or sponsored by the Federal Government promote quality and efficient delivery of health care through the use of health information technology, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers.

Executive Order of the President , August 26, 2006

“People deserve to know what their health care costs, how good it is, and the choices available to them.”

Department of Health and Human Services
Secretary Michael O. Leavitt,
commenting on the Executive Order

President George W. Bush's executive order of last summer is one manifestation – albeit an influential one – of the movement in health care in the United States towards measuring and communicating information about the quality and value of health care services. All parts of the health care delivery system: institutional providers like hospitals and long-term care facilities, organizers of care like health maintenance organizations, and, most recently physicians, are finding themselves the subject of measurement sets, report cards and the probability that payment for health care services will be tied to some measure of performance.

The purpose of this paper is to provide leaders of professional societies and practicing clinicians with:
1. Definitions of key terms.
2. A summary of the major developments in research and policy that have led to the current focus on performance measurement.
3. Descriptions of the major players in performance measurement, their roles and the results of their work.
4. Explanations of measurement methodologies.
5. The outlook for performance measurement.
6. Suggestions for supporting the valid and effective use of performance measurement.

With this information, physicians and specialty societies will be better prepared to take their necessary place in the ongoing development of this environment of “transparency regarding health care quality and price.”
1. Key terms

Any discussion of physician performance measurement presumes a basic understanding of a few important terms:

- **Quality**. The most important term, and for many the most difficult to define precisely. After much study and debate, the Institute of Medicine (IOM) in 1990 published a landmark report providing the health care delivery system with this now widely-accepted definition of health care quality:

  “The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

- **Value** is also a challenging term to define, but the multi-stakeholder AQA Alliance (see below) defines “Value of Care” as: a measure of specified stakeholder’s (such as an individual patient’s, consumer organization’s, payor’s, provider’s, government’s, or society’s) *preference-weighted assessment* of a particular combination of quality and cost of care performance. The ability to assess value requires a mechanism for measuring both quality and cost.

- **Performance measurement**, therefore, is this mechanism. The Institute of Medicine recently called for “a coherent, robust, integrated performance measurement system that is purposeful, comprehensive, efficient, and transparent.” The American health care system is lurching towards the development of such a system: this paper will describe some of its components.

- **Transparency** is the belief that providing information about quality or value will be useful to both providers and consumers of health care services. Patients and their families have the right to the information that will help them make informed choices about health care services. If relative value information is made available to health care purchasers, the expectation is that they will make more informed decisions and may perhaps reward higher value providers of care with their business. In this way, the market will drive the provision of higher-value health care.

- **Pay for Performance** means enhancing or reducing payments through fee schedules, bonuses or other incentives, based on performance on certain measures of quality and value.

- **Efficiency** is the use of resources to get the best value. For the Institute of Medicine, “the opposite of efficiency is waste.”

  The use of the term “efficiency” makes many physicians and policy makers uncomfortable in its implication of the need to cut back on health care services. Others focus instead on the potential for making more resources available for health care by reducing the waste in the system.

  The AQA Alliance (see p. 7), in order to clarify the place of efficiency in health care quality measurement, has defined “efficiency of care” as “a measure of cost of care associated with a specified level of quality of care.” In this way, the Alliance has stressed that efficiency and quality cannot be separated, nor one achieved at the expense of the other.

---

3 Institute of Medicine, Performance Measurement: Accelerating Improvement, Board on Health Care Services, 2006, Washington D.C., National Academy Press, p. 3.
• **Information Technology** is a collective noun for the tools used to support performance measurement and/or quality improvement. Capturing and processing information from and about huge numbers of providers and patients is impossible without modern information technology.

• **Continuous Professional Development** is the term used by Medical Societies and Certifying Boards that denotes the need for lifelong learning and demonstrated improvement in practice. There is a potentially important linkage between Performance Measurement and Continuous Professional Development using feedback on actual performance.

### 2. Background to the current focus on performance measurement

Research shows variation, error, inequity and lack of recommended care:

In the past few years, research has begun to reveal the nature and extent of variation in the quality of health care provided in the United States. To cite only a few of the best-known examples:

• In 2003, researchers from the Rand Corporation found that participants in a broad study of a representative sample of the American population received only 54.9% of the care recommended for their age, gender and condition.6

• In 2002, John Wennberg and his colleagues showed wide variation in Medicare spending by geographic region, largely due to variation in the use of what they termed “supply-sensitive services,” especially for those with chronic illness or at the end of life.7

• The Committee on the Quality of Health Care in America of the Institute of Medicine, in its 2000 report *To Err is Human: Building a Safer Health System*, found significant morbidity and mortality resulting from preventable medical error.8 In 2001, the Committee followed up this work with *Crossing the Quality Chasm, a New Health System for the 21st Century*, which identified a fundamental need for a new approach in health care, one that focuses more directly on providing safe, effective, patient-centered, timely, efficient and equitable care.9

• In a follow-up report published in 2003, the Institute of Medicine’s Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care found that racial and ethnic minorities “tend to receive a lower quality of health care than whites do, even when access-related factors, such as patients’ insurance status and income, are controlled.”10 The Committee also found that these differences in care contribute to higher death rates for minorities.11

These quality-related issues come at a high cost:

• Health spending per capita in the U.S. grew at an average annual rate of 4.4% from 1980-2003, the second-highest rate among countries in the Organization for Economic Cooperation and Development (OECD).12

---


8 The Institute of Medicine, To Err is Human: Building a Safer Health System, Committee on Quality of Health Care in America. 2000, Washington, DC: National Academy Press.

9 Institute of Medicine, Crossing the Quality Chasm, a New Health System for the 21st Century, Committee on Quality of Health Care in America. 2001, Washington, DC: National Academy Press.


• U.S. citizens’ health spending per capita in 2002 was 53% more than any other country.¹³

• There is no evidence that these higher expenditures lead to higher quality care.¹⁴ In fact, The Commonwealth Fund has found that “the U.S. is one-third worse than the best country on mortality from conditions ‘amenable to health care’—that is, deaths that could have been prevented with timely and effective care.”¹⁵

And these costs are ever-increasing:

• Although the rate of increase is slowing, health expenditures were expected to grow in the United States by 7.4 percent in 2005, and to grow more quickly than the Gross Domestic Product overall over the next ten years. By 2015, researchers expect health care spending will account for 20 percent of the GDP.¹⁶ Given this rate of cost escalation and the robust data on variations in care, it is highly probable, if not inevitable, that greater attention to performance assessment and transparency will be a feature of the US health care system for the foreseeable future.

Transparency as part of the solution

In their article on the health care delivery system’s failure to provide recommended care, Dr. McGlynn and her Rand Corporation colleagues concluded: “The deficits we have identified in adherence to recommended processes for basic care pose serious threats to the health of the American public. Strategies to reduce these deficits in care are warranted.”¹⁷

Some policy-makers and others involved in the health care delivery system believe that the most important of these strategies should be the widespread dissemination of information about the performance of different health care providers. Their expectation, although to date unproven, is that improvement will surely follow such transparency, as consumers will seek out the providers of higher quality care.

In addition, The Commonwealth Fund, in its January, 2007 report Slowing the Growth of U.S. Health Care Expenditures: What are the Options?, includes “increasing the effectiveness of markets with better information and greater competition” as one of six strategies “that have the potential to achieve savings, slow spending growth, and improve system performance.”¹⁸ With the current focus in American government on market-driven solutions, making the imperfect health care market more perfect through initiatives that support transparency has become the favored policy initiative.

In fact, the jury is still out on the effectiveness of the strategy of public reporting of performance data and pay-for-performance initiatives. Discussion of the topic at a major health care conference in Washington, D.C. in April, 2007, ranged across the spectrum of opinion. But one comment, a Health Affairs reporter noted on her blog of the conference, did generate applause from the audience: the Center for Medicaid and Medicare Service’s acting deputy director Herb Kuhn’s conclusion that “Because it’s hard doesn’t mean it’s not worth doing.”¹⁹

¹⁷ McGlynn, op. cit., p. 2635.
3. The major players

Who are the stakeholders in performance measurement? They range from policy-makers and purchasers to provider groups, insurers, and researchers. Increasingly, most of the work around performance measurement is done under the auspices of coalitions and alliances of providers, government entities and purchasers.

The key organizations are:

For the government:

- **The Center for Medicare and Medicaid Services (CMS)**, the branch of the federal government (in the Department of Health and Human Services) that sets policy, as the payer, for the Medicare and Medicaid programs.

- **The Agency for Healthcare Research and Quality (AHRQ)**, also part of the Department of Health and Human Services. AHRQ is the research arm, developing the science of performance measurement.

- **The Medicare Payment Advisory Commission (MedPAC)**, a 17-member independent commission established as part of Congressional legislation in 1997 that specifically advises Congress on the Medicare program, including the quality of care provided under Medicare. MedPAC's June, 2006 *Report to the Congress: Increasing the Value of Medicare* called for increased provider accountability to be achieved through increased measurement of "physician resource use."

- **The United States Government Accountability Office (GAO)**, was directed to look at the compensation of physicians in the fee-for-service Medicare program as part of the Medicare modernization legislation passed in 2003. The GAO's April, 2007 report *Medicare: Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency*, calls for physician performance measurement with the results being used “to improve the efficiency of care financed by Medicare."

- **State Medicaid agencies.** Although Medicaid is partially financed by the federal government, each state designs, manages and partially finances its own program. Many states have instituted some sort of pay-for-performance component for their Medicaid services (see below).

- **State programs that publicly report health quality data.** As of 2005, 11 states had some sort of governmental requirement to report hospital quality information to the public. Some of these reports (most notably New York State’s report on mortality in cardiac surgery, described below in more detail) contain physician-specific information.

In a public-private partnership:

- **The National Quality Forum (NQF)**, established on the recommendation of a Presidential Advisory Commission. The NQF is a private, not-for-profit, public benefit corporation with a wide membership from throughout the health care delivery system. Its main work is to endorse quality measures and practices; any indicator endorsed by the NQF has been reviewed, discussed, vetted and voted upon by literally hundreds of health care stakeholders.

---

Independent accrediting bodies:

- **The Joint Commission** accredits about 15,000 health care organizations and programs in the United States, focusing on hospitals and free-standing facilities. Since 1997, the Joint Commission has been working to incorporate performance data into its accreditation process.

- **The National Committee for Quality Assurance (NCQA)**, which accredits health plans and also manages the HEDIS® set of measures of health plan performance, supporting the collection and reporting of HEDIS® performance data and the development and testing of new health care quality measures. NCQA has also developed a series of programs related to physician performance.

Collaborations and alliances:

- **AQA Alliance (AQA)**. AQA is the leading body working on the development and use of measures of physician care for the purpose of creating an “industry standard” approach to performance assessment. Founded by the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans and AHRQ, the Alliance has over 150 members (including most organized medical societies) and focuses on (a) providing physicians with information to help them improve care and (b) rationalizing and regularizing the performance measurement system.

  AQA has three workgroups:
  - Performance measurement
  - Data sharing and aggregation
  - Reporting

  Each has wide membership. In 2006, AQA issued its **Parameters for Selecting Measures of Physician Performance**. The fourteen parameters call for the use of measures that:
  - Have been endorsed by the NQF.
  - Support the IOM's six aims for the improvement of health care.
  - Complement measures of hospital care and care in other health settings.
  - Reflect the spectrum of health care.
  - Can be implemented in a way that is not burdensome to providers.

- **Hospital Quality Alliance (HQA)**. Subtitled “Improving Care Through Information,” HQA involves hospital, medical and nursing associations, CMS, AHRQ, NQF, the Joint Commission, insurers, and business organizations in an initiative to measure and publicly report the quality of health care provided in U.S. hospitals.

- **The Quality Alliance Steering Committee (QASC)** is a joint venture of AQA and HQA that seeks to coordinate the work of both organizations.

- **Physician’s Consortium for Performance Improvement (PCPI)**. Convened by the American Medical Association (AMA), PCPI works to develop evidence-based measures of clinical performance. It also provides resources for physicians to use as they become familiar with performance measurement. Members of PCPI include state medical societies, national medical specialty societies, AHRQ, CMS, the American Board of Medical Specialties and the Council of Medical Specialty Societies.

- **The Leapfrog Group**. The Leapfrog Group is a membership organization made up of purchasers of health care services, primarily businesses and business coalitions that provide health benefits to their employees. Leapfrog's focus is on safety, primarily in hospitals. The group has developed a set of patient safety standards, annually surveys hospitals on their compliance with these standards, and publishes this information on its Web site.
• **Other business alliances.** These operate on both the national and regional level, and are often referred to as “Business Groups on Health.” The **National Business Group on Health** is based in Washington D.C. and serves as an advocacy group for major employers around national health policy. Based in San Francisco, the **Pacific Business Group on Health** has long been a leader in the public reporting of health provider performance. Business groups are membership organizations: most members are major employers seeking to improve the value of the health services they purchase for their employees. They are active throughout the United States.

• **America's Health Insurance Plans (AHIP),** the advocacy group for private-sector insurers. AHIP is an NQF member. In April, 2007, AHIP proposed a “National Strategy to Improve Health Care Safety and Quality” through, among other actions, establishing a new national evaluative body for health technology, and increased accessibility of information about treatment options for patients and physicians.

• **Private Insurers,** who run a variety of performance assessment and/or incentive programs for physicians. Horizon Blue Cross Blue Shield of New Jersey, for example, has pay-for-performance programs (increased fees for the top 15 percent of performers) for physicians in 12 medical specialties.23

Representing Consumers:

• **AARP.** AARP has 38 million members to whom it offers a variety of health and health insurance products. In its role as a purchaser of health services, AARP stresses its interest in insuring health plan accountability through public performance reporting. In its role as a lobbyist, AARP conducts policy analysis of health care quality trends and pending legislation.

• **The National Partnership for Women and Families** is a national advocacy organization. With support from the **Robert Wood Johnson Foundation,** the Partnership leads a project — **Americans for Quality Health Care** — that seeks to build consumer demand for transparency and accountability in ambulatory and preventive care.

Supporting information technology:

• **The American Health Information Community (AHIC),** managed by the Department of Health and Human Services as “a federal advisory body, chartered in 2005 to make recommendations to the Secretary of the U.S. Department of Health and Human Services on how to accelerate the development and adoption of health information technology.”24 The Community manages workgroups that look at seven key applications of the integration of health and information technology: consumer empowerment; chronic care; confidentiality, privacy and security; electronic health records; quality; population health; and personalized health care. The Quality workgroup focuses specifically on the role of health information technology in the development of performance measures.

• **The Certification Commission for Healthcare Information Technology (CCHIT).** Formed in 2004 as a collaboration of the American Health Information Management Association, the Healthcare Information and Management Systems Society and The National Alliance for Health Information Technology, CCHIT is developing, for the Department of Health and Human Services, a certification program for electronic health records for both outpatient and inpatient care, and for the components through which they may share information.

---

24 http://www.hhs.gov/healthit/community/background/
Key results, so far, of their work

The work of these different groups, as they both collaborate and work separately, has resulted in a number of initiatives related to physician performance measurement:

• CMS, representing the federal government and in response to the president's executive order referenced above, has developed an initiative for Value-Driven Health Care. The initiative serves as a coordinating entity for a range of Medicare-based performance measurement and reporting activities; CMS intends that it will also catalyze and convene private sector, other public sector, and public-private partnerships to accelerate the adoption of public performance reporting and pay-for-performance approaches to improving quality. The work of this initiative includes developing standards for health information technology, for quality, for pricing and for incentives for improvement.

• The Better Quality Information (BQI) pilots are part of the Value-Driven Health Care Initiative. In these pilots, CMS will work with six pre-existing coalitions of purchasers and providers of health care to publicly report measures of physician performance that are based on both Medicare claims and private data. CMS's intent is that combining information on Medicare and other patients will make the data on physician performance more robust, and that the information will lead to more physician improvement and informed consumer choice. The pilots are taking place in California, Massachusetts, Indiana, Arizona, Minnesota and Wisconsin.

• The Physician's Quality Reporting Initiative (PQRI) was established by the Tax Relief and Health Care Act of 2006 and is managed by CMS. Under the PQRI, in CMS's words, "eligible professionals who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for covered Medicare physician fee schedule services." The initial data set will consist of 74 measures; for more information, visit www.cms.hhs.gov/pqri/.

• The PQRI builds on a number of earlier Medicare pilots, including the Physician Voluntary Reporting Program, in which information on performance treating Medicare patients was reported back to physicians confidentially, but not made public, and the Physician Group Practice Demonstration, Medicare's first pay-for-performance program. The Commonwealth Fund has reported on the results of the Physician Group Practice Demonstration, see below.

• Hospital Compare, an initial result of HQA’s work. Accessible at www.hospitalcompare.hhs.gov, this Web site allows users to view and compare hospital performance in treating Medicare patients on a range of quality measures. Currently, measures of care for heart attack, heart failure, pneumonia, and for surgical care, are publicly available. Additional measure categories will be published beginning in June, 2007. The current measures are of processes of care, especially those that reflect effective coordination among physicians, nursing staff, ancillary services, pharmacy and other parts of a hospital.

• The NQF's voting draft of National Voluntary Consensus Standards for Ambulatory and Hospital Care: Specialty Clinician Performance Measures, sent to NQF members in April, 2007, as part of NQF's process for obtaining reaction to, and building consensus on, all the measures it endorses. NQF has been working since October, 2006 on this set of measures; those formally endorsed will be used to inform the PQRI and other specialty physician measurement efforts. Topics covered include eye care; dermatologic conditions; osteoporosis; gastrointestinal conditions; geriatric conditions; the care of stroke patients and emergency care.

• **CAHPS Physician and Group Survey.** This most recent addition to the family of consumer satisfaction surveys for health services will be launched in May, 2007. The purpose of the survey, developed by AHRQ, American Institutes for Research, Harvard Medical School and the RAND Corporation, is to collect information about the patient's experience receiving health care services. Different survey manuals cover adult primary care, adult specialty care and primary care for children. Like the other CAHPS surveys (for health plans and hospitals), this one will be in the public domain.

• Over half of **state Medicaid programs** include some type of pay-for-performance structure, and almost 85 percent intend to do so within five years, according to a report published in April, 2007 by The Commonwealth Fund. The report also notes that in many states, Medicaid’s programs are run in conjunction with the private sector and in collaboration with providers.

• At the request of AHIC, the Office of the National Coordinator for Health Information Technology, part of the federal department of Health and Human Services, has drafted a "**use case,"** laying out the purpose, roles and potential application of health information technology.

• The CCHIT has recently issued its **first set of electronic health record certification criteria** and its **first list of certified products**, for ambulatory care, providing much-needed guidance for providers as they purchase information technology software and hardware.

### 4. Measurement methodologies

There are several ways of measuring and presenting provider quality, and these are growing in sophistication as more detailed clinical information about patients becomes easily accessible. Three commonly-used methodologies are:

- Percent compliance
- Actual vs. expected performance
- Performance against a benchmark

**Percent compliance**

The most basic measures of provider quality are numerator/denominator equations:

- The denominator represents **the number of times that a provider had the opportunity to provide an element of recommended care to a patient who was a candidate for that care.**

- The numerator consists of **the number of times that the care was provided.**

The resulting proportion is expressed as a percent that indicates compliance with the measure. Examples of this type of measure include NCQA’s **HEDIS®** measures and the measures of hospital quality published by Medicare in its **Hospital Compare** tool.

---


The usefulness and accuracy of these measures are governed by several factors:

- **The evidence** behind the recommended care being measured. The IOM's definition of quality (see page 1) states that health care services need to be “consistent with current professional knowledge.” As many of the performance measures currently in use assess whether certain processes have taken place (for example, does a heart attack patient receive aspirin within 24 hours of arrival at a hospital?), the process needs to be proven to be of benefit to the patient.

  The NQF’s process for endorsing measures provides many opportunities for providers and researchers to weigh in on the strength of the evidence behind measures under consideration.

- **The definition** of the denominator. Not all processes of care, even the most widely applicable, are appropriate for all patients. Some heart attack patients, for example, have contraindications for aspirin, and an accurate performance measure ensures that these patients are not counted in the group of people who “should” have received the treatment.

- **The source** of the data. Currently, the source of these measures is most often administrative data, that is, billing or claims data. (The measurement specifications for CMS's PQRI, for example, tell which Current Procedural Technology [CPT] category II codes apply in calculating the numerator for each measure.) This use of administrative data makes many potential users of performance measures uncomfortable, out of concern that administrative information does not include enough clinical nuance to ensure accuracy. This concern has driven many initiatives to base performance measurement on data taken from, for example, electronic health records (EHRs.)

- **The comparability** of the data. One goal of transparency in performance measurement is to give patients and their families information so they can make informed decisions about health care services — decisions that most likely will involve choice. In choosing between two options, a patient needs to know that the comparison presented is of like to like.

**Actual vs. expected performance**

Many of the measurement sets being used in pay-for-performance initiatives look at process data: if someone should have received a type of care, did they in fact receive it? The “percent compliance” measures are well suited to measurement of processes.

Measurement becomes more difficult when the information is about patient outcome. Some patients are frailer than others and outcomes will vary regardless of actions taken by providers. One method used to account for the underlying patient condition reports on whether the outcome of a patient (mortality, for example) is above, below or equal to the outcome that would be expected for a group of patients with similar underlying conditions and health status.

Several State government-sponsored reports on provider performance in coronary artery bypass graft surgery, such as New York State’s, compare the observed mortality rate for a hospital or cardiac surgeon to the expected mortality rate for the mix of patients treated at that hospital or by that surgeon. These reports also present a risk-adjusted mortality rate that compares a provider’s performance to the performance of all providers in the state as a whole.
In order to calculate expected and risk-adjusted mortality rates, producers of such reports need to account for the risk factors for each patient. New York State collects about 40 specific clinical characteristics per patient. The accuracy of the resulting reports is dependent on the accuracy of the information about these clinical conditions. These reports also depend on having effective, robust, tested statistical models that account for these patient characteristics in predicting mortality rates.

One criticism of this type of quality reporting is that it provides a disincentive for providers to care for the sickest patients, those most likely to have a bad outcome. The research is inconclusive on whether this is, in fact, the case.

Performance against a benchmark

A third type of performance reporting seeks to push performance improvement by comparing a provider’s performance level to the benchmark, or the best in class; the AQA says benchmarks “should reflect the best current assessment of optimal care and efficiency rather than average performance, wherever possible.”

As the AQA definition indicates, these comparisons against benchmarks are used to capture the notion of efficiency. Often, these assessments of efficiency use as their point-of-comparison an entire episode of care, that is, all the range of treatments (physician, pharmacy, hospital, physical therapy, home care) provided for one instance of a condition or illness. In some cases, providers make use of “groupers,” sophisticated data systems, to track all of the costs associated with an episode of care, so the determination of efficiency can include all parts of the health care delivery system. The efficiency of each part of the system can then be compared to a benchmark, to identify where improvement work could be best targeted.

5. The Future of Performance Measurement

If physicians discover or are provided with credible, actionable information that points to an area in their practice where value provided to their patients can be improved, they will want to do so. There is pent-up demand among physicians to improve the system directly, having lacked much of the information need to do so at the ground level.

The Commonwealth Fund’s report on CMS’s Physician Group Practice Demonstration, referenced above, found that the participating group practices had “used the demonstration as a vehicle for expanding data systems, care management programs, coordination-of-care efforts, and other interventions that are not directly reimbursed in (fee-for-service) payments.”

So, there is demand, and some evidence that making the right information available and changing payment incentives can help physicians improve care. This paper has described a movement for performance measurement and the reward for good performance that is gaining momentum, and is perhaps a bit more consolidated than it was even a few years ago.

There are likely to be both failures and successes in this time of significant experimentation, and while various approaches and tools may or may not succeed, it is likely that the trend towards significant transparency and performance measurement is robust and potentially transformative.

Ultimately, the goal is a coherent, organized, comprehensive, useful system of performance measurement and reward. This goal will never be achieved, however, without the participation of physicians.

---

6. The Role for Physicians

As the system continues to develop, physicians – especially groups of physicians acting collectively, such as the medical specialty societies – need to play a central and vital role in its evolution. Specifically, physicians and their societies need to:

- Develop the evidence base for clinical practice guidelines from which the performance measures are generated.
- Develop the decision support that informs quality improvement subsequent to performance measurement.
- Exert leadership in advancing scientifically valid and expertly designed assessment initiatives. The AQA is one vehicle that gives physicians a voice and platform for this leadership.
- Fight for standardization of measures (or face the consequences of having multiple measures and measurement systems). The NQF was established to give the health care delivery system a mechanism to rationalize the measures of performance it will use. The NQF’s endorsement process offers many opportunities for participation in measure development.
- Devote resources, expeditiously, to the development of useful and valid performance measures for the important clinical areas in their field of medicine.
- Share information with colleagues and members about developments in performance measurement and the use of these measures.
- Support their members in data collection, especially through activities that support the use of electronic health records and the development of helpful and useful standards for information technology.
- Include the concept of performance assessment – and the use of this assessment for quality improvement – in any and all continuing medical education activities.
- Develop methodologies to integrate performance, as measured through the use and reporting of carefully-designed and valid measurement sets, into ongoing Board certification.

Finally, physicians and physician groups need to accept the challenge of adding the physician’s voice to the communication of performance information to the general public. The true goal of all these measurement efforts is, ultimately, the improvement of quality that should result from transparency and from a concomitant realignment of payment incentives (as the Physician Group Practice Demonstration showed.) This hypothesis will only be proven true, however, if transparency includes true understanding of the meaning of the information provided in public performance reports. Physicians have the information to help build this understanding – both in the public arena, through work with AQA and NQF, and in their ongoing interactions with, and care of, their patients.
To Learn More....

Visit the Web sites of the organizations cited in this report:

Agency for Health Care Research and Quality ................................................. www.ahrq.gov
AARP ................................................................. www.aarp.org
America’s Health Insurance Plans............................................................... www.ahip.org
American Health Information Community ................................................. www.hhs.gov/healthit/community/background
AQA Alliance ................................................................. www.aqaalliance.org
Centers for Medicare and Medicaid Services, Quality of Care Center ......................... http://www.cms.hhs.gov/center/quality.asp
The Certification Commission for Healthcare Information Technology ....................... www.cchit.org
Hospital Compare ................................................................. www.hospitalcompare.hhs.gov
Hospital Quality Alliance ....... www.cms.hhs.gov/HospitalQualityInits/15_HospitalQualityAlliance.asp
The Institute of Medicine ................................................................. www.iom.edu
The Joint Commission ................................................................. www.jointcommission.org
The Leapfrog Group ................................................................. www.leapfroggroup.org
Medicare Payment Advisory Commission (MedPAC) ............................................. www.medpac.gov
National Business Group on Health .......................................................... www.businessgrouphealth.org
National Committee for Quality Assurance ................................................ web.ncqa.org
National Partnership for Women and Families .............................................. www.nationalpartnership.org
National Quality Forum ........................................................................www.qualityforum.org
New York State Cardiac Reporting ...... http://www.health.state.ny.us/nysdoh/heart/heart_disease.htm
Pacific Business Group on Health ............................................................. www.pbgh.org
Physician’s Quality Reporting Initiative ....................................................... www.cms.hhs.gov/pqri/
Outreach
Public Relations
Helping SNM Tell Its Story of Serving Humanity

An Integrated Strategic Communications Proposal for the Society of Nuclear Medicine

Presented By

Revised
November 20, 2007
Thank you for giving Porter Novelli the opportunity to submit this proposal to the Society of Nuclear Medicine (SNM).

SNM has conducted extensive research and planning to identify its five-year goals and key areas of focus, from providing education and training to supporting advocacy, promoting collaboration with other medical groups, fostering innovation, and positioning molecular imaging as an essential tool in patient care. It is clear that the Society has ambitious plans for the future, and we would love to be part of making those plans come to fruition.

Porter Novelli won’t just throw the typical tactical suggestions at this challenge. We will develop a custom-tailored strategy for SNM that is nimble, appropriate, and flexible. We will assign top people who understand non-profits and professional societies like yours, who have experience working on medical and public policy issues, and who have the wisdom and skill set to navigate clients through a variety of situations.

Recognizing that it is not possible for SNM to “do it all” with an annual budget of $75,000, we would like to offer a menu of options, as well as propose the most useful and efficient way to maximize your resources spent on Porter Novelli’s services. At a minimum, we believe SNM should utilize Porter Novelli for expert counsel, developing your strategic communications plan, and creating a messaging system that will resonate with your key audiences. The total estimate for a more comprehensive integrated communications campaign is $200,000. In addition, we’ve set apart $200,000 for contingency advocacy support services to complement your lobbying efforts.

The following represents our initial suggestions to help SNM achieve its basic communications goals.

**STRATEGIC PLAN DEVELOPMENT**

$20,000

The Marines have a saying, “Perfect preparation precedes perfect performance.” It’s as true in executing a PR strategy as it is a military exercise. As SNM goes to the next level in its history, it is imperative that the organization have a plan in place that not only covers the essential communications elements, but anticipates a variety of contingencies.

At Porter Novelli, we believe that addressing communications challenges begins by asking several key questions: who are we trying to reach, what are they like, what are their current perceptions, and how can they be engaged? This understanding is essential to developing a messaging and outreach strategy that will speak to an audience’s needs and aspirations in an engaging and meaningful way.

Porter Novelli’s goal is to develop a communications plan that does more than tell your target audiences and key stakeholders what SNM is doing. We will recommend tactics that convey what SNM stands for in a way that motivates people to take action, be it visiting the Web site, telling a colleague about your mission, or supporting a funding initiative.
We believe that a strategic communications plan provides an orderly, understandable road map for all communication activities that SNM will undertake. By ensuring that every team member works from the same strategic framework, the plan ensures that the messages, products, and activities undertaken consistently work toward the same end result.

The plan will include four basic elements:

- Communications objectives to be achieved
- Profiles of our primary and secondary audiences
- Specific tactics that support each element of the framework
- A timeline

Communications Objectives

The communications objectives are perhaps the most important decisions in the communications planning process. Brilliant communications programs executed against the wrong communications objectives are ultimately a waste of time, money, effort, and opportunity. Conversely, even under-funded projects grounded in the right communications objectives are likely to be at least modestly successful.

After consultations with SNM staff, we will develop and include key communications objectives against each of your overall organizational objectives. This distinction is important; for your overall objective of supporting advocacy for molecular medicine could encompass many potential communications objectives – everything from increasing the number of practitioners who take part in advocacy activities to increasing public understanding of what molecular medicine can achieve – we need to identify and focus on the ones that make the most sense for the scope, communications support, and timeline we have for this project.

Audience Profiles

A written document that clearly identifies and profiles the target audience(s) becomes a key asset for every subsequent planning step. Your existing research is distilled into a statement that includes: demographics (who are they?), psychographics (what do they think and feel about molecular medicine?), behavioral analysis (what are they currently doing, and why?) and communications opportunity analysis (where can they be reached, by whom, and with what forms of content?). The audience profiles will also include a rationale for our segmentation strategy, key findings (the “differences that make a difference”) about our audiences, the rational and emotional triggers that are most effective, and what barriers to the desired behavior exist.

Tactics

Selecting the appropriate tactics and materials requires an unerring focus on the target audience and corresponding communications objectives, and also a great sensitivity (and adaptability) to resources available to the program. We know, from 30 years of social marketing work, that
Successful communications programs must be based on, and respond to, the situation as perceived by members of the target audience, and strategies, tactics, and materials must respond to the unique sensibilities and mindset of target audience members.

Existing resources must also be considered in developing strategies and tactics. For example, your website, annual meeting, and existing internal communications activities are all activities that will be factored into the final plan.

At the same time, the tactical elements of the plan are where we can give our creativity full rein, looking for innovative ways to reach our audiences. Event sponsorships, media partnerships, a speakers’ tour, or personal stories captured on the campaign Web site are all elements we might consider.

**Timeline**

Finally, the plan also will identify a program timeline. The timeline will include recommendations for when activities should occur, estimated time needed for materials development, suggestions for outreach to and coordination with other organizations active on this issue, and key evaluation milestones. While communications processes, both planning and implementation, are notoriously fluid and often time consuming, the timeline will reflect our best understanding of how and when to conduct the most effective program possible.

| STRATEGIC COUNSEL | $20,000 |

One of Porter Novelli’s greatest assets is its team of seasoned communications professionals. We will make available to you experts who each have decades of experience, in a variety of realms – public relations, public affairs, government affairs, broadcast media – as well as a solid understanding of the inner workings of association and non-profit organizations. We pride ourselves at not only being accessible to our clients when they need us, but responding rapidly to a client’s request to demonstrate that what’s important to them is also important to us. SNM got a taste of this nimble accessibility a few weeks ago as our creative team developed and placed in record time an issue advocacy ad encouraging Congress to restore $20 million in nuclear medicine research funding to the Department of Energy appropriations bill. Porter Novelli also provided counsel on how to turn this ad into an earned media opportunity, as evidenced by the press release on the SNM Web site.

We provide thoughtful, practical insights that work in real life. Our collective wisdom will be valuable to SNM at many levels, including assistance with:

- prioritizing communications goals
- crisis management
- responding to media inquiries on sensitive issues
- creating opportunities for news coverage
- identifying potential allies and third party experts
From the CEO to the administrative assistant, we provide the same dedicated service to everyone we work with, earning their trust, respect, and confidence. And we have the track record of success to prove it.

**MESSAGE DEVELOPMENT** $20,000

We believe there are three key elements of a strong campaign to set SNM apart:

- **Define** SNM’s mission so that no one misunderstands its purpose. This is especially important for audiences outside SNM’s traditional space.
- **Distinguish** the new SNM as “the voice of molecular imaging.”
- **Differentiate** the uniqueness of SNM versus similar professional societies. This sets the SNM apart from the rest, not as a “competitor,” but as a special group with a unique mission that not only promotes knowledge and medical advances, but ultimately brings help and hope to patients everywhere.

To accomplish these elements, we will work with you to develop core messages to help SNM communicate to a wide variety of national and international audiences.

Creating messages requires two things: a thorough understanding of what information is most important to your key audiences and the skill to translate these practical benefits into memorable and effective language. After outlining our communications objectives and audiences, Porter Novelli will create a focused, one-page message map to guide all communications materials. The map includes an overall message that supports the broad goals of SNM; key supporting messages for each of your communications pillars (i.e., education, advocacy, training), and important facts that support each element.

When complete, the message map ensures that every SNM staff person and member has the ability to communicate consistently and clearly in support of your overall communications aims.

With this map in hand, SNM will have the thematic guidance for developing an array of other messages. These messages will articulate the uniqueness of SNM, not just for SNM members and potential members, but for the media, policymakers, thought and opinion leaders and the public. These messages will serve as the foundation of all of SNM’s media outreach, collateral materials, and internal communications.

**RESEARCH TO TEST MESSAGES** $20,000

To ensure that messages are credible, believable, compelling, and persuasive, we recommend that SNM conduct four focus groups. The composition of the focus groups would depend on which audiences SNM seeks to influence first. To reach policymakers and opinion elites, we would suggest one focus group in Washington, D.C. To reach physicians, scientists, and academics, one option would be to do an “online” focus group with a sampling from across the country.
After analyzing the message testing data, we will refine the messages and strategy before beginning the materials development and message execution phases.

**MATERIALS DEVELOPMENT**  $25,000

As an option, Porter Novelli would be happy to assist SNM in the development of key materials, including the development of fact sheets, FAQs, talking points, op-eds, letters to the editor, one-pagers for lobbyists to distribute to policymakers, press releases, anecdotal stories of patients whose lives were saved or improved because of nuclear medicine/molecular imaging, etc.

**MESSAGE DELIVERY**  $7,500

Once SNM has its messages and materials in hand, Porter Novelli will help the organization prepare key SNM spokespersons to respond rapidly to media inquiries. We would recommend two half-day media training sessions at your headquarters with no more than five SNM officials in each group.

**LOGISTICAL SUPPORT SERVICES**  $62,500

Porter Novelli offers the full range of communications services, and can provide the SNM team with the daily media support services requested in your RFP including:

- developing and refining media lists
- distributing/pitching SNM press releases, and
- tracking media coverage, provide press clippings/report of all SNM-related articles (print, Web based) and transcripts from all radio/television broadcasts and summarize in monthly report.

**ANNUAL MEETING SUPPORT**  $25,000

- Logistics, planning of press conference
- Annual Meeting on-site support
- Prep session with SNM leaders on dealing with the media
- Radio media tour (possible)
ADVOCACY SUPPORT  (CONTINGENCY)  $200,000

- Communication strategy development for legislative initiatives
- Support for lobbying efforts, including materials, testimony, witness preparation, etc.
- Support for grassroots mobilization
- Third party recruitment

EVALUATING RESULTS

Porter Novelli subscribes to the belief that effective programs can and do have measurable impact at three levels: on the communications landscape, on target audience awareness, attitudes and behavior, and on our clients' success in the marketplace. Our approach to evaluation is based on these fundamental tenets:

- Set clear and measurable objectives to be tracked over time
- Gauge the impact of communications through media coverage (strategic content and quality of message), Web traffic, distribution of collateral materials, audience feedback, etc.
- Evaluate program outcomes – the extent to which our efforts have had impact on the audiences' awareness, attitudes, preferences, or behaviors
- Measure the programs’ effectiveness in achieving your goals

CONCLUSION

Thank you for giving Porter Novelli the opportunity of serving the Society of Nuclear Medicine. We look forward to helping you achieve many of your top priorities by building a powerful new name that builds on the superb reputation you have built over the years.

The following pages provide more information about Porter Novelli, our team dedicated to SNM, and some of our more relevant client cases.

If you have any questions about this proposal and budget, or our capabilities, please do not hesitate to contact Carolyn Tieger at 202-955-6200 or Michael Schick at 202-419-3246.

Thank you again for the opportunity to present this proposal. We look forward to getting started.
ABOUT PORTER NOVELLI

Porter Novelli is both a leading social marketer and one of the world’s largest integrated marketing communications firms. Porter Novelli was established in 1972 on the revolutionary premise that the basic, disciplined marketing process employed in the private sector could be harnessed to serve as a powerful driver of social change. Over the last three and a half decades, we’ve brought this premise to life in our work, whether it’s helping Americans eat healthier, get recommended health screenings, get treatment for mental health issues, or quit smoking. Clients consistently praise our strategic thinking, creative ideas and collaborative approach. They respect our deep knowledge and high ethical standards. And they share our passion and commitment to making the world healthier. Organizations large and small rely on Porter Novelli’s deep understanding and appreciation of the unique dynamics, complex sensitivities and unprecedented pace of change occurring in health care arena.

Our specialties include strategic planning, formative research and evaluation, communications program development and implementation, and our knowledge spans the gamut of important health issues facing our nation; from healthy eating and physical activity to HIV/AIDS, tobacco control, diabetes, childhood vaccines, and more. We also have a special focus on youth outreach and persuasive media; helping our clients harness the power of new technology to reach new audiences in innovative and meaningful ways. Porter Novelli is a part of Omnicom Group Inc. (NYSE:OMC), one of the world’s largest communications organizations, and has offices in more than 100 locations globally including U.S. offices in Atlanta, Boston, Chicago, Ft. Lauderdale, Los Angeles, New York, Sacramento, San Diego, San Francisco, Seattle, Austin and Washington, DC.

SNM’S TEAM AT PORTER NOVELLI

Carolyn Tieger
Partner and Managing Director, Washington, D.C. Office

A Washington D.C. communications veteran, Carolyn Tieger is considered one of the top public affairs strategists in the country, especially on tough legislative issues, as well as corporate and industry crisis, litigation, and reputation management. A Partner and the firm’s Global Public Affairs Leader, Carolyn brings more than 25 years of public and private sector experience to Porter Novelli. Her portfolio is broad and diverse ranging from Capitol Hill to the White House to large and small public relations and public affairs firms. Carolyn joined Porter Novelli in 1999 when the firm acquired Goddard Claussen, where she was a partner and general manager of the firm’s Washington, D.C. office. As a partner in Porter Novelli, she is responsible for overall business development and management of four offices in Washington, D.C., and Sacramento, Irvine, and San Diego. Under her leadership, Porter Novelli’s Public Affairs Practice has grown significantly in size and accounts, and today boasts a diverse range of associations and corporate clients with primary interests in health care, liability, environmental, financial and chemical issues.
Her current clients include the U.S. Chamber of Commerce, Business Roundtable, the Asbestos Alliance, and the American Beverage Association, among others. Prior to joining Goddard Claussen, Carolyn also spent more than a decade at Burson-Marsteller, ultimately rising to executive vice president and co-chair of the company's Worldwide Environmental Practice Group. From 1981-1983, Carolyn was with the White House, where she directed communications and special projects for the Office of Private Sector Initiatives and served as director of communications for President Reagan’s Task Force on Private Sector Initiatives, which encouraged private sector involvement in community development. In 1980, she became deputy director of intergovernmental affairs for the Secretary of Commerce, where she coordinated the department’s programs with governors, mayors and county officials.

Michael Wm. Schick
Senior Vice President
Alliance Building Specialty Leader

Michael Wm. Schick brings more than two decades of communications experience in providing strategic and tactical counsel to a variety of corporate, association and non-profit clients. He was recently appointed as Porter Novelli’s specialty leader on alliance building. Michael’s client work at Porter Novelli Public Affairs includes managing integrated communications campaigns, including media relations, ally development, crisis management, litigation communications support, issue advocacy campaigns and special events. He is the account leader for several key client projects that deal with a range of public affairs issues, such as legal reform, health policy, technology, food and nutrition. Michael previously served as Director of Communications at the U.S. Chamber Institute for Legal Reform in Washington, D.C., one of the most successful civil justice reform groups in America. Prior to joining the U.S. Chamber of Commerce in 2001, Michael was Chief Operating Officer of Justice Fellowship, the public policy arm of Prison Fellowship Ministries, where Michael was responsible for their day-to-day operations. Michael also served for 15 years as Senior Advisor at the international public affairs firm of Civic Service Inc., representing major corporate and non-profit clients such as Nippon Telegraph and Telephone, DoCoMo and the American Medical Association. In the early 1980s, Michael spent four years as Deputy Press Secretary to U.S. Senator Strom Thurmond (R-SC) during his term as President Pro Tempore of the U.S. Senate and Chairman of the Senate Judiciary Committee. Before moving to Washington in 1981, Michael was a television producer and director in South Carolina. An honors graduate of the University of South Carolina and a former Fellow at the C.S. Lewis Institute, Michael is the editor of 19 books and is a frequent guest lecturer. He has served on or chaired boards of several non-profit organizations.

Carrie Schum
Senior Vice President

Carrie is a Senior Vice President at Porter Novelli in Washington, D.C. In her nine years with Porter Novelli, clients ranging from the American Red Cross to Busch Entertainment Corporation have benefited from Carrie’s leadership, strategic insights, and creativity. Carrie leads strategic planning for all accounts, helping clients develop and implement formative research plans, develop brand identities, and create integrated communications plans that get
their messages to those who most need to hear them. By developing concrete, measurable objectives, and ensuring that tactical plans work toward the client’s ultimate goals, Carrie develops programs that deliver results.

Carrie currently is working with Cincinnati Children’s Hospital and Medical Center, helping develop a new advertising campaign and web portal. She also is helping to create an awareness campaign on automating 401K participation, supported by AARP, the Brookings Institution, and NASD. Carrie has a broad background in issues relating to children’s health, including vaccine safety and premature birth.

Carrie has extensive experience in tobacco control, having managed Porter Novelli’s work promoting GlaxoSmithKline Consumer Healthcare’s suite of nicotine replacement therapies. She also was a key member of the team for the State of Florida’s “truth” anti-tobacco campaign, which resulted in the largest single-year decline in youth tobacco use in the U.S. ever recorded. The campaign won numerous awards, including the 2000 CIPRA (Creativity in Public Relations) Best of Show, the 1999 Public Relations Society of America Silver Anvil Award of Excellence.

Carrie holds a bachelor’s degree in English Literature from Swarthmore College and a master’s degree in English Literature from the University of Maryland at College Park.

**Adam Burns**  
Research Manager

Adam has an impressive history of quantitative and qualitative research design, analysis, and implementation, with particular expertise in social marketing. He is a professional focus group moderator, and he excels in formative research and message testing design and implementation among varied target audiences such as children, teenagers, adults, and older Americans. He led the research efforts behind the development of the new Food Guidance System (adult and child versions) for the U.S. Department of Agriculture and the US Department of Health and Human Service’s (HHS) 2005 Dietary Guidelines for Americans. His current projects include strategic planning research for the American Cancer Society and the American Heart Association and assisting HHS in how to disseminate Dietary Guidelines information to minority audiences. He also develops research evaluation programs for Porter Novelli’s new media offerings.

Prior to Porter Novelli, Adam served as the lead qualitative research analyst for Caliber Associates on a number of projects for the Department of Defense, including exploring soldier reaction to deployments associated with Operation Iraqi Freedom and examining benefits of military installation commissaries and exchanges. He also served as Research Director at Teenage Research Unlimited (TRU), a leading consulting firm specializing in teens and young adults. There, he coordinated projects exploring teen response and reaction to social issues including teen volunteerism, school violence, 9/11, and youth tobacco-use prevention. On the quantitative side, Adam conducted concept and product testing, usage assessment, positioning, purchase-driver analysis, and market segmentation. His client list included “truth,” MasterCard, and Sony.

In his career, Adam also served as Vice President at a leading Washington, DC political consulting/market research firm. He conducted research for a number of elected officials, as well as enterprises such as Intuit, Madison Square Garden, Washington Sports and

Adam received his Master of Public Policy from Georgetown University with a concentration in Education Policy and graduated Phi Beta Kappa from the University of North Carolina at Chapel Hill.

**Dawn Bergantino**  
**Account Supervisor**

Dawn is a communications and public affairs professional with more than ten years experience in the public, private and non-profit sectors. Prior to joining Porter Novelli, Dawn worked on Capitol Hill, first as Deputy Press Secretary to U.S. Senator Jack Reed (D-RI) and then as Communications Director to U.S. Representative Anna Eshoo (D-CA). Dawn’s experience on Capitol Hill spans the impeachment of former President Bill Clinton, the contested 2000 Presidential elections, the September 11 terrorist attacks and the subsequent anthrax attacks on the U.S. Capitol.

In addition, Dawn worked as Communications Manager for Wehner and York, P.C., a litigation communication firm based in Reston, Virginia; and for the American Psychological Association (APA), where she helped to coordinate the launch of a public education campaign on resilience in partnership with the Discovery Health Channel, and coordinated media outreach for a multi-organizational rally on the steps of the U.S. Capitol in favor of mental health parity legislation. While at APA, Dawn also worked on the successful Warning Signs campaign, a national youth anti-violence initiative in partnership with MTV.

Dawn has worked on a variety of topics, including issues and legislation related to the Patients Bill of Rights, consumer assistance, financial services modernization, housing, national missile defense, childhood lead poisoning, mental health parity, gun control, campaign finance reform, prescription privileges for psychologists, the changing face of HIV/AIDS, VA health care, adding pharmacists to the National Health Service Corps, home health care, and childhood immunizations and vaccines, among others.

Dawn holds a master’s degree in public communication from American University and a bachelor’s degree from the University of Rhode Island, with concentrations in political science and sociology.

**Carolyn Sofman**  
**Senior Account Executive**

Carolyn Sofman joined Porter Novelli’s public affairs practice in June 2005. As a senior account executive, her responsibilities include media outreach, research, collateral preparation, and the day-to-day public affairs operations for a number of clients including Wyeth Pharmaceuticals and the U.S. Chamber of Commerce Institute for Legal Reform. For the Wyeth EFFEXOR XR® account, she supports issues management efforts surrounding the use of antidepressants, including regulatory and policy issues, as well as in the medical/scientific community. Carolyn
also assists in the development and execution of a third-party coalition to raise awareness about the seriousness of depression. For the U.S. Chamber of Commerce, she performs research and materials development on behalf of the Chamber’s Institute for Legal Reform on topics ranging from securities litigation to silica/asbestos fraud. Before officially joining Porter Novelli, Carolyn worked as a summer intern in the office for three summers. In May 2005, she graduated from the University of Notre Dame with a Bachelor of Science in Civil Engineering.

Christina Dakkak
Senior Account Executive

Christina has spent much of her career working with clients in the financial services industry. Prior to joining Porter Novelli, Christina worked for several Financial Planning Association (FPA) chapters, using public and media relations to raise industry and consumer awareness about the importance of the Certified Financial Planner® credential. She has worked on campaigns to promote the Certified Management Accountant and Certified Financial Manager designations, and has supported other service-based clients on topics including personal wealth management, retirement plan consultation and administration, and management accounting.

CASE STUDIES

The following are case studies representing the work Porter Novelli has successfully undertaken for clients with health care and/or legislative goals and objectives.

MAJOR LEGISLATIVE CAMPAIGNS

Association of American Medical Colleges

The Association of American Medical Colleges (AAMC) retained Porter Novelli in 1997 to raise public awareness and understanding of the special roles that U.S. medical schools and teaching hospitals play in our nation’s health care. In addition to this strategic positioning effort, PN developed and placed paid media for AAMC on a variety of federal legislative priorities, such as opposing cuts in Medicare support for teaching hospitals and increasing NIH funding for medical research. Our efforts included helping AAMC develop and implement a national strategic communications program called Tomorrow’s Doctors, Tomorrow’s Cures, which provided AAMC and its member institutions with research-based messages aimed at opinion leaders and policy makers; print and broadcast advertisements on key national issues; sample materials ranging from brochures to opinion editorials to issue advertisements for use by individual institutions; training in issue advocacy communications, and support of the association’s media relations and general communications. With nearly 250 participants, AAMC estimated that more than 160 million media impressions of the campaign’s messages were achieved. In addition, follow-up research showed that an increasing percentage of Americans cited medical schools and teaching hospitals as the primary sources of medical innovations.
Biotechnology Industry Organization

The Biotechnology Industry Organization (BIO) is the preeminent trade association representing more than 1,100 biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and 31 other nations. BIO members are involved in the research and development of healthcare, agricultural, industrial, and environmental biotechnology products. BIO retained Porter Novelli to help them raise awareness among policymakers on Capitol Hill about the value of biotechnology innovations to alleviate many of the problems plaguing society, such as diseases, food shortages, pollution, and alternative fuels. For BIO members to continue innovating, it is essential that biotech firms, especially small, start-up enterprises, have strong patent protections. PN’s mandate was to help BIO amend or defeat complex legislation in two key areas – patent reform and follow-on biologics (also known as generics). PN implemented an aggressive print media campaign inside the beltway and outreach to reporters and editorial boards at major daily newspapers such as the New York Times, Los Angeles Times, Wall Street Journal, and weekly magazines such as Business Week. PN also produced a 30-second TV spot aired during Sunday talk shows to establish both the BIO brand “For a living world” and to communicate to opinion elites and the public the diversity of BIO’s contributions to humankind. Our efforts provided BIO’s lobbying team with the air cover they needed by reinforcing to lawmakers that patent protections will ensure future breakthrough innovations, and thorough testing of follow-on biologics are essential to protecting patients. PN is also in the process of producing video vignettes of patients suffering from cancer, MS and rare diseases whose lives have been saved or enhanced because of biotechnology. These “bio-stories” will be used in TV commercials, as banner “teaser” ads, and at trade shows. In addition, PN has written several op-eds for placement in key daily newspapers. BIO also partnered with eight other biotech and academic research organizations to sponsor a print ad campaign urging Congress to increase funding for NIH research.

Medical Imaging & Technology Alliance

The Medical Imaging & Technology Alliance (MITA) hired Porter Novelli to provide a wide range of strategic communications services to help MITA communicate the value of medical imaging to Members of Congress, state legislators, patient groups, the media, and the public. One of PN’s first assignments has been to help MITA and its government relations team push back on legislation moving through Congress that would cut Medicare coverage of medical imaging, a bill that would limit access to vital life-saving technologies and stifle future innovations. PN provides regular media relations services, from media monitoring to writing letters to the editor and op-eds to arranging deskside briefings and editorial board meetings. PN’s has launched an aggressive Inside the Beltway print ad campaign to support its lobbying objectives. We have also provided strategic direction in revamping the MITA Web site, are serving as secretariat for several events on Capitol Hill to educate Member and staff, and are managing MITA’s outreach to third party groups, such as patient groups, senior citizens groups, and other organizations whose constituents will be adversely affected by medical imaging cuts. PN conducted a thorough literature review to identify gaps in MITA’s current data portfolio, and we are currently facilitating a major research project for MITA to provide the necessary backup data they need to support their lobbying efforts and to serve as the basis of future messages. PN’s
Interactive group has begun a highly-targeted blog outreach effort to get MITA’s message out to key online influencers in the medical and policy communities.

U.S. Chamber of Commerce

In the last decade, class action lawsuits, originally designed to protect consumers and hold companies accountable, have been badly abused in certain state courts around the country. When the U.S. Chamber of Commerce Institute for Legal Reform launched a major effort for congressional legislation, it turned to Porter Novelli to lead the communications effort.

Earlier attempts at reform have failed due to a lack of bipartisan support. Porter Novelli devised and executed the successful earned and paid media strategy that led to passage of the landmark Class Action Fairness Act by an overwhelmingly bipartisan vote in February of 2005.

We carried out a massive effort to obtain favorable editorials from newspapers around the country by setting up editorial board visits and by writing to and speaking with editorial page editors. We also recruited third parties and others to sign op-eds that we helped write and place in key general, business and legal publications. Aggressive pitches were made to national, state and Capitol Hill reporters to generate stories about the need for the legislation and various developments in the legislative process. We also worked with national broadcast reporters and producers on daily news and newsmagazine stories on class action lawsuit abuse. In an April 14, 2003 article for the Legal Times, reporter Jonathan Groner wrote of the opposition, “ATLA’s [Association of Trial Lawyers of America] current woes are due in part to the power of its opponents’ lobbying and public relations efforts. Industry and insurance groups have pushed their stories into the center of the public debate with accounts of class actions that benefit no one but plaintiffs lawyers...In the face of such a media barrage, ATLA’s views have barely registered.”

Our efforts resulted in more than 125 positive editorials from newspapers across the country, including several from newspapers that had opposed other legal reform measures in the past, as well as multiple editorials from the Washington Post, Wall Street Journal, Chicago Tribune, Financial Times, and others. We placed op-eds and columns in the San Francisco Chronicle, the Seattle Post-Intelligencer, the Houston Chronicle, the Providence Journal, the Palm Beach Post, and in numerous business and legal publications, including the Legal Times. Major broadcast hits included segments on 20/20’s “Give Me A Break,” 60 Minutes, Lou Dobbs Moneyline, and Newsnight With Aaron Brown. We also secured coverage of reform legislation in major national newspapers, including several feature stories in the New York Times, Washington Post, Wall Street Journal, and Financial Times, and in major national newsmagazines, including U.S. News and World Report and Business Week.

Complementing the earned media effort was an issue advocacy ad campaign. As noted earlier, Porter Novelli’s ads won many public relations awards. But more important than awards, our advocacy ads helped reframe the debate and generate the bipartisan support that led to enactment of the bill after years of failed efforts. Working closely with the Class Action Coalition lobbyists, we created and placed numerous print ads, both Inside the Beltway and in target states, customizing the latter. The ads not only supported the lobbying campaign, but complemented the earned media efforts and helped deliver our winning messages.
The Asbestos Alliance

Porter Novelli has served as strategic communications counsel to The Asbestos Alliance since the spring of 2001. Led by the National Association of Manufacturers, this disparate group of asbestos defendant companies (representing a wide swath of American industry) is seeking congressional legislation to solve America’s asbestos crisis once and for all. Neither the courts nor Congress had made any headway in solving this problem in nearly 30 years. At least ten times since 1977, Congress tried and failed to enact a legislative solution. Our challenge was to reframe the issue and stimulate Congress to act. To meet this challenge, we developed an integrated strategy that includes messaging, aggressive media outreach, materials development, ally and third party recruitment, advertising, crisis management, a Web site, grassroots mobilization, spokesperson training and other elements.

Implementation of PN’s strategy and recommendations resulted in extraordinary success in shining a light on the litigation crisis and making a strong case for asbestos legislation. Our earned media efforts have resulted in hundreds of positive media hits. This includes numerous editorials and columns calling for asbestos litigation reform in publications such as the Washington Post, New York Times, Washington Times, Los Angeles Times, Indianapolis Star, Rocky Mountain News, Mobile Register, Detroit News, Chicago Tribune, Cleveland Plain Dealer, Detroit News, Pittsburgh Post-Gazette, and Financial Times. We have also worked closely with numerous reporters and producers to garner positive articles and broadcasts, including several front-page stories and major features in such outlets as the New York Times, Washington Post, Wall Street Journal, Los Angeles Times, Fortune, TIME, U.S. News & World Report, NBC Nightly News, CNBC, National Public Radio, and CNBC. Our work has also included preparing congressional testimony and speeches, crafting and placing op-eds, providing media training and setting up press interviews and events.

In the past year, tremendous progress was made, and the U.S. Senate began debate on a bipartisan bill in February. That debate came to a halt due to a parliamentary maneuver that the Senate fell one vote short of overriding. While this is a setback, the Senate will reconsider the bill later this year.

Business Roundtable

Trade with China

When the U.S. House of Representatives voted to extend Permanent Normal Trade Relations (PNTR) status to China, the U.S. business community celebrated its hardest-fought victory in nearly a decade. Porter Novelli played a central role in the China debate – managing an integrated campaign of strategic counsel, message development, earned and paid media, and grassroots communications on behalf of Business Roundtable. The campaign included the development of dozens of specifically tailored print and radio ads aimed at more than 100 congressional districts, as well as television advocacy spots that aired nationally. Our advertisements were included in ABC’s “World News Tonight,” CNN, and PBS coverage of the political battle for votes. While the PNTR advertising campaign built awareness and support for the issue broadly, the focused earned media effort provided texture and key arguments in support of the legislation as the debate evolved. PN identified stakeholders from across America’s
business and agricultural sectors and built a campaign that got the attention of Congress. The integrated campaign focused on demonstrating, district-by-district, why it was in America’s interest to pass the legislation. PN assisted in arranging dozens of local news conferences, placed op-eds and letters to the editor, and released more than 120 reports demonstrating the value of trade to local economies. Defying the skeptics, the U.S. House of Representatives voted for permanent normalized trade relations with China in May 2000. The New York Times declared it “a stunning victory for corporate America.” The Senate vote followed in September, and President Clinton signed the bill into law on October 10, 2000.

Chlorine Chemistry Council

For more than a decade, Porter Novelli provided strategic communications support to the Chlorine Chemistry Council (CCC) to promote the benefits of chlorine and counter attempts by environmental activists to force bans or limits on chlorinated products. Our efforts for CCC included an extensive earned media campaign, carried out through the operation of a “benefits news bureau” that provides a regular stream of positive information about chlorine chemistry to national, local and trade media outlets. In addition, we also developed and deployed a variety of other communications tools, including paid media, trade show exhibits, and a wide range of print and online materials to communicate CCC’s messages to opinion leaders, policymakers, ally organizations and key downstream users of chlorinated products. Our work also included outreach to and partnership activities with key health and safety organizations. Our success in communicating industry messages can be seen both from the volume of positive coverage we have generated in leading print and broadcast media, as well as from our track record in anticipating and preempting negative stories. Recent polls show that despite numerous attacks by environmental groups, support among informed Americans for the products of chlorine chemistry remains high.

OTHER HEALTHCARE EXPERIENCE

The Alzheimer’s Association:

A Rebranding Campaign Brings New Hope to the Elderly and America’s 77 Million Baby Boomers

“Maintain Your Brain!” That was the catchy title given to a new campaign to help Americans reduce their risk for Alzheimer’s disease. It was all part of Porter Novelli’s highly successful national rebranding effort for the Alzheimer’s Association that put a sharp new focus on the Association’s efforts to convince Americans that Alzheimer’s is not like the weather – we can do something about it to reduce our chances of getting it!

Formative Research

The first step was to conduct a series of focus groups with the two primary target audiences: individuals with family members who had or have Alzheimer’s disease, and baby boomers who had no personal connection with the disease but were entering the age of risk. The focus groups found that while Alzheimer’s awareness was high, the disease scared people to the point of
inaction. This, along with the public's perception that little progress had been made in the fight against the disease (a perception which was inaccurate) and that individuals could do nothing to reduce their risk (another misperception) the public was unlikely to get involved with the Association.

The focus groups showed that it was necessary to create a sense of urgency, and that fear and inaction had to be overcome by educating the public about the great progress that has been made in the fight against Alzheimer's, and that much more progress could be made in the next 10 years. The focus groups also showed that if baby boomers were to join the fight, they needed to know they could do something now to reduce their risk of Alzheimer's.

To support the effort, a new Coalition of Hope was formed, comprised of organizations with 50 million members, all pledged to spread the message and support the Association’s other major effort, to advocate for research to find a cure. The rebranding worked. Media coverage of the Association’s work soared by 200 percent, and Web advertising generated 9.4 million impressions and 61,000 click-throughs to the donation page – three times the industry average. New excitement and energy had been brought to the fight against Alzheimer’s.

Social Marketing/Public Relations/Media Campaign

To encourage boomers, a message of hope was needed. Porter Novelli recommended that the Association urge each boomer to “Maintain Your Brain.” The science was available to support the message; there was a growing body of evidence that the same health habits needed to support cardiovascular health – regular exercise, weight control, maintaining proper blood pressure and cholesterol levels, etc. – could also help maintain brain health and reduce risk for Alzheimer’s. By urging boomers to “Maintain Your Brain,” the Association could take ownership of the issue of brain health, put Alzheimer’s disease in a more positive light and elevate care of the brain to the same level of importance Americans had for the care of the heart.

The brand campaign featured a print, radio and Internet advertising campaign, public service advertising, a national and local public relations program, a public advocacy outreach effort and a direct mail component.

Communications Messages and Materials

Porter Novelli recommended that the Association continue to advocate for those already affected by Alzheimer’s disease as well as their caregivers. But if it were to be successful in changing the way Americans think about Alzheimer’s, the brand campaign needed to target baby boomers, because they will be the next group of Americans to become at risk for the disease. There was another reason to target the boomers: Because of this group’s great size (77 million people), the number of Americans liable to get the disease is expected to soar in the next few decades.

Media Buying and Leveraging for Additional Media Exposure

Eighty percent of participants in creative focus groups said the “Maintain Your Brain” video was effective in convincing them that now was the time to get active in the fight against Alzheimer’s disease. Seventy-six percent said they were more optimistic they could reduce their risk for the disease, and 66 percent said they felt motivated to join the Association.
In order to manage the Association’s budget, advertising focused on print, radio and the Web. Follow-up to chapters in the campaign target markets found that call volume was up throughout the radio campaign. Web advertising results were also strong, with one in four people clicking through to the donation page and giving money. For the first 12 weeks of the campaign, Web advertising generated 9.4 million impressions and 61,000 click-throughs – three times the industry average.

**Media Relations**
Media coverage was up 200 percent in 2004 over 2003. The February 2004 campaign launch generated more than 40 million impressions, including coverage by The Associated Press, AP Radio, CNN Radio and “Inside Edition,” and resulted in the second-largest number of visits to the Association’s Website in its history. Another media outreach effort concerning the impact of Alzheimer’s disease on Hispanic Americans resulted in coverage in every major Hispanic news outlet, including Univision, El Diario and CNN en Espanol. Coverage of the Association’s Ninth Annual International Research Conference on Alzheimer’s Disease in July 2004 led by Association staff, with assistance from Porter Novelli, generated more than 350 million media impressions.

**Press Conference Support and Ad Hoc Support**
The new brand and “Maintain Your Brain” campaign were introduced at an event in New York City on Feb. 12, 2004. Sheldon Goldberg, president and CEO of the Alzheimer’s Association; Marc Mortal, President of the National Urban League; James Parkel, President of AARP; journalist Deborah Norville; and Jeanne Phillips [a.k.a. “Dear Abby”] were among those participating.

**Identifying, Building and Activating Grassroots and Outreach Partnerships and Coalitions for the Targeted Population**
Porter Novelli also recommended that the “Maintain Your Brain” platform focus on more than just brain care – “Maintain Your Brain” would also serve as an advocacy message to help the Association recruit new partners and expand its reach. Prior to beginning the campaign, the Association had not significantly expanded its advocacy efforts beyond those who were personally affected by Alzheimer’s disease. Porter Novelli recommended that the Association create the Coalition of Hope, a national grassroots organization consisting of a diverse group of organizations numbering 50 million members that would call on all Americans to “Maintain Your Brain.” This was designed to increase the size of the Association’s constituency, help to advocate for increased funding for Alzheimer’s and demonstrate to policymakers that the number of Americans with Alzheimer's would escalate rapidly without a strong commitment to research to find new treatments and a cure.

In addition, Porter Novelli worked with the Alzheimer’s Association to establish partnerships with the National Council of La Raza (NCLR) and the National Urban League (NUL) to educate their constituencies about Alzheimer’s disease and the “Maintain Your Brain” campaign. This included creating a new “Maintain Your Brain” education curriculum and toolkit for training workshops co-led by local chapters of the Alzheimer’s Association and NCLR and NUL affiliates. In addition, NCLR assisted in the dissemination of Spanish-language PSAs to broadcast and print media outlets that reach Hispanics.
Awards
Porter Novelli’s work for the Alzheimer’s Association was awarded a Certificate of Excellence in the 2005 Toth Awards and was a finalist in the 2005 Telly Awards.

American Cancer Society
Creating a Global Forum to Gain New Allies in Tobacco Control Advocacy

Overview
In 2006, Porter Novelli partnered with the American Cancer Society to produce a live, interactive event to coincide with the closing of the 2006 International Union Against Cancer (UICC) World Cancer Congress and the opening of the 13th annual World Conference on Tobacco or Health (WCTOH) at the Washington Convention Center. For the first time, the Society sought to host these conferences concurrently in Washington, DC, in July 2006.

Tobacco is the second major cause of death in the world, and if current trends continue, it will become the number one cause of preventable death by the year 2020. The United States and most of Western Europe are finally seeing declines in smoking and cancer death rates. As the markets for tobacco in the developed world have matured, the tobacco industry has shifted its focus to underdeveloped, heavily populated nations in Africa, Latin America and Asia.

Challenge
The goal of the “Combined Plenary” session was to bridge the oncology and tobacco-control advocacy communities—by encouraging oncologists to become tobacco-control advocates.

Strategies
Our strategies included:

- Convincing our target audiences of oncologists, nurses, the public health community, and government officials/global NGO leaders that the connection between tobacco use and premature death is real;
- Inspiring them with stories and illustrations of how others became powerful and effective tobacco control advocates;
- Arming oncologists with tools they can use in their practice to counsel patients against tobacco.

Planning and preparation began in August 2005, one year prior to the event. Activities included interviewing and meeting with many oncologists, scientists and tobacco-control advocates from around the globe; careful analysis and review of current scientific research on smoking and tobacco; content development and scripting of program and coordination of all production elements.

Execution/Tactics
Porter Novelli produced a fast-paced 90-minute program closely mirroring a live TV program format. Porter Novelli secured CNN’s Larry King and Dr. Sanjay Gupta to serve as the Combined Plenary’s respective Anchor and Master of Ceremonies.
The Combined Plenary was divided into five segments:

1) “The Tobacco Pandemic”—An overview of the problem in a historical context, making use of a video presentation that chronicled smoking and tobacco control around the world—and featuring live speakers on stage (in an interview format with Dr. Gupta) Dr. John Seffrin, CEO of the American Cancer Society, and Dr. Catherine le-Gales Camus, Assistant Director General of the World Health Organization.

2) “Science on Smoking”—A scientific presentation, highlighting the latest research on the effects of smoking on the brain, on cancer treatment and cessation options given by Dr. Nora Volkow, Director of the U.S. National Institute on Drug Abuse, Dr. Ellen Gritz of M.D. Anderson Cancer Center and Dr. Mike Fiore of the University of Wisconsin Medical Center and a subsequent presentation by Dr. Volkow.

3) “Newsmakers”—A Larry King interview with world leaders in the anti-tobacco movement including Irish Deputy Prime Minister Mary Harney via live satellite, Former U.S. Surgeon General C. Everett Koop, New York City Health Commissioner Dr. Thomas Frieden, South African public health leader Dr. Yussuf Saloojee, and U.S. Congressman Henry Waxman (D-CA).

4) “Town Hall”—An interactive session in which questions were asked of six leading international tobacco control advocates from the Czech Republic, Australia, India, Guatemala, the United States, and Zimbabwe—all of whom shared their personal stories as insights into global best practices for combating tobacco use.

5) “Call to Action”—A conclusion featuring Dr. David Bristol, President of the St. Lucia Cancer Society, and Dr. Franco Cavalli, incoming UICC President, jointly issuing a formal call to the audience to expand their commitment to health by becoming an active member of the global anti-tobacco advocacy community. The first step: visiting the Global Smoke Free Partnership Website for more information and resources.

Impact and Results
Presenting to 4,000+ attendees, the Society hoped the audience would leave and demonstrate their commitment to joining the global anti-tobacco advocacy community. Since the event, more than 15,000 people have visited the Global Smoke Free Partnership Website for more information.

Center for Nutrition Policy and Promotion, USDA
MyPyramid.gov, A New Food Guiding System

Overview
When the U.S. Department of Agriculture (USDA) and Porter Novelli worked together in the early 1990s to create a healthy eating brochure, no one at the time imagined that the supporting visual Porter Novelli designed for it would take on a life of its own. More than a decade later, that visual – the Food Guide Pyramid – had achieved icon status with 85 percent consumer awareness. But it was being used independently, without the nutrition guidance it was meant to symbolize, and statistics show that Americans today are not eating as healthfully as they should.
Following years of research and preparation, and in anticipation of the updated 2005 Dietary Guidelines for Americans, USDA asked Porter Novelli to create a new Food Guidance System.

Formative Research
From an analysis of Porter Novelli’s Styles database, USDA’s primary target audience was the estimated 135 million adults who are normal or overweight, and who are interested in nutrition. Interest in nutrition was a key factor because initial target audiences needed to be at least somewhat inclined to pay attention to Food Guidance System messages and materials in order for them to motivate behavior change.

Extensive consumer research, which included focus groups, online concept testing and Web usability testing, revealed recurring themes. These themes – including success and achievement, personal appeal and motion and activity – guided the development of the symbol, its slogan and the Web site.

Porter Novelli conducted extensive benchmark research that explored questions such as: How do consumers feel about the pyramid shape – should it stay or go? What primary nutrition messages did stakeholders believe should be included in the new system? Should the new symbol be a teaching tool or a visual cue to remind consumers of general messages and point them to additional information?

Technology not widely available in the early 1990s offered new and better ways to engage people in a more personalized, interactive way. Porter Novelli’s proprietary, annual Styles survey showed that the Internet was the top media source for health and nutrition information, and helped lead us to these objectives: create a symbol that encourages consumers to visit a new Web site where they can learn about healthy eating and the importance of exercise, and present the food and physical activity recommendations from the federal government’s 2005 Dietary Guidelines for Americans in an easily understandable, relevant and interactive way.

Social Marketing/Public Relations/Media Campaign
A Web site would enable USDA not only to offer more nutritionally appropriate recommendations to individuals, but also to deliver personally relevant guidance to them directly and immediately, as consumers have now become accustomed. The strategy also met the USDA’s needs by leveraging their very limited financial resources for maximum impact.

To encourage consumers to seek out this personal information, the new symbol for the Food Guidance System needed to be simple and devoid of any detail that could be misinterpreted as “all the information you need.” It should be anticipated that as with the Food Guide Pyramid, the symbol could be placed on packaging and materials developed by food manufacturers, grocery retailers, health and nutrition professionals, educators, NGO’s and government agencies.

Communications Messages and Materials
Porter Novelli was involved in all aspects of the new Food Guidance System including:

- The Name: The name, MyPyramid, was chosen to emphasize the new personalized approach to healthy choices.
• The Symbol: The symbol for USDA's new MyPyramid Food Guidance System builds on the brand equity of the Food Guide Pyramid, but features three new key components:
  - Food groups re-oriented from horizontal to vertical bands, with the broader base encouraging foods with less added sugars and fats across all food groups;
  - A figure climbing steps up the pyramid for personal connection and to emphasize the importance of physical activity; and
  - Prominent placement of MyPyramid.gov URL as a call to action.
• The Web site: One of the key features of MyPyramid.gov is a diet “wizard” into which users can enter their gender, age and daily physical activity level to generate tailored recommendations. And for the first time, daily recommendations are communicated in easy to understand household measurements.
• A First – Animation: The team created flash animation to introduce MyPyramid, demonstrating the transition from the Food Guide Pyramid. This animation – probably the first for a Federal nutrition program launch – was a key tool in briefing the media at the launch event.

Media Relations
Wherever Americans prefer to turn for their news – network morning shows, radio drive time or the local paper – MyPyramid was featured on national TV and radio generating more than 110 million impressions in the first few days after the launch. Articles in the national and top 10 market newspapers and national newsweeklies reached more than 70 million readers in the six months following the launch.

Consumers clamored for more information and individualized recommendations, generating exceptional traffic to MyPyramid.gov. In the first 24 hours, there were nearly 50 million hits to MyPyramid.gov. In its first week, the “food pyramid” was the fourth most searched-for term on Google. In the first six months following the launch, there were nearly 1 billion hits to the site.

Press Conference Support and Ad Hoc Conference Support
In April 2005, the U.S. Secretary of Health and Human Services unveiled MyPyramid and its new symbol with the animation at a national press event in Washington, D.C. Fitness personality Denise Austin was engaged as a spokesperson at the launch event to underscore the important addition of physical activity to MyPyramid.

Identifying, Building and Activating Grassroots and Outreach Partnerships and Coalitions for the Targeted Population
MyPyramid also has triggered a rapid and enthusiastic response from the food industry, which is critical to helping consumers shop for healthy choices. Grocery retailers such as Stop & Shop and Giant began promoting MyPyramid’s symbol and messages at point of purchase within the first week of its existence, and food companies such as General Mills quickly adjusted food packaging to increase MyPyramid’s symbol and messages within a month.

Educational publishers have also quickly embraced MyPyramid, developing textbook content, teaching aids and lesson plans for use during the new school year, just four months after the launch. New applications for handheld devices also have been created.
Cincinnati Children’s Hospital Medical Center (CCHMC)

Everyone in Cincinnati knows that Cincinnati Children’s is the best place to take a sick child, but tracking research showed that very few local residents were planning to donate to the hospital. In fact, just as many local residents contributed to St. Jude’s Children’s Research Hospital as CCHMC. Porter Novelli was asked to create an outreach plan to drive awareness and, ultimately, increase the hospital’s donor pool. Discussions with the board and staff revealed a wide range of appealing strengths and a strong sense of passion and commitment among those connected to the hospital, key strengths that were not being effectively communicated to the public.

To build upon the learnings from these discussions, we conducted a series of triads with high-income married women 40+ (identified as those who had the greatest propensity to donate locally) to determine which benefits resonated most. We found that a combination of emotional pull—true stories of the passion and commitment that lead to cures for sick children—and the new information that the hospital is a non-profit, combined for powerful appeal. We conducted additional online testing which further validated this approach.

Porter Novelli created an integrated campaign of television, print, and outdoor advertising, combined with an NPR sponsorship, as well as a campaign landing page on the CCHMC website. Thus far, only a few months after the campaign launched, we have seen impressive results. Tracking research indicates that nearly 64% of our target audience recalls having seen Cincinnati Children's advertising, and that awareness of key

American Heart Association (AHA)

When Porter Novelli created and launched AHA’s “Face the Fats” consumer education campaign, we generated more than 133 million earned impressions in less than three months through traditional media coverage that included the CBS “Early Show” with Dr. Emily Senay, CNN’s “House Call with Dr. Sanjay Gupta,” U.S. News & World Report, the Associated Press and more. We created two animated characters—Sat and Trans, the Bad Fats Brothers—and brought them to life in an “edutaining” Webisode featured on the Brothers’ own site, BadFatsBrothers.com. The Brothers hit the blogosphere right away, generating comments like “I’m glad that normally stuffy agencies like the AHA are thinking ‘out-of-the-box’ and creating PSA campaigns that people will actually remember. I hope that more groups will follow their example and create entertaining campaigns.” Porter Novelli also worked to develop a multi-hour minority outreach radio tour for AHA. The objective of the tour was to promote the campaign and discuss the effects of heart disease among the Latino and African American communities. The minority outreach efforts earned over 7.5 million impressions alone. Ultimately, measurement will include gauging how successful we are at driving traffic to the Brothers’ site, as well as traffic driven from their site to the core campaign site and its personalized My Fats Translator tool at AmericanHeart.org/FaceTheFats.
The Health Benefits Coalition (HBC)

As one of the largest employer-based health care coalitions ever formed, the HBC was created out of concern that “patients’ rights” legislation introduced in Congress would dramatically increase health care costs for families and businesses. The coalition retained Porter Novelli to help stave off passage of such legislation by educating Congress and voters about the unintended consequences of a “right to sue.” To support HBC and their lobbying efforts, Porter Novelli developed and continues to implement a multi-faceted public affairs campaign that included message development, media relations, advertising, and lobbying/grassroots support.

Porter Novelli developed a single and concise message that all involved parties agreed on that served as the rallying cry of the campaign: New lawsuits will increase costs and the uninsured. Through consistent communications with the media, Porter Novelli successfully injected HBC’s messages into news stories—whether print, television or radio—that discuss the issue of a “patient’s bill of rights.” Tactics included drafting and distributing annually more than 100 press releases, fact sheets, and coalition letters to the media and Capitol Hill offices; conducting numerous editorial board conference calls and press conferences; organizing interviews for coalition spokespersons on radio news talk shows; writing and placing numerous op-eds, including two key placements in The Washington Post days before crucial votes in Congress; and advertisements that not only complimented the earned media, but also created a buzz of their own on public affairs shows such as “Meet the Press” and “Inside Politics.”

Depression Is Real Coalition

Overview
“Depression is real. So is hope.” That was the driving message Porter Novelli recognized the need to convey to the American people in the face of the stigma and misinformation surrounding mental illness. With support from client Wyeth, Porter Novelli set out to establish a diverse coalition of prominent physician, patient, and civic nonprofit organizations to spread this important message. With members including the American Psychiatric Foundation (APF), the Depression and Bipolar Support Alliance (DBSA), the League of United Latin American Citizens (LULAC), Mental Health America (MHA), the National Alliance on Mental Illness (NAMI), the National Medical Association (NMA), and the National Urban League (NUL), the Depression Is Real Coalition was born, and a public education campaign to tell Americans the truth about depression was launched.

Situational Analysis
Depression has often been misunderstood, feared, and stigmatized. In 2005, scientologists led by Tom Cruise fueled misconceptions surrounding depression by labeling psychiatry a “pseudoscience” and criticizing Brooke Shields for taking medication to treat her post-partum depression. The bias against mental illness in our society is further evidenced by insurers, both public and private, who continue to reimburse mentally ill patients at a lower rate than patients suffering from purely physical illnesses.

In addition, antidepressant use had been under scrutiny at the highest levels. In 2003 and 2004, British regulatory authorities and the U.S. Food and Drug Administration (FDA) were reviewing...
the safety of antidepressant medication use in children. In 2005, FDA issued strong warnings about the potential for pediatric suicidality for all antidepressants—a move that many medical experts fear over-reached and may have only served to limit patient access to potentially beneficial therapies—and has since expanded that warning to include young adults under the age of 25.

The Challenge
More than 19 million Americans suffer from depression each year, and nearly everyone knows a friend, family member, or co-worker who is one of the 19 million. Unfortunately, many people believe depression is “just the blues” or an “imaginary disease” that is “all in your head,” with fewer than half those suffering from the disease ever seeking treatment. Finding a way to reduce this stigma and correct the abundance of misinformation portrayed in entertainment and the media called for a dramatic public education campaign that would get in the heads of the American people, specifically the African-American and Latino communities, where stigma is especially high.

Porter Novelli’s Approach
The best way to combat broadly disseminated misinformation is to broadly disseminate the facts from an authoritative source. Porter Novelli believed that a coalition built around the leading mental health groups—APF, DBSA, MHA, and NAMI—would provide the stamp of authority to tell the American public the truth behind depression.

Strategy
Working with this coalition of mental health groups, Porter Novelli developed a public education campaign to inform Americans about the serious, debilitating, and potentially life-threatening nature of depression; reduce the stigma surrounding the disease; provide hope to those whose lives are touched by it; and address issues surrounding access to mental health treatment. The coalition settled on a PSA campaign as the best method for reaching Americans. This early coalition also recognized the need to include other organizations representative of minority populations so specifically affected by depression, and invited LULAC and NUL to join the coalition and campaign.

Execution and Tactics
Porter Novelli created the concept behind the coalition and set out to build it from the ground up, reaching out to a number of physician, patient, and minority civic nonprofit organizations. Once the coalition was assembled, Porter Novelli assisted in the development of the overall mission and theme of the campaign, including creative and interactive development, and coordinated the official launch.

PSA Campaign
Three print PSAs, a radio PSA, and a television PSA, all in both English and Spanish, were developed to illustrate the elevator-like nature of depression. Recognizing that depression has many levels, the PSAs address how depression, which starts with sadness, sleeplessness, and isolation, can lead to lost job, despair, and even suicide—or alternatively, to hope, treatment, and recovery. The PSAs also illustrate that depression does not discriminate: it affects people of both sexes and all backgrounds. A coalition Web site, www.depressionisreal.org, also launched, maintaining the look and feel of the PSA campaign and providing background information on depression.
Advertising
Porter Novelli approached Dr. Paul Greengard, 2000 Nobel Laureate in Medicine, to participate in paid print and radio advertisements to promote the launch of Depression Is Real. Online banner ads maintaining the look and feel of the Depression Is Real Campaign and a targeted online media placement plan were also developed.

AudioCast
Second to their doctors, more and more Americans are turning to the Internet for information about health. A Pew Internet & American Life Project survey from November 2004 found that eight out of ten Internet users look for health information online and 23 percent of Internet users (32 million people) have searched online for information on depression, anxiety, stress or mental health issues. Given this growing trend, Porter Novelli developed an audiocast—“The Down & Up Show”—as an innovative way to help educate the public about depression.

Congressional Outreach
In spring 2007, the coalition recognized the need to expand their educational efforts to policymakers, especially as Congress considers mental health parity legislation. To kick-off May and Mental Health Awareness Month, the Depression Is Real Coalition hosted a Congressional reception for members of the four key caucuses—the Mental Health Caucus, the Caucus for Women’s Issues, the Black Caucus, and the Hispanic Caucus—and their staffs to serve as an opportunity for coalition members to share with Representatives the seriousness of depression and the importance of equitable treatment for all.

Results and Impact
Through PSAs placement, print and radio advertisements, the Web site, “The Down & Up Show,” and other educational activities, the Depression Is Real Coalition is educating Americans that depression is a serious, debilitating disease that can be fatal if left untreated, and providing hope for recovery.

PSAs
The print, radio, and television PSAs were sent to media outlets around the country, with a first flight in November of 2006 following the coalition’s launch, and a second flight scheduled for July 2007. To date, the PSA campaign has been phenomenally successful, obtaining placement in each of the Top 10 U.S. markets, with placement still continuing. Print insertions, including three placements in the New York Daily News, have reached over 6.5 million newspaper and magazine readers, while the radio PSA has aired on 267 stations nationwide. The television PSA has been even more successful, with airings on 239 stations in addition to national and local cable. The overall value for the PSA campaign to date is nearly $6 million.

Online traffic to DepressionIsReal.org also continues to grow, particularly with the launch of “The Down& Up Show,” with over 90,000 unique visitors since the launch.

Advertising
During the launch of the Coalition in September 2006, advertisements featuring Dr. Greengard appeared in top-tier publications including The New York Times and The Washington Post, as well as inside-the-Beltway publications. In October, Roll Call, one of the premiere public policy newspapers in Washington, and one of the top papers read by Members of Congress, staff, and
lobbyists, awarded the Depression Is Real Coalition the AD-Q Award for Outstanding Advertising in recognition of Dr. Greengard’s advertisement, which achieved the highest readership response as measured against all other ads appearing in *Roll Call*. Radio ads also played on major news stations in the Washington area surrounding the fall launch. Online banner ads of the PSAs continue to appear on various Web sites, including Google, AOL, CNN, MSN, Weather.com, and Yahoo!

Audiocast
The inaugural episode of “The Down & Up Show” aired on April 26, 2007. Porter Novelli secured Dr. Ellen Frank, a world-renowned expert in mood disorders and professor of psychology and psychiatry at the University of Pittsburgh School of Medicine, to serve as host and new episodes are available every Thursday on the “Down & Up Show” microsite, housed on DepressionIsReal.org and iTunes. Guests so far have included Dr. Darrel Regier, Director, Division of Research at the American Psychiatric Association; Congressman Patrick Kennedy (D-RI); and Terrie Williams, best known as an inspirational author, mental health advocate, and celebrity public relations agent for star clients such as Eddie Murphy and Miles Davis. Topics have included “Facts & Myths” about depression; depression and families, military service, and the African-American community; “Recovery is Possible;” and, following the tragic events at Virginia Tech, “Mental Illness & Campus Life.” Future guests include Joshua Shenk, author of best-seller *Lincoln's Melancholy*, Kitty Dukakis, and Mary Jo Codey, former first lady of New Jersey. The microsite for the show includes a weekly poll surrounding the next episode’s topic, as well as transcripts and an archive of past shows. Since the launch, there have been nearly 5,000 downloads of the audiocast, with listenership continuing to grow, and over 14,000 unique visitors to the microsite.

Congressional Outreach
The Capitol Hill reception was a resounding success. Four Members attended, including Congressman Patrick Kennedy (D-RI), one of the lead sponsors of the Paul Wellstone Mental Health and Addiction Equity Act; Congressmen Harry Mitchell (D-AZ) and Don Payne (D-NJ); and Congresswoman Sheila Jackson Lee (D-NY), with staff members from many other offices and representing all four caucuses. Staffers from Senator Hillary Rodham Clinton’s office also attended. The print advertisement featuring Dr. Greengard appeared in the Capitol Hill public policy publications the day of the event to raise awareness.

Shaping the Market for a New Cancer Vaccine

Challenge
A leading vaccine manufacturer charged Porter Novelli (PN) with shaping a favorable public health environment for the launch of a breakthrough vaccine targeting the virus that causes a deadly cancer in women.

Environmental Overview
In the summer of 2006, a competitor vaccine was approved and launched. The client’s candidate vaccine will be second to market by well over a year. The market itself was not prepared for this type of breakthrough. In fact, PN identified the following environmental challenges that were critical to address in order to create a successfully-primed marketplace:
• Women lacked an established “medical home” for routine use of the vaccine
• Key players in the cancer community were not united under one voice
• Preventive screening programs were successful, but failing underserved communities
• Consumers didn’t understand that a virus causes the disease

Communications Objectives
• Increase public awareness of the importance of optimal cancer prevention as part of routine health care for women
• Bring together the organizations who collectively can create the demand for access to optimal cancer prevention

Approach
PN worked closely with the client’s marketing, public policy and advocacy teams to identify the key stakeholders in all aspects of the public health community that would be instrumental in shaping the market for the new vaccine. PN recommended creating a unique coalition comprising the leading organizations in the areas of women’s health, policy, public health, consumer health and various medical specialties.

Activities included:
• Amassing members from well-respected organizations across the public health spectrum with a vested interest in working to improve access to preventive health care for all women
• Galvanizing members to identify the four key barriers impeding women’s access to preventive health care for this particular cancer
• Establishing specific workstreams to concretely address these barriers, led by influential members of the coalition
• Encouraging members, through the workstreams, to identify and execute programs that would:
  o Highlight current needs and set benchmarks for future programming addressing achieving universal access to preventive care for women
  o Spur positive change in the public health arena

Impact/Results
In just one year …
• The client was seen as a trusted partner in shaping the dialogue among public health opinion leaders and leading public health organizations about policies and programs relating to broad access.
• The client successfully built strong relationships with members and identified future opportunities for collaboration.
• The client was positioned as a leader in breakthrough preventive health care for women.
• The coalition was seen as a trusted resource.

The National Network for Immunization Information
A group of top experts in the immunization field formed the National Network for Immunization Information (NNii) in 1998 to tell the positive story of vaccines to the public.
(especially parents), health care professionals, legislators, and the media, before that story was forgotten. NNii hired Porter Novelli to help them become a leading source for accurate and reliable science-based information on immunization issues.

From February through September 1999, Porter Novelli conducted extensive audience research. Parental beliefs, feelings, and behaviors related to immunization were explored in several rounds of focus groups and a national survey. The findings of the national survey of parents were peer-reviewed and published in the November 5, 2000, issue of Pediatrics. Other focus groups with parents looked at their reactions to media coverage of immunization, and NNii’s proposed media messages. Porter Novelli also held focus groups with pediatricians and surveyed health committees in state legislatures.

Using the research findings, Porter Novelli worked with NNii to develop several tools for key audience segments. These included a set of core messages that formed the cornerstone of all NNii communications and served as a means to ensure that the various entities that issue immunization information and recommendations speak with one voice at times of crisis. Porter Novelli also helped NNii develop a health care professional resource kit with simple, easy-to-understand patient handouts and guidance on immunization issues.

In addition, Porter Novelli developed NNii’s Website, www.immunizationinfo.org, which features sections specifically tailored for parents, health care professionals, and legislators and provides current immunization news, feature articles, and the facts on “hot topics.” Porter Novelli and NNii conducted a Web usability study in 2001 that lead to the creation of the “Vaccine Information” section, which allows users to access everything NNii has to offer on a given vaccine or disease, including state vaccine requirements, in one place. Porter Novelli worked with NNii to transition the site maintenance to their internal staff during 2003, but continues to contribute new content and site development counsel as needed.

The NNii resource kit became the Website’s most frequently downloaded file and has been accessed nearly 50,000 times since 2000. In its first four months, the NNii Website received 78,000 site hits and was featured in 71 print and online publications. The site was selected as USA Today’s “Hot Site of the Day,” coolsiteoftheday.com’s “Cool Site of the Day,” Popular Science Magazine’s “Editor’s Choice,” and refdesk.com’s “Site of the Day.” Moreover, site attention has grown through the years – for example, in 2002, the NNii Website had 437,000 hits, and as of December 2002, there were approximately 1,090 links to NNii’s homepage from outside sites.

* * * * *
INTRODUCTION

The following plan is designed to build awareness for SNM and molecular imaging among other medical professionals, the scientific community and, to the extent possible, mainstream media and the general public. The basis for the plan has been our discussions with SNM leadership and staff, and the strategy summit held with members of the SNM Board of Directors on January 7, 2008. Of the many ideas discussed at that meeting, we have included as many as possible that fit within our current budget; additional ideas are included in the “Optional Activities” section, with estimated budget figures attached.

SNM faces several key challenges in promoting molecular imaging. First, the term molecular imaging itself, while broadly used, is not well understood by many audiences. Despite the fact that SNM has developed a thorough and accurate clinical definition of the term, this definition is not easily translated to a lay audience. Second, clinical outcomes data has not been organized for easy review, or widely promoted to other physicians; as such, many physicians are not convinced of the value of newer molecular imaging procedures over more familiar diagnostic procedures. This communications plan addresses each of these challenges specifically, while also looking broadly at communications opportunities within the key audiences and medical communities identified during the strategy summit.

To match tactics against our program budgets, the tactical elements of the plan are organized in the same format as our original proposal dated November 20, and budgets have been assigned accordingly.

COMMUNICATIONS OBJECTIVES

1) Raise awareness and understanding of molecular imaging, including emerging technologies, among other clinicians
2) Increase other clinicians’ understanding of SNM’s core competencies
3) Underscore SNM’s preeminent role as the voice of molecular imaging

KEY AUDIENCES

- Referring physicians, including:
  - Radiologists
  - Radio-oncologists
  - Oncologists
  - Cardiologists
  - Neurologists
  - Primary care physicians (family physicians, general practitioners, internists)
  - Surgeons
  - Obstetricians and gynecologists
As noted above, while a percentage of each of these audiences has embraced molecular imaging technology, it is not widespread in most specialties. The reasons for a lack of uptake vary by specialty and provider; however, common reasons include:

- Lack of perceived therapeutic value
- Perceived complexity of the procedure(s)
- Lack of reimbursement by insurance companies

We know that influential channels to reach physicians include medical journals and meetings, fellow clinicians and top-tier media. Therefore, the communications plan is designed to deliver a constant stream of information to this audience via a mix of these channels.

- **Influencers**
  - **Technologists**

Technologists tend to be the primary contact for patients, and they are well-positioned to communicate effectively with lay publics, including local-market media and business groups. By creating new materials designed to facilitate communication with these audiences, we will equip the technologists with effective tools to amplify and deepen the reach of other SNM efforts.

**COMMUNICATIONS STRATEGIES**

- Actively reach out to specific, high-priority clinicians who are most likely to be activated on the issue
- Focus primarily on PET in outreach, as a gateway to learning about other technologies
- Where possible, activate SNM members (particularly technologists) as emissaries to the public

**COMMUNICATIONS TACTICS/ACTIVITIES:**

<table>
<thead>
<tr>
<th>Strategic Plan Development</th>
<th>$20,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeline: January-February 2008</td>
<td></td>
</tr>
</tbody>
</table>

The final deliverable under this task is the delivery of this document. Preparation has included a number of activities, including:

- Preparing for and hosting a strategy session, and delivering notes post-meeting to SNM.
- Conducting conference calls with the SNM team and holding internal Porter Novelli team meetings to discuss/refine the communications focus.
Strategic Counsel $20,000
Timeline: Ongoing
Our ongoing strategic counsel, which includes access to Porter Novelli’s senior leadership, will help SNM’s communications campaign stay on course this next year. Our weekly calls will fall under this line item, as well as any other miscellaneous work we might do for SNM outside of the scope outlined below.

Message Development $20,000
Timeline: February 2008
The repetition of simple, clear messages in multiple outlets over time is a core principal of behavior-changing communications campaigns. Because of the perceived complexity of the issues around molecular imaging and the need to explain them to multiple audiences, we first recommend creating a set of core messages and materials that can be used by spokespeople throughout the year. We envision a message map that unites the most important elements of your communications efforts, as well as a set of eight to 10 fact sheets on the most important communications topics. Note: A sample message map has been provided at the end of this document for your reference. The messages, in particular, will be crucial to ensuring those speaking on behalf of SNM during presentations, interviews and meetings are speaking with one voice.

At the summit, the leadership identified the core barrier to the uptake of molecular imaging to be the lack of data supporting improved therapeutic/clinical outcomes. Porter Novelli’s budget for this task assumes the mining of existing SNM data will be conducted by SNM separately, with appropriate information and references available for our use (and incorporated into the materials we plan to develop). However, if you need our assistance in gathering and reviewing appropriate material, we have provided an optional budget for our assistance in the “Optional Activities” section below.

As identified at the summit, the following are key message areas to cover throughout the materials we develop:

1. An overview of SNM
   a. Your vision and a simplified definition of molecular imaging
   b. Your role and promotion of molecular imaging
   c. Definitions/uses of common procedures

2. Safety and Use of Imaging
   a. Benefits of molecular imaging over previous techniques:
      i. Ease and safety for patients
      ii. Precision of results
   b. Expression/comparison of radiation risks
3. **Reimbursement**  
   a. Rationale for reimbursement to be based on therapeutic rather than diagnostic criteria  
   b. Specifics relating to reimbursement of Bexxar/Zevalin (and other relevant issues, as identified by SNM)

4. **Facilitating the promise of personalized medicine**  
   a. Explanation, with examples of how molecular imaging can deliver the right drug to the right patient at the right time

5. **State of the art/The best there is**  
   a. An explanation of the development of molecular imaging  
   b. Comparison of molecular imaging techniques to other diagnostic and therapeutic tools

6. **PET/CT**  
   a. Information (perhaps a fact sheet) specifically on PET/CT, outlining its mechanism, use and value

Messages also will be designed to address and overcome the key barriers identified at the Summit, including:  
- Fear of radioactivity  
- Homeland Security issues  
- Potentially adverse events/contrast toxicity  
- “Fuzziness” of images/perceived lack of information in reports

**Materials Development**  
**$35,000**

**Timeline: February-March 2008**

Once the messages are final and approved, we will develop the following core set of materials for SNM:  
- **Provider and patient materials** about molecular imaging:  
  - Standard fact sheets about each of the priority topic areas  
    - Cancers—lymphoma, prostate, breast  
    - Alzheimer’s  
    - Heart Disease  
    - Sentinel Node Testing  
    - PET  
  - Common myths/facts brochure or fact sheet  
  - “What is MI?” piece for either providers or patients  
- A **“stump speech”** (canned speech) about molecular imaging and a PowerPoint presentation for use by SNM members/chapter leaders and other influencers during speaking opportunities.  
- A **table-top exhibit** that can be used at the annual meetings of other medical specialty groups.
All materials will use a general creative template consisting of similar colors, fonts, styles, and images, etc., which will help to define SNM communications among your many audiences.

**Message Delivery**  
**Timeline: March 2008**
As mentioned in our proposal, we will help prepare key SNM spokespeople (applicable leadership and others) for interviews with the media and other audiences about SNM. We will host two half-day media training sessions at our office, with five SNM officials participating in the training each day.

During this training, we will review key messages, identify tips for speaking to reporters and execute mock interviews with each participant as practice. We also will be available during your annual meeting to provide guidance about speaking with any media that may be in attendance at this event.

**Logistical Support**  
**Timeline: Ongoing**
The bulk of our outreach activity for the year falls under this line item, which includes the following activities originally identified in our proposal:

- **Outreach via consumer media to elevate SNM as the leader in molecular imaging.**
  - Developing and distributing a maximum of three consumer press releases per month. We will work with SNM staff to ensure that the release topics apply to key focus areas/messages mentioned above.
    - One specific and identified release will be around the molecular imaging supplement to the *Journal of Nuclear Medicine*, tentatively scheduled for release in April.
  - Developing and maintaining consumer and trade media lists.
    - Lists will be refined and revised on an ongoing basis per feedback from reporters during pitching, etc.
  - Writing and pitching one op-ed or guest article, if applicable, per month for SNM.
  - Developing one consumer-friendly paper for each of the aforementioned key issues (drawing on the fact sheets and expanding to incorporate key messages) to have when needed for rapid response.
  - Offer three “exclusive interviews” to consumer publications, as opportunities arise, on key issues relevant to SNM’s core messages and of interest to the public.
  - Track media coverage and provide press clippings and transcripts at the end of each month, as applicable, from all coverage.
In addition, we have identified the following elements that would be conducted under this line item:

- **Editorial calendar review and news hook identification:** We will review the editorial calendars of key news outlets, such as the *New York Times*, the *Wall Street Journal*, *Time*, *Newsweek*, *US News and World Report* and others, to identify upcoming stories where we can insert information about SNM and/or molecular imaging. From these findings, we then will tailor outreach to those applicable outlets, in addition to our ongoing media outreach, and pitch the appropriate contacts about including information on molecular imaging in the upcoming issue.

- **Outreach to key clinician audiences via attending and exhibiting at relevant conferences.** *NOTE: Our budget assumes that exhibit fees and staffing will be handled by SNM. Should our services be needed to man booths at these conferences, we would be happy to provide a budget for your consideration upon SNM identification of conferences.* Porter Novelli’s efforts will include:
  - Identifying appropriate conferences and working with SNM staff to decide which to exhibit at and which to solicit for a speaking role.
  - Identifying mechanisms for collecting booth/conference attendee names for later outreach activities.
  - Assisting SNM with writing abstracts for submission to select conferences for speaking engagements (estimated three submissions in 2008)
    - We also will help promote these speaking engagements with relevant trade and general market media.
  - Assisting in the development of a standard presentation for delivery by SNM members at these conferences (building off the aforementioned canned speech and PowerPoint presentation template).
  - Promoting your conference involvement to attendees and trade media.
  - In 2008, in addition to your participation at the American Heart Association Scientific Sessions Meeting in November we recommend that SNM consider a presence at the following meetings:
    - **ASTRO Meeting:** September 21-28, Boston
      - SNM is already sponsoring session; we might suggest hosting a booth here to give attendees a place to immediately get additional information about imaging and SNM.
    - **ASCO Meeting:** May 30-June 3, Chicago
      - SNM is already conducting a breast cancer session at this meeting; we suggest also hosting a booth here.
    - **American College of Radiology Meeting** (date TBD)
    - **American College of Cardiology Meeting:** March 29-April 1, Chicago
      - Note: space is filling up quickly and deadline for listing in exhibitor booklet is January 31.
    - **American Academy of Neurology Meeting:** April 12-19, Chicago
**Annual Meeting Support**

**Timeline: May-June 2008**

As discussed in our original proposal, we will provide the specific support initially requested for your annual meeting, including:

- Logistics planning of press conference at annual meeting
- On-site support/staffing
- Prep session with SNM leader on dealing with the media (conducted as part of the Message Delivery task listed above)
- Radio Media Tour (if possible)

In assisting SNM staff with your preparation for the meeting, we will work with you to ensure that the potential media hooks identified for promotion the meeting reinforce your key strategic topic areas, and support the key message pillars.

**EVALUATION**

To identify the success of this campaign, and the impact it has had on our audiences, it will be important to evaluate what was done.

Throughout our plan, we have included opportunities to collect the needed information to accurately evaluate this campaign and will work with you throughout this program to ensure goals are being met and identify areas, if any, that need to be refined or altered per audience/media feedback.

**OPTIONAL ACTIVITIES**

- **Message Testing**
  
  Our original proposal included a budget for message testing with consumers and clinicians. For this plan, we have removed that item from the core program for several key reasons. 1) Consumer testing is now included under the separate consumer awareness proposal (a.k.a., Siemens); 2) The feedback from the SNM leadership at the strategy summit gave us extensive insight into clinician barriers; and 3) The need to create new materials is our most pressing task. Therefore, the $20,000 originally budgeted in that task has been divided between the materials development and logistical outreach tasks.

  However, in-depth message testing with a variety of clinicians would still be valuable, if the budget is available. This line item covers the cost of a three-day, online bulletin board with clinicians, which could include members of the priority specialties (including oncology, cardiology, neurology, and internal medicine).
• **Literature Review** $25,000
  As mentioned earlier, Porter Novelli could conduct a literature review to mine existing SNM data if SNM staff/leaders were not able to do so. As a reminder, this data will largely serve as the basis for our message development.

• **Editorial Board Development** $15,000
  To continuously drip information about SNM to the media, we suggest the development and coordination of a quarterly editorial board held via conference call. This call would be held with consumer reporters and could potentially be hosted by the editors of the *Journal of Nuclear Medicine* (JNM). The purpose would be to update key reporters about the new stories/issues being addressed in the nuclear medicine/molecular imaging industry, and their relevance to the public. JNM editors would provide the credibility needed to support such an event.

• **Trade Advertising** $15,000-$75,000
  A great way to target SNM’s audiences is to reach out to them via the groups they belong to and the publications they read. As such, we suggest developing a print or online ad for use in the journals or on the Web sites of priority industry organizations, such as the American College of Radiology and the American Medical Association, among others. Should this activity be of interest to you, we would work with our media buying team to develop the ad plan best suited to your needs and provide you with a detailed list of outlets we’d suggest outreach to, per the budget.

• **Additional Evaluation** $12,500
  To track the effect our efforts are having on clinicians, we suggest tracking the campaign’s key messages via our DocStyles survey. Each year, Porter Novelli surveys 1,000 primary care physicians about a host of health and communication topics. By placing questions about use of molecular imaging, perceived relevance and importance, and importance of potential concerns, we can understand physicians’ attitudes and information needs, and tailor our outreach accordingly. DocStyles fields in late spring, and so the 2008 survey could be considered a baseline, to be repeated each year. We recommend placing five questions on the 2008 survey.

**CONCLUSION**
After your review of this plan we would like to request a call to further discuss details and answer any question you may have. In the meantime, we look forward to continuing our work with you to move SNM to the forefront of molecular imaging.
TIMELINE

The following is a general timeline, per the aforementioned activities, for the execution of SNM’s PR plan. Please note this timeline may shift and change if programmatic and other time-sensitive activities change.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Plan Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Counsel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Message Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Materials Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Message Delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Logistical Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Meeting Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
We know that automatic 401Ks work. And that's why our three organizations have come together to form Retirement Made Simpler. We're here to provide the encouragement and support employers need to automate their 401K plans, and ultimately help their employees achieve a safe and secure retirement.

**Reassurance**
Automatic 401(k) plans are the solution to three big problems all at once: they help employees save significantly more for retirement, protect your company from non-discrimination testing, and increase employee satisfaction.

**Simple**
Most people want to participate in their 401(k), but they get overwhelmed by the decisions they need to make. Automation makes it easy for them to be part of their company's 401K plan.

**Successful**
Automating makes your 401(k) plan work better for both employees and employers. Employees save more, and employers cut down on paperwork and ensure that they pass non-discrimination testing.

**The Time is Now**
Every day, American workers leave millions of dollars on the table that they could be saving for a secure retirement. With a simple administrative change, employers can ensure that this doesn't happen.

A 2007 Wells Fargo study shows that 66 percent of plan sponsors are or plan to automatically enroll new employees compared with 36 percent in 2006. Rates of participation are can increase to between 85 and 95 percent in an automatic 401(k).

More than half of all workers have less than $50,000 saved for retirement.

The Retirement Made Simpler website offers background, tools, and case studies to help every employer make the decisions they need to automate their 401(k).

Automation is particularly beneficial for those least likely to participate in a 401(k) plan: women, minorities, and low-income workers.

**Call to Action**
One simple change will help your employees save hundreds of thousands more for retirement -- automating your company's 401(k) plan.
Spreading the Word About MI and PET
A Molecular Imaging Consumer Awareness Project
Sponsored by SNM (The Society of Nuclear Medicine)  
January 31, 2008

Special Note: This proposal is a draft, and as such is a work in progress that will continue to evolve as SNM leaders and other interested parties continue to provide insights and input that shape the scope and direction of this effort. A more detailed plan will be developed after interested parties have examined, discussed and reached consensus on which options to execute going forward.

Introduction

The Society of Nuclear Medicine (SNM) has before it an exciting opportunity to raise consumer awareness about how molecular imaging, generally, and positron emission tomography (PET), specifically, offers patients with viable options for the effective detection and treatment of a variety of deadly and debilitating diseases, including cancer, Alzheimer’s and heart disease. This new endeavor is one of the most far-reaching consumer outreach efforts in SNM history, and would usher in a new era of understanding of and appreciation for the great contributions being made by pioneering advances in the molecular imaging community.

This initiative is, for lack of a better term, a direct-to-consumer (DTC) campaign. Such campaigns, while extremely effective at getting the word out about a product, require a significant investment on the part of the interested parties. To get a better idea of what pharmaceutical companies pay, on average, we looked at a *New England Journal of Medicine* August 16, 2007 article, “A Decade of Direct-to-Consumer Advertising of Prescription Drugs.” The following is a sample taken from the top 20 pharmaceutical products in terms of DTC advertising in 2005:

- 

- 

- 

- 

- 

- 

- 

- 

- 

Perhaps the best known DTC campaign in America is “Got Milk?”, which cost an average of $180 million annually, but has resulted in a national awareness level of 90 percent. We share these figures, not to overwhelm you, but to provide a point of reference as SNM explores its own DTC program.
Campaign Goals

The goals of this consumer awareness campaign are:

1) Increase consumers’/patients’ understanding about the application of molecular imaging procedures, especially PET
   a. Explain in simple terms the role and benefits of PET relative to other imaging options, including an easy-to-understand definition of molecular imaging
   b. Explain how PET helps doctors do the right thing and provide patients with the best care
2) Increase the dialogue around PET between consumers/patients and their doctors in the hope that patients will take advantage of the many benefits PET offers in diagnosis and/or treatment
3) Distinguish SNM as the preeminent leader in the world of molecular imaging.

Purpose of This Proposal

The purpose of this proposal is to provide SNM with Porter Novelli’s thinking about the process we will follow to develop a strong and effective consumer awareness campaign. This document will deal with such items as:

- Current challenges
- Situation analysis
- Target audience
- Proposed approached, including
  - Research
  - Advertising
  - Internet
  - Media relations
  - Collateral materials
- Budget (including five plan options)
- Timeline

In addition, we have included a separate public service announcement campaign that will serve a distinctly different purpose of encouraging consumers to be screened for early detection of diseases.

After SNM considers this proposal and reaches consensus on how to proceed, Porter Novelli will then begin developing the various components of this proposal, such as ad concepts and testing, and formative audience research to form the basis of SNM’s fundraising efforts.

Current Challenges

The New England Journal of Medicine has called medical imaging one of the top 11 innovations of the past 1,000 years. The National Institutes of Health regards imaging as one of the most important medical tools of the future. And while there are many beneficial modalities in the world of imaging, it is clear that some of the most exciting cutting-edge tools being used today, and being developed for the future, involve molecular imaging, especially PET. Despite this reality, PET remains a mystery to many consumers.
Current Awareness/Attitudes About PET/CT

In the fall of 2006, Siemens commissioned Greenfield Online Research Center to conduct an omnibus survey of 1,111 men and women about their knowledge of PET/CT scanners, and their receptivity to the kind of information such scans provide. The results were rather disturbing.

When given four options about what a PET/CT scanner is, only 256 (47.5 percent) of men and 333 (58.2 percent) of women correctly answered that a PET/CT scanner is “an imaging exam that can identify diseases, such as cancer or Alzheimer’s, on a cellular level.” The rest of the respondents, including a majority of men, thought it was either a device used by veterinarians to monitor brain waves in animals, a high intensity screening device used in airport security or a high resolution imaging machine used to monitor pregnant women.

The survey then asked respondents if they would take a test that identifies diseases they will have 20 years before symptoms occur, and a majority said “yes”—72 percent of men and 71.2 percent of women. When asked if they would want to learn today that they will be diagnosed with a curable disease in the future, 66.8 percent of men and 64.9 percent of women answered yes. These numbers dropped dramatically when asked if they wanted to know in advance about an incurable disease, with only 34 percent of men and 35.8 percent of women interested in such information.

While people didn’t particularly want to know bad news in advance, more than 46 percent wanted to know if they would develop cancer, heart disease or Alzheimer’s disease. Less than 40 percent wanted to know if they had Parkinson’s disease or Multiple Sclerosis.

Obstacles

There are other obstacles that can be overcome, given the right communications program. Some of those obstacles include:

- Nuclear medicine (and molecular imaging) is still somewhat a “hidden discipline” that is not well understood by physicians and the public, largely because of its complexity.
- People within the medical community still view nuclear medicine/molecular imaging “as we were 50 years ago”, not “as we are today” and certainly not “how we will be in the future.”
- PET images do not have as sharp a resolution as MR or CT, so physicians, much less consumers, will have a hard time appreciating or interpreting what a PET image shows.
- PET and PET/CT are underutilized, given the great potential benefits they offer to patients.
- Some claim PET scans are too expensive, not just because of the cost of imaging, but also because of the advanced training physicians must undergo to accurately read and interpret the images.
- Government officials on Capitol Hill and the Centers for Medicare and Medicaid Services view it as expensive and are reluctant to pay for molecular imaging.
- People are afraid of harmful radiation exposure from PET (and other imaging) scans.
- People are simply unaware of what a PET scan involves and how it can help in the diagnosis and treatment of diseases.

Positive Benefits of Molecular Imaging

While there are very real obstacles, there also are very real assets. These threats are real and will require an effective communications strategy that speaks truth to the misperceptions that exist in the minds of many. Fortunately, SNM has some impressive facts to share as part of its story to consumers, namely that molecular imaging:

- is a less invasive, more comfortable and more effective alternative to previous medical procedures, such as exploratory surgery;
• reduces complications of surgery;
• diagnoses diseases earlier and more accurately; and
• can better inform when treatment will be effective and/or necessary.

Molecular imaging also is cost effective, because it offers:

• prompt detection results in less disability;
• less invasive procedures that result in faster recoveries and shorter hospital stays;
• tailoring of treatments according to patient response; and
• improved treatments that allow patients to return to work sooner.

One of the important messages the consumer awareness campaign needs to communicate is that medical imaging, while viewed primarily as a diagnostic technology, needs to be equally viewed as a therapeutic technology. We believe that the therapeutic angle—particularly the promise of personalized medicine—is a critically important theme that needs to be emphasized. We will work with SNM to refine messaging that demonstrates molecular imaging’s role across the entire continuum of care, beginning with diagnosis, prediction and prevention up through treatment and follow-up.

In addition, the SNM campaign’s messages should also incorporate “factoids” on the benefits of molecular imaging. For example:

• **Diagnoses earlier and more accurately**
  Used alone or in tandem with other modalities, PET has a proven track record of diagnosing diseases effectively and accurately. From PET scans’ effectiveness in identifying recurrence of suspicious tumors in cancer patients; to the combined use of PET and MRI scans to detect the early pathological changes of Alzheimer's disease long before the development and symptom of dementia; and to determining the amount of inflammation in atherosclerotic plaque and estimating the chances of plaque causing a future heart attack or stroke, PET has clearly taken imaging and patient care to the next level.

• **Improves patient care by guiding treatment and reducing complications**
  The study reported by Australian researchers and presented at SNM’s annual meeting in June 2007 showed that advanced combined PET and CT imaging can be used to guide the treatment of women with ovarian cancer. Combined with findings supporting medical imaging’s ability to avoid unnecessary treatments and invasive procedures, these results will be strong arguments for molecular imaging’s role in improving the quality and efficiency of care.

• **Helps avoid invasive procedures**
  A 2007 study conducted in Taiwan concluded that “PET-CT can provide us more accurate information about the characteristics and localization of these lesions before biopsy.” Helping patients avoid uncomfortable tests is always a welcomed message among consumers.

• **Better informs treatment decisions/avoids unnecessary procedures**
  A 2003 study showed that PET scans can reduce futile operation for lung cancer by 50 percent. And the report unveiled at the November 2007 RSNA meeting confirms that referring physicians often adjust their cancer treatment management in 38 percent of cases (range was 31 percent to 46 percent) based on PET imaging results. Significantly, a change from non-treatment to treatment was much more common than vice versa—29.6 percent compared with 8.4 percent.

**The Need to Spread the Word**

As the aforementioned Siemens research indicates, people more often than not want to know if they have a disease, especially if knowing it early leads to their eventual healing. If, as Socrates noted, “Knowledge is power,” then SNM has before it a powerful opportunity to communicate vital information to consumers/patients about the benefits and value of molecular imaging and PET.
SNM’s molecular imaging consumer awareness initiative comes at an important time. Not only is there a lack of awareness among consumers, but there is a lack of appreciation for the value of tests such as PET among health care professionals and policymakers alike. Add to this a deep suspicion in certain circles about the dangers and risks associated with radioactivity, and it becomes apparent that now is the time for a public education campaign that portrays PET in the most favorable light.

**Target Audiences: Active Health Information Seekers and Specific Disease Groups**

After much discussion internally and with the leadership of SNM, it is increasingly clear that the primary target audience of SNM’s consumer awareness campaign is what we at Porter Novelli call the “Active health information seeker,” with a special focus on men, seniors and boomers.

The majority—57 percent—of these individuals are women. How do we know this? From Porter Novelli’s propriety database, Styles. Styles is a research and planning database that enables Porter Novelli to help its clients not only precisely define the demographics of a selected target audience, but also identify how likely that audience is to take action on a given issue, and bring to life the lifestyle in which a message strategy will need to operate.

Each year, Porter Novelli surveys more than 12,000 people from all walks of life to glean information on a variety of health-related issues. This treasure trove of data allows us and our clients to better understand what consumers, physicians and other interested parties are thinking.

So how and where does Porter Novelli get such insights?

**The Insight:** When it comes to seeking health information, consumers fall into segments based on how actively they seek this information, and the extent to which they rely on themselves or their doctors in doing so.

**The Implication:** Consumers take in health and nutrition messages in a variety of ways. Tailored messages that take into account individual interest levels and leverage appropriate channels will have more impact.

**The Data: Health Information Seeking**

With the growth in availability of health information on the Internet as well as in traditional media, it has become imperative for us to be able to understand and predict consumers’ use of and trust in a variety of health information sources. According to 2006 Porter Novelli Styles, consumers fall into four key health information seeking categories:

- **Independent Actives** (28 percent of adults) avidly seek out health information from a variety of sources and maintain a partnership relationship with their doctors.
- **Doctor Dependent Actives** (24 percent of adults) also value health information, but typically rely on their doctors to tell them what they need to know to manage their health rather than seek out answers on their own.
- **Doctor Dependent Passives** (20 percent of adults) are not very interested in health information or being healthy. Although they rely on doctors, they have rather poor relationships with them.
- **Independent Passives** (28 percent of adults) are least health-involved and are generally skeptical of, and avoid interaction with, the medical community.
Chart 1: Health Information Seeking Audience Segments

<table>
<thead>
<tr>
<th></th>
<th>Independent Active</th>
<th>Independent Passive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active</strong></td>
<td>24% of men</td>
<td>31% of men</td>
</tr>
<tr>
<td></td>
<td>31% of women</td>
<td>26% of women</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Dependent Active</th>
<th>Dependent Passive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active</strong></td>
<td>22% of men</td>
<td>22% of men</td>
</tr>
<tr>
<td></td>
<td>26% of women</td>
<td>18% of women</td>
</tr>
</tbody>
</table>

When it comes to key sources of health and nutrition information, doctors and the Internet rank as the most frequently used information channels, followed by a variety of other sources such as magazines, family and friends and mass media channels. However, the extent to which each information source is used varies across the health information seeking audience segments. Doctors rank highest for both Doctor Dependent audience segments, as well as for Independent Active consumers. Yet our Independent Actives are making high use of the Internet to feed their knowledge. Not surprisingly, both segments of Passive information seekers are less likely to turn to any of these sources.

Other Target Audiences

In addition to active health-information seeking audiences, we also want to target our campaign to specific disease groups, specifically persons (or family members) impacted by:

- Breast cancer
- Lung cancer
- Prostate cancer
- Lymphoma
- Heart disease
- Alzheimer’s disease

Not only do we know what the target audience looks like for the consumer awareness campaign, but we know where they go for information. Together, this information will serve as a valuable compass, guiding us to the places where our messages and our audiences will most likely intersect—whether it’s a publication, place or portal.

**NOTE:** SNM is reaching out to the physician community as part of a separate PR initiative, so the combination of that effort with this consumer outreach campaign will help ensure that the MI value proposition is being communicated simultaneously to relevant parties, albeit on parallel tracks.
Proposed Approach

Using the pharma model of direct to consumer marketing, Porter Novelli will employ a variety of tactics to maximize the reach and impact of the consumer awareness campaign.

Research

Developing Effective Messages

Creating messages for testing requires two things: a thorough understanding of what information is most important to your key audiences, and the skill to translate these practical benefits into memorable and effective language. Information from SNM and its partners will serve as the basis of a creative brief that will be used to guide message development. The creative brief will capture the core of what we need to achieve, the benefits that are most important to the audiences who will hear these messages, the environment that might affect how the messages are heard and a core insight that unites all this information into a strategic platform on which all messages will be based.

Our award-winning creative team will explore diverse ways to bring this platform to life, ensuring that we test a wide range of potential options. For example, one salient benefit to molecular imaging procedures is likely to be improved clinical outcomes. Messages that address this desire might be based on variety of tones and platforms, from “peace of mind,” to “the best of the best,” to “be there for your children,” using different language to express each of these concepts.

We also will explore potential delivery mechanisms for our messages, including use of a celebrity or patient spokesperson.

As we learned from our strategic summit with SNM’s leadership, there are several key messages we will want to ensure are incorporated into the copy we develop around molecular imaging. While it will not be possible to include each element in every execution, each of our test concepts will include a slightly different focus so that, taken together, we test each of these appeals for salience with our target audience.

Key messages for testing around molecular imaging:

- Useful
- Easy for patient
- Reimbursable
- Quick and helpful in nature
- Safe
  - Radiation exposure risks are relatively low (compared to daily life [living in Denver, flying from LA to DC, etc.]).
  - Because it’s so safe and effective, nuclear medicine has lowest rates of medical malpractice premiums because they rarely get sued.
- Facilitating the promise of personalized medicine
  - The right drug for the right patient at the right time.
  - Customized care maximizes treatment and better patient outcomes.
- State of the art—the best there is
  - Patient needs to tell doctor “I deserve the best and right test.”

Ad Concept Testing

At Porter Novelli, research—and the strategic planning that results from it—is the foundation of our communication approach. In fact, Porter Novelli is widely regarded as a leader in using research to plan, develop, implement and evaluate communication campaigns. Done properly, audience research turns a chaotic welter of information into an orderly assessment of the situation. Porter Novelli is particularly
adept at harnessing both the art and science of formative research to identify, analyze and meaningfully interpret information to inform our communications campaigns. Our full-time, in-house professional research staff works seamlessly with our clients and our creative teams to ensure a timely and accurate translation of knowledge and insights into appropriate materials and measurable results.

To test our umbrella concepts and ideas for this campaign, focus group research is an optimal method. It allows us to elicit a range of ideas and opinions that provide rich detail that helps inform the development of an effective advertising campaign.

For this project, we suggest conducting focus group research with our target audience of health information seekers, so that we get first-hand feedback on potential umbrella concepts that will unify the consumer campaign. Because of the sensitive nature of health topics, and also because men tend to be less verbal than women, and might not be heard in a mixed-gender focus group, we recommend segmenting groups by gender and holding two focus groups (of 8-10 people each) with women and two triads (three-person focus groups) with men.

The groups will be held in the Washington, DC-area, and each group will be presented with 4-5 potential campaign positionings for review and comment. (We can explore the possibility of focus groups in other cities, as well, keeping in mind that we’re trying to contain costs by minimizing travel outside of the DC area.) A professional moderator will guide the discussion, ensuring that we elicit in-depth, useful and appropriate feedback from participants about the issue, the concepts and other potential campaign activities such as the choice of an appropriate and compelling celebrity spokesperson. Findings will be delivered via a summary conference call within 48 hours of the completion of the groups, and a summary report of the findings will be provided within two weeks of the conference call.

**Online Creative Testing**

While focus groups provide deep insight into consumer motivation, they are directional rather than projectable. Therefore, we recommend one additional research element to ensure that our advertising is appealing to a representative sample of health information seekers. After follow-up discussions with SNM on our findings from the concept testing, we then will refine our concepts into several potential creative executions and conduct a quantitative online test of our top two creative concepts to ensure that we have feedback from a broad sample of our target audience. The test would be conducted with 200 people; each of whom would review and comment on one of the two concepts for a total sample of 100 per concept.

This method of materials testing does not require interviewers or travel and can reach a wider, more representative spectrum of individuals. Results are quantitative and can be tabulated within days.

**Campaign Evaluation**

One of the most important elements of a communications campaign is tracking its effectiveness. Regular evaluation allows us to allocate resources where they will do the best, refine messaging to be most effective and demonstrate to stakeholders that their efforts are being rewarded.

We recommend using another facet of Porter Novelli’s proprietary Styles surveys—HealthStyles—to track the campaign’s awareness and effectiveness. HealthStyles surveys approximately 5,000 Americans each year on a host of health attitudes and behaviors. A set of questions for the consumer awareness campaign would explore knowledge about molecular imaging procedures, perceptions of benefits from those procedures and likelihood to ask their physician for a certain imaging study. We can track changes in attitudes by demographic and psychographic segments, and can also repeat questions each year to track changes in beliefs and behaviors over time, as well as knowledge about the campaign itself.
Accordingly, we would also conduct pre- and post-campaign testing in target markets to determine how well all the campaign components (ads, media relations, online, third parties, etc.) have “moved the needle” with respect to audience awareness of molecular imaging and PET and PET/CT. Eventually, this survey could include measuring attitudes among consumers about MI technologies and the providers of such scans in terms of favorable-unfavorable and confidence/trust ratings. This would be particularly important for determining how MI and PET compare against other modalities, and in light of counter-messages influencing public opinion, such as radiation exposure and cost vs. benefit analyses. In time, one option would be to measure actual behavior – namely how many people in our control group sought out and had a PET or PET/CT scan.

One possible scenario would be to conduct online surveys in five cities, targeting 300 respondents in each, for a total of 1,500 respondents. The first survey establishing the baseline of awareness and attitudes would be conducted just prior to the launch, followed by interviews either immediately after the conclusion of the media flight and/or one year later. Again, the specific timeline for this survey would crystallize with the final plan, once the interested parties have reached consensus. The plan development would reflect mutually agreed upon criteria, basing expectations on variables such as how long the campaign runs, how big a media buy is executed, how aggressive the earned media effort is, etc.

Based on our experiences with similar campaigns, the most realistic expectation is that it will take several years to move the needle in terms of increased consumer awareness.

**Advertising**

Effective creative is one element of a successful advertising effort. The second key part is effective placement. If your advertising is not appearing in the places your audience will see it—or if it appears incongruous within the outlets it appears—you are less likely to see the results you want.

Working closely with our media buying partner, we will develop a multi-faceted paid media effort that reaches our target—health-involved adults, both men and women, as well as boomers and seniors—in multiple outlets and on multiple occasions over time.

We’ve put together several sample media plans, at different funding levels, which are an attachment to this document. Our strategy for developing the media plans was to select mediums that will provide broad coverage of the target, have a high composition of information seekers and have editorial relevancy. Given the content of the campaign, the behavior of your target audience and the budgets, we recommend focusing on female health seekers, 35 years-of-age and older, for maximum awareness and frequency. However, we have included print, online and broadcast opportunities that will provide a bonus of reach across all demographics (such as seniors, men, and baby boomers). Our media plans are in the draft stage at this point. Once a budget is finalized, we will conduct a deeper competitive analysis of the various sites and publications and provide a final recommendation. Below is a quick recap of our media strategy.

**Online**

Online advertisements will be a critical component of the media plan and is one we recommend you support consistently throughout the year. After their own doctors, the Internet is the source that health information seekers turn to most when looking for health-related information. Reaching them during their online time allows us to hone in on this audience during times they will be most receptive to the messages.

Online advertising also:

1. Generally appeals to health information seekers
2. Allows for the targeting of Web sites that address certain health issues.
3. Provides the opportunity to maximize and gain exposure through key word searches
We recommend focusing on sites that target women and include run of site (ROS) and specific targeted sections within site. We also recommend buying space on medical specific sites (e.g., WebMD and Mayo Clinic, etc.), which will allow you to extend your reach to other audiences, such as men, seniors, and baby boomers. Where possible, we also suggest complementing your print buy with the corresponding online site. Lastly, two sites that are not currently in our plan but may also be relevant are Eons.com (a MySpace for 50+) and AARP.com. The former is a good way to reach Internet savvy seniors and boomers, and the latter is a trusted resource for seniors.

**Print**

Another key component of your ad buy is print publications. Similar to online resources, magazines are another trusted source for health information seekers. We recommend considering similar major women’s publications (e.g., *Ladies Home Journal*, *Family Circle*, *Woman’s Day*, *Good Housekeeping*, *Redbook*, etc.) to maximize your frequency, as well as specific editorially-appropriate titles such as *Prevention*, *Health*, *Self*, *Fitness*, *Shape*, among others. We also will analyze the editorial calendars of various publications so we can find opportunities where our messages align with timely and relevant editorial content. For instance, we know that Breast Cancer Awareness month is October; therefore, we recommend supplementing your buy with an insertion in the health sections of the *New York Times* and/or *USA Today*. This will allow you to extend your reach beyond the female target while capitalizing on a relevant and audience-applicable subject.

**Television**

For the larger budgets, we believe there is an opportunity with cable networks that have a large concentration of female viewers (e.g., Oxygen, WE, Oprah) and possibly other health/science networks (e.g., Discovery) if we could align our advertisements with relevant programming. Again, we would recommend focusing on the female networks, but there may be opportunities to align ourselves with programming that extends to the broader group of men, seniors, and boomers.

**Web Site**

SNM already has an excellent Web site filled with rich content and we also understand that the current MI site (housed within the SNM site) is where, currently, the majority of consumer-related information exists. Our recommendation is to revise this MI site so that it reflects the look, feel and advertisements of the consumer awareness campaign—ensuring the consumer has a seamless experience with our communications—and use this space to provide useful information for consumers.

Some of the functionality SNM may want to consider for this site includes:

- General information/fast facts about the molecular imaging and PET, including easy to understand definitions and terms.
- Positive news articles, editorials, op-eds or letters to the editor on MI and PET.
- A downloadable Real Player or Media Player version of existing video that explains the PET process.
- A zip code driven function to help consumers find the nearest imaging facility/physician that offers PET scans.
- A section that dispels common myths or misunderstandings about PET and MI, including radiation risks.
- Helpful info on how to prepare people, young and old, for these tests.

In addition, we would encourage all SNM members to put a link to this campaign on their own Web sites.
Media Relations

Porter Novelli stands ready to undertake a very aggressive earned media effort to help raise awareness about SNM’s campaign. This includes researching, approaching and negotiating the involvement of a celebrity spokesperson, for use with the media, who would help to raise awareness of the issues overall, as well as potentially appear as the “face” of the PSA effort (mentioned in the next section). This will also include a focus on entertainment industry media.

We will approach journalists who have traditionally covered your issues, as well as other non-healthcare writers who find the campaign intriguing and valuable to the public. To that end, we will maintain a News Bureau that will:

- Update media materials, issue press releases, help develop new fact sheets, ad slicks, etc., as needed throughout the campaign.
- Work with SNM to identify and train spokespersons and third-party experts, as needed. (NOTE: While SNM leaders will be media trained as part of a separate SNM PR program, this would focus on a distinct set of messages, as well as the possibility of training a number of non-SNM spokespersons from patient groups, academia, or even a celebrity.)
- Prepare and place op-eds by key figures both within and outside the organization.
- Respond to media inquiries, as well as correct inaccurate or incomplete coverage, through direct contact with reporters and letters to the editor.
- Set up interviews with influential journalists and meetings with editorial boards.
- Monitor media coverage and send to our client contact at SNM.
- Package favorable coverage for use on Web site and other materials.

Celebrity Involvement

Based on our past experience with high-level celebrity talent, securing participation in a campaign that would encompass television, print, radio and online advertising can require a commitment of $750,000 or more. However, it is possible to secure donated talent for PSAs if there is a strong personal connection between the celebrity and the organization/issue that is being promoted (although we may need to cover travel and other personal expenses relating to the PSA shoot or other campaign involvement).

Another important consideration is the funding source of the campaign as talent is more likely to waive or lower fees for well-known, established non-profits or causes that are not affiliated with corporate or business interests. On the other hand, patient spokespersons are non-union. Therefore, you as the advertiser can set their fees. In the past we have seen other companies offer $500 and travel accommodations. Generally, as long as they are interested and available, the fee is up to you. One caution in using patients/consumers in a campaign is that you will want to ensure they can deliver your message with the level of sincerity and power required to get keep the viewer’s attention, raise awareness and change their attitudes.

Collateral Materials

It also important to note there are several components to our recommendation that are not included in the paid media plan, but nonetheless critical to our integrated campaign. For instance, we have dedicated a good portion of our production budget towards developing disease specific brochures, so we can educate patients and/or their caregivers about the benefits of PET. These brochures can be distributed in doctors’ offices or mailed directly to consumers (especially those who do not have access to a computer and the campaign’s Web site) or even members of the media.
To raise awareness about the campaign, we believe SNM should have a portable exhibit (either stand alone screens or a table top unit) or posters that feature the messages and branding of the campaign to be featured at hospitals, clinics or even malls.

We strongly think there should be an attractive give away that grabs people’s attention. One give away idea we would like to explore is the creation of a lenticular card that, when viewed from slightly different angles, shows different images. So, at one angle, for example, it could show a normal human body, but when turned could reveal how an organ looks in a PET scan. On the back of these cards could be fast facts about the value and benefits of PET scans, in keeping the look and feel of our campaign brand.

Lastly, we recommend the production of a video on “What is MI?” that can be played as a loop (repeating video) at exhibits or distributed to consumers upon request.

Public Service Announcement (PSA) Campaign

Because the public’s awareness of molecular scanning is comparatively low, we do think there is a benefit and opportunity for building a PSA campaign and making this topic relevant to the public. It’s important to remember that a public service announcement is a non-commercial advertisement for the public’s good. Therefore, the PSA cannot push a specific product or service or include any branding from the underwriting sponsor. That’s why the branding of the PSAs must be a coalition, preferably made up of well-known disease groups that are dedicated to the public health.

This PSA campaign would inform consumers/patients that their diseases would be better managed and treated with the latest imaging technologies. Again, this PSA cannot endorse one type of scan—such as PET—over another, so the messaging will have to be carefully crafted.

We have outlined two possible scenarios for developing and executing a PSA campaign below.

SNM Sponsorship

One approach we could take is to reach out to the various publications and sites we are negotiating with on the paid side and see if we can include PSA placement in return for our buy. Because you are a registered nonprofit organization under section 501(c)(3), you can produce your own PSA.

Pros:
1) You have control over your message, provided you don’t reference a product or brand.
2) You need the long lead time needed for creating and managing a coalition.
3) We can include this PSA as a negotiating point in our buy and possibly have more influence over when and where the spots get picked up.

Cons:
1) If the majority of the media outlets don’t want to negotiate this, we lose the competitive edge/control in our negotiations.
2) If SNM is not a widely know organization with the various outlets, it might negatively impact our pick up.

Coalition Sponsorship

The other approach involves creating a coalition with leading health and disease organizations and leveraging their recognition to help gain placement in our distribution efforts. If we took this approach, we would suggest creating a coalition with various health and disease prevention organizations, including but not limited to:
• Susan G. Komen for the Cure
• Lance Armstrong Foundation
• Alzheimer Association
• American Heart Association
• Colon Cancer Alliance
• Lung Cancer Alliance
• Men's Health Network
• National Ovarian Cancer Coalition
• Ovarian Cancer National Alliance
• Vital Options
• Y-Me
• Society for Women's Health Research
• Us Too International
• Intercultural Cancer Coalition

Rather than developing a campaign that talks specifically to molecular imaging, a PSA from this group may focus more on detecting a variety of diseases in their early stages.

Pros:
1) Various coalition members will provide a sense of authority and sincerity to the message.
2) Blue chip coalition members (like Komen or Armstrong or AHA) help garner pick up.
3) Well known coalition members can help gain celebrity endorsement.

Cons:
1) Takes more time to develop and requires more time to manage.
2) The message, creative and strategy will require unanimous coalition buy in and support.

Porter Novelli followed a similar approach a few years ago when we began developing our Depression Is Real (DIR) PSA campaign. Depression has often been misunderstood, feared and stigmatized and in recent years been scrutinized by insurers, FDA and celebrities. In an effort to combat this bias, we developed a seven member coalition with various leading mental health and civic organizations and ultimately launched a successful PSA campaign with an estimated media value of over $15 million in 2007. Given the success of our first launch, we are now refreshing our PSAs with new creative and preparing for our next round of distribution soon. Our annual budget for the DIR campaign is approximately $3.5 million. The costs and fees entailed with developing an even larger coalition and PSA campaign for SNM will be proportionately larger, depending on the number of coalition members, the level of engagement with them and the scope and duration of the PSA campaign.

If SNM chooses to pursue a PSA campaign, we believe the primary costs for development, conceptualization, production and distribution of the PSA to cable and broadcast TV, radio, newspapers, magazines and online outlets will be approximately $1.5 million per year. Based on our past experiences with other similar campaigns, we think it is reasonable to expect media value for this campaign to be worth $10 million to $13 million per year.

Regardless of which PSA approach we take, we would suggest reserving celebrity efforts/endorsements to the PSA campaign. For starters, celebrity endorsements are much more economical in the PSA arena. In addition, well known coalition members or causes (i.e. focusing on prevention of disease vs. specifically on molecular imaging) tend to be more attractive to celebrities. And last but not least, incorporating a celebrity in a PSA campaign greatly increases your chances of pick up.

The cost of the celebrity depends on whom you choose, how involved you want them in the campaign beyond appearing in a PSA (speeches, appearances at trade shows or annual meetings, conducting media
interviews, etc.), and how long the campaign lasts. We will work with SNM to develop a “dream list” of potential celebrities, then explore various options and budgets with their respective agents.

The timing of the PSA launch will depend largely on how long it will take to bring together the coalition that will serve as the face of the PSA campaign. Once we have assembled this group of “sponsors” (not to be confused with underwriters), we would begin regular meetings to develop specific plans of action. While Porter Novelli can begin development of the PSA before this team is assembled, we would caution about getting too far down the road on the creative execution without having significant buy-in and direction from these key stakeholders.

At this point, there are a lot of things to discuss within the PSA realm. We would recommend setting up a meeting with the key players so we can talk about the objectives and prepare for next steps.

**Timeline**

Recognizing that raising awareness on a subject as esoteric and complex as molecular imaging will not happen overnight, it is important to stress that this campaign would be a multi-year project, to conclude at the middle of 2011 or as late as 2013.

Year One: Launch MI consumer awareness campaign; PSA campaign launches later in year.
Year Two: Fine tune campaign messages/tactics based on research and other evaluation metrics. Revise creative for MI and PSA campaigns and re-launch.
Year Three: Maintain campaign momentum, with major emphasis on MI outreach.
Years Four & Five: Optional $4-$5 million maintenance campaign, based on the successes of the previous years.

The following is a tentative timeline for the initial months of development, launch and execution of this new campaign:

- **January 22** Porter Novelli submits proposal.
- **January 25** SNM approves proposal.
- **January 28** Porter Novelli begins development of creative initial concepts and messages.*
- **February 16-19** Porter Novelli presents proposal to SNM board and potential funders at mid-winter meetings in Newport Beach, CA.
- **February 19-23** Porter Novelli conducts two in-person focus groups of 4-5 concepts in Washington, DC-area.
- **February 27** Porter Novelli provides top line findings of focus groups and begins refining 2 concepts.
- **February 28** Porter Novelli begins development of fundraising kits (to include cover letter, creative concepts, budgets, etc.).
- **March** Porter Novelli begins meetings with SNM leadership and funders to develop and reach consensus on a more concrete plan of action for campaign.
- **March 11-13** Porter Novelli conducts online test of ad concepts.
- **March 14** Porter Novelli begins writing and designing of brochure, exhibit and giveaways.
- **March 27** Porter Novelli finalizes print ads; finalizes media buy in long lead publications.
- **March 28** Porter Novelli begins design of dedicated Web site housed at [www.snm.org](http://www.snm.org).
- **March 29** Porter Novelli begins creation of banner ads for target Web and blog sites.
- **April 1** Porter Novelli begins concepting and writing of “What is MI? video.
- **April-May** Field HealthStyles tracking survey.
- **May** Conduct baseline survey to measure MI awareness prior to launch of MI consumer campaign.
- **June 14-18** SNM launches consumer awareness program at annual meeting in New Orleans, including press conference, satellite and radio media tours.
June 14 and beyond  Ads begin to appear in key publications; Web site goes live; ship out brochures to physician offices and other venues.

May-June 2009  Conduct post-campaign survey to measure how needle has moved on MI awareness in the span of one year.

*NOTE: In the interest of time, the initial creative concept testing will focus on print ads. Should SNM wish to develop TV ads, the direction we receive from these focus groups will inform the positioning of TV ads, which will require several more weeks of design and concepting, as well as additional focus group testing.

**Budgets**

The following are estimated costs for SNM’s molecular imaging consumer awareness project on an annualized basis. Some of these are subject to change, depending on such factors as the number of publications the ads run in, the frequency of media relations activities, and the level of interaction with third party groups, etc.:

**Fixed Costs**

<table>
<thead>
<tr>
<th>Cost Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of ad concepts for testing</td>
<td>$43,075</td>
</tr>
<tr>
<td>Focus group testing</td>
<td>$70,000</td>
</tr>
<tr>
<td>Online testing</td>
<td>$47,000</td>
</tr>
<tr>
<td>HealthStyles campaign evaluation</td>
<td>$10,000</td>
</tr>
<tr>
<td>“What is MI” video</td>
<td>$150,000</td>
</tr>
</tbody>
</table>

**Subtotal**  

| $320,075 |

**Optional Media Buys & Development Costs**

**Plan 1:** This plan covers the most basic scope of activities, with ad buys focused primarily on a few print and online outlets, limited alliance development activities and production of collateral materials.

<table>
<thead>
<tr>
<th>Cost Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print buy:</td>
<td>$1,038,000</td>
</tr>
<tr>
<td>Online buy:</td>
<td>$132,000</td>
</tr>
<tr>
<td>Development of ad concepts for testing</td>
<td>$43,075</td>
</tr>
<tr>
<td>Ad and online production &amp; development cost:</td>
<td>$115,475</td>
</tr>
<tr>
<td>Media relations (including media training of 5 SNM officials)</td>
<td>$130,000</td>
</tr>
<tr>
<td>Strategic counsel/admin/management</td>
<td>$48,000</td>
</tr>
<tr>
<td>Third party outreach (patient groups, etc.)</td>
<td>$60,000</td>
</tr>
<tr>
<td>Consumer brochure</td>
<td>$69,775 (per million)</td>
</tr>
<tr>
<td>Give-aways</td>
<td>$21,475</td>
</tr>
<tr>
<td>Design and production of banner ads</td>
<td>$18,475</td>
</tr>
<tr>
<td>Design and creation landing page for Web site</td>
<td>$20,425</td>
</tr>
<tr>
<td>Design and production of portable exhibit</td>
<td>$30,875</td>
</tr>
</tbody>
</table>

**Fixed costs:**  

| $320,075 |

**Total:**  

| $2,047,650 |
Plan 2: This plan continues to focus on print and online ads but increases the buy to expand frequency and ensure greater message retention among target audiences. We also invest in keyword search ads to help drive Internet users to our campaign site.

- Print buy: $1,851,000
- Online buy: $579,500
- Keyword search ads: $40,000
- Development of ad concepts for testing: $43,075
- Ad and online production & development cost: $232,350
- Media relations (including media training of 5 SNM officials): $130,000
- Strategic counsel/admin/management: $48,000
- Third party outreach (patient groups, etc.): $60,000
- Consumer brochure: $69,775 (per million)
- Give-aways: $21,475
- Design and production of banner ads: $18,475
- Design and creation landing page for Web site: $20,425
- Design and production of portable exhibit: $30,875
- Fixed costs: $320,075
- Total: $3,465,025

Plan 3: This plan represents a far more aggressive print, online and keyword search ad buy. We also increase the number of brochures printed.

- Print buy: $2,056,000
- Online buy: $2,032,500
- Keyword search ads: $400,000
- Development of ad concepts for testing: $43,075
- Ad and online production & development cost: $349,600
- Consumer brochure: $70,000
- Give-aways: $21,475
- Design and production of banner ads: $18,475
- Design and creation landing page for Web site: $20,425
- Design and production of portable exhibit: $30,875
- Media relations (including media training of 5 SNM officials): $130,000
- Strategic counsel/admin/management: $48,000
- Third party outreach (patient groups, etc.): $60,000
- Fixed costs: $320,075
- Total: $5,600,500

Plan 4: This plan expands print, online and keyword search ads, but also doubles our third party outreach efforts, more than doubles production of collateral materials and give-aways for distribution at various third party events/venues (annual meetings, hospitals, doctors offices, etc.) and produces many more banners for displays at hospitals or clinics. We have also added a relatively small fee for endorsers. Media relations activities are boosted, as well.

- Print buy: $5,219,178
- Online buy: $2,718,000
- Keyword search ads: $500,000
- Development of ad concepts for testing: $50,000
- Ad and online production & development cost: $400,000
- Endorser fees (if applicable): $50,000
- Media relations (including media training of 5 SNM officials): $200,000
- Fixed costs: $320,075
- Total: $5,600,500
<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic counsel/admin/management</td>
<td>$ 60,000</td>
</tr>
<tr>
<td>Third party outreach (patient groups, etc.)</td>
<td>$ 120,000</td>
</tr>
<tr>
<td>Consumer brochure</td>
<td>$ 180,000</td>
</tr>
<tr>
<td>Give-aways</td>
<td>$ 80,000</td>
</tr>
<tr>
<td>Design and production of banner ads</td>
<td>$ 30,000</td>
</tr>
<tr>
<td>Design and creation landing page for Web site</td>
<td>$ 40,000</td>
</tr>
<tr>
<td>Design and production of portable exhibit</td>
<td>$ 100,000</td>
</tr>
</tbody>
</table>

Fixed costs: $320,075
Total: $10,067,253

**Plan 5:** This plan focuses on production and distribution of TV ads. We’ve upped the amount for brochure production and distribution and increased the endorser fee considerably. The print and online buy would be smaller than Plan 4 but larger than Plan 3.

- Print buy: $3,896,326
- Online buy: $2,095,000
- Cable buy: $5,500,000
- Keyword search ads: $500,000
- Development of ad concepts for testing: $75,000
- Print & TV production & development cost: $1,040,000
- Endorser fees, if applicable: $250,000
- Media relations (including media training of 5 SNM officials): $200,000
- Strategic counsel/admin/management: $60,000
- Third party outreach (patient groups, etc.): $120,000
- Consumer brochure: $250,000
- Give-aways: $80,000
- Design and production of banner ads: $30,000
- Design and creation landing page for Web site: $40,000
- Design and production of portable exhibit: $100,000

Fixed costs: $320,075
Total: $14,556,401

**PSA Campaign:** This includes concepting, testing, production and distribution of TV, radio, online, and print PSAs.

Total: $1.5 million

**Conclusion**

While this project holds great potential for SNM, its members and patients, there are also significant pitfalls that must be avoided. While one of the measures of success of this campaign is the increase in the number of people asking for and receiving PET scans, the down side is that it could cause a spike in utilization rates—the very thing that has drawn fire on Capitol Hill and in CMS. Our challenge will be to position this campaign in such a way that we are emphasizing the medically essential and appropriate nature of PET scans as a valuable public service. Our messaging, whether it is for advertising or media relations, will take this delicate factor into account. In all that we do in the preparation for and execution of the SNM project, our mission is to get it right from the very beginning.
Thank you for choosing Porter Novelli to help SNM develop and launch this exciting and worthwhile program. We look forward to helping SNM reach its strategic objectives – taking the organization to the next level and ultimately benefiting the health outcomes of hundreds of thousands of Americans.

We can’t wait to get started.

****
<table>
<thead>
<tr>
<th>Date</th>
<th>Month</th>
<th>National Magazines</th>
<th>Online</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-14-21</td>
<td>7-14-21</td>
<td>7-14-21</td>
<td>7-14-21</td>
<td>7-14-21</td>
</tr>
<tr>
<td>5-12-20</td>
<td>5-12-20</td>
<td>5-12-20</td>
<td>5-12-20</td>
<td>5-12-20</td>
</tr>
<tr>
<td>3-11-19</td>
<td>3-11-19</td>
<td>3-11-19</td>
<td>3-11-19</td>
<td>3-11-19</td>
</tr>
<tr>
<td>1-8-18</td>
<td>1-8-18</td>
<td>1-8-18</td>
<td>1-8-18</td>
<td>1-8-18</td>
</tr>
<tr>
<td>10-17-17</td>
<td>10-17-17</td>
<td>10-17-17</td>
<td>10-17-17</td>
<td>10-17-17</td>
</tr>
<tr>
<td>4-11-14</td>
<td>4-11-14</td>
<td>4-11-14</td>
<td>4-11-14</td>
<td>4-11-14</td>
</tr>
<tr>
<td>10-17-12</td>
<td>10-17-12</td>
<td>10-17-12</td>
<td>10-17-12</td>
<td>10-17-12</td>
</tr>
<tr>
<td>8-14-11</td>
<td>8-14-11</td>
<td>8-14-11</td>
<td>8-14-11</td>
<td>8-14-11</td>
</tr>
<tr>
<td>6-13-10</td>
<td>6-13-10</td>
<td>6-13-10</td>
<td>6-13-10</td>
<td>6-13-10</td>
</tr>
<tr>
<td>4-11-09</td>
<td>4-11-09</td>
<td>4-11-09</td>
<td>4-11-09</td>
<td>4-11-09</td>
</tr>
<tr>
<td>12-29-08</td>
<td>12-29-08</td>
<td>12-29-08</td>
<td>12-29-08</td>
<td>12-29-08</td>
</tr>
</tbody>
</table>

**Target:** Women - Health gatekeepers

- **4th of July**: Labor Day
- **TARGETED MEDIA**
- **CREATIVE**
- **COSTS**

### Print Total
- **TARGETED MEDIA**
- **CREATIVE**
- **COSTS**

<table>
<thead>
<tr>
<th>Media</th>
<th>Format</th>
<th>Units</th>
<th>CPM</th>
<th>Impressions</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ladies Home Journal</td>
<td>FP4CB</td>
<td>3</td>
<td>100,000</td>
<td>3,000,000</td>
<td>$445,000</td>
</tr>
<tr>
<td>Red Book</td>
<td>FP4CB</td>
<td>3</td>
<td>70,000</td>
<td>2,100,000</td>
<td>$210,000</td>
</tr>
<tr>
<td>Prevention</td>
<td>FP4CB</td>
<td>3</td>
<td>121,000</td>
<td>3,630,000</td>
<td>$363,000</td>
</tr>
</tbody>
</table>

**Online Total**
- **TARGETED MEDIA**
- **CREATIVE**
- **COSTS**

<table>
<thead>
<tr>
<th>Media</th>
<th>Format</th>
<th>CPM</th>
<th>Impressions</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web MD</td>
<td>TBD</td>
<td>TBD</td>
<td>1,500,000</td>
<td>$90,000</td>
</tr>
<tr>
<td>Revolution Health</td>
<td>TBD</td>
<td>TBD</td>
<td>700,000</td>
<td>$42,000</td>
</tr>
</tbody>
</table>

**Total**
- **TARGETED MEDIA**
- **CREATIVE**
- **COSTS**

<table>
<thead>
<tr>
<th>Media</th>
<th>Format</th>
<th>CPM</th>
<th>Impressions</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Magazines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Print Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong> Total</td>
<td></td>
<td></td>
<td></td>
<td>$1,170,000</td>
</tr>
</tbody>
</table>

**Notes:**
- **DRAFT** Costs are 2008 planning estimates, as of 1/15/08.
# 2008 - SOCIETY OF NUCLEAR MEDICINE

**DRAFT** Costs are 2008 planning estimates, as of 1/15/08

**Target:** Women - Health gate Keepers

### National Magazines

<table>
<thead>
<tr>
<th>Targeted Media</th>
<th>Creative</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ladies Home Journal</td>
<td>FP4CB</td>
<td>5</td>
<td>155,000</td>
<td>775,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red Book</td>
<td>FP4CB</td>
<td>5</td>
<td>70,000</td>
<td>350,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention</td>
<td>FP4CB</td>
<td>6</td>
<td>121,000</td>
<td>726,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Print Total:** $1,851,000

### Online

<table>
<thead>
<tr>
<th>Online Media</th>
<th>Creative</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web MD</td>
<td>TBD</td>
<td>500,000</td>
<td>1,000,000</td>
<td>500,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IVillage</td>
<td>TBD</td>
<td>200,000</td>
<td>300,000</td>
<td>200,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revolution Health</td>
<td>TBD</td>
<td>200,000</td>
<td>300,000</td>
<td>200,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red Book</td>
<td>TBD</td>
<td>300,000</td>
<td>500,000</td>
<td>300,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td>TBD</td>
<td>300,000</td>
<td>500,000</td>
<td>300,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention</td>
<td>TBD</td>
<td>300,000</td>
<td>500,000</td>
<td>300,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Google Key Word Search</td>
<td>TBD</td>
<td>40,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Online Total:** $619,500

**Plan Total:** $2,470,500

---

**Note:**
- Costs are 2008 planning estimates, as of 1/15/08.
- National Magazines:
  - Ladies Home Journal: 5 units, cost $155,000, gross cost $775,000
  - Red Book: 5 units, cost $70,000, gross cost $350,000
  - Prevention: 6 units, cost $121,000, gross cost $726,000

**Online Media:
- Web MD, IVillage, Revolution Health, Red Book, Health, Prevention, Google Key Word Search**

**Plan Total:** $2,470,500
### 2008 - SOCIETY OF NUCLEAR MEDICINE

**SAMPLE DRAFT**

Costs are 2008 planning estimates, as of 1/22/08

<table>
<thead>
<tr>
<th>JUNE</th>
<th>JULY</th>
<th>AUGUST</th>
<th>SEPTEMBER</th>
<th>OCTOBER</th>
<th>NOVEMBER</th>
<th>DECEMBER</th>
<th>JANUARY</th>
<th>FEBRUARY</th>
<th>MARCH</th>
<th>APRIL</th>
<th>MAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>16</td>
<td>23</td>
<td>30</td>
<td>7</td>
<td>14</td>
<td>21</td>
<td>28</td>
<td>9</td>
<td>16</td>
<td>23</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>16</td>
<td>23</td>
<td>30</td>
<td>7</td>
<td>14</td>
<td>21</td>
<td>28</td>
<td>9</td>
<td>16</td>
<td>23</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>11</td>
<td>18</td>
<td>25</td>
<td>1</td>
<td>8</td>
<td>15</td>
<td>22</td>
<td>5</td>
<td>12</td>
<td>19</td>
<td>6</td>
</tr>
<tr>
<td>13</td>
<td>20</td>
<td>27</td>
<td>4</td>
<td>11</td>
<td>18</td>
<td>25</td>
<td>1</td>
<td>8</td>
<td>15</td>
<td>22</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>13</td>
<td>20</td>
<td>27</td>
<td>4</td>
<td>11</td>
<td>18</td>
<td>25</td>
<td>1</td>
<td>8</td>
<td>15</td>
<td>22</td>
</tr>
<tr>
<td>9</td>
<td>16</td>
<td>23</td>
<td>30</td>
<td>7</td>
<td>14</td>
<td>21</td>
<td>28</td>
<td>9</td>
<td>16</td>
<td>23</td>
<td>2</td>
</tr>
</tbody>
</table>

**TARGETED MEDIA**

<table>
<thead>
<tr>
<th>CREATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print</td>
</tr>
<tr>
<td>Online</td>
</tr>
</tbody>
</table>

**NATIONAL PRINT**

- **Ladies Home Journal**
- **Health**
- **Prevention**

**ONLINE**

- Web MD
- iVillage
- Revolution Health
- Health
- Prevention
- The Breast Cancer Site
- Mayo Clinic.com
- MedicineNet.com
- Yahoo Health
- Google & Yahoo

### National Print

<table>
<thead>
<tr>
<th>MEDIA</th>
<th>CREATIVE</th>
<th>TOTAL UNITS/GRP</th>
<th>EST UNIT COST</th>
<th>TOTAL GROSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ladies Home Journal FP4CB</td>
<td>6</td>
<td>$155,000</td>
<td>$930,000</td>
<td></td>
</tr>
<tr>
<td>Health FP4CB</td>
<td>4</td>
<td>$100,000</td>
<td>$400,000</td>
<td></td>
</tr>
<tr>
<td>Prevention FP4CB</td>
<td>6</td>
<td>$121,000</td>
<td>$726,000</td>
<td></td>
</tr>
</tbody>
</table>

**Online**

- Web MD TBD: TBD
- iVillage TBD: TBD
- Revolution Health TBD: TBD
- Health TBD: TBD
- Prevention TBD: TBD
- The Breast Cancer Site TBD: TBD
- Mayo Clinic.com TBD: TBD
- MedicineNet.com TBD: TBD
- Yahoo Health TBD: TBD
- Google & Yahoo TBD: TBD

### Plan Total

**Est CPM Total IMP's**

- $60 6,000,000 $360,000
- $25 2,800,000 $70,000
- $60 4,800,000 $288,000
- $30 2,400,000 $72,000
- $25 2,800,000 $84,000
- $30 5,000,000 $150,000
- $50 6,230,000 $311,500
- $30 5,000,000 $150,000
- $30 4,900,000 $147,000
- TBD TBD $400,000

**Online Total**

**Total Gross**

- $2,056,000
- $2,032,500
- **$4,088,500**

**PLAN TOTAL**

- **$2,056,000**
- **$2,032,500**
- **$4,088,500**
## 2008 - SOCIETY OF NUCLEAR MEDICINE

**SAMPLE DRAFT**

**Costs are 2008 planning estimates, as of 1/22/08**

<table>
<thead>
<tr>
<th>Target: Women - Health gate Keepers</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>TOTAL UNITS/GRP</th>
<th>EST. UNIT COST</th>
<th>TOTAL GROSS COST</th>
</tr>
</thead>
</table>

### NATIONAL PRINT

<table>
<thead>
<tr>
<th>TARGETED MEDIA</th>
<th>TOTAL UNITS</th>
<th>CREATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ladies Home Journal FP4CB</td>
<td>7</td>
<td>$155,000</td>
</tr>
<tr>
<td>Red Book FP4CB</td>
<td>6</td>
<td>$70,000</td>
</tr>
<tr>
<td>Woman’s Day FP4CB</td>
<td>7</td>
<td>$100,000</td>
</tr>
<tr>
<td>Health FP4CB</td>
<td>6</td>
<td>$100,000</td>
</tr>
<tr>
<td>Prevention FP4CB</td>
<td>8</td>
<td>$121,000</td>
</tr>
<tr>
<td>USA Today FP4CB</td>
<td>2</td>
<td>$178,700</td>
</tr>
<tr>
<td>New York Times FP4CB</td>
<td>6</td>
<td>$181,463</td>
</tr>
</tbody>
</table>

### WEB

<table>
<thead>
<tr>
<th>TARGETED MEDIA</th>
<th>TOTAL UNITS</th>
<th>CREATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web MD TBD</td>
<td>6</td>
<td>$60,000</td>
</tr>
<tr>
<td>Revolution Health TBD</td>
<td>6</td>
<td>$60,000</td>
</tr>
<tr>
<td>Red Book TBD</td>
<td>6</td>
<td>$100,000</td>
</tr>
<tr>
<td>Health TBD</td>
<td>6</td>
<td>$100,000</td>
</tr>
<tr>
<td>Prevention TBD</td>
<td>8</td>
<td>$121,000</td>
</tr>
<tr>
<td>The Breast Cancer Site TBD</td>
<td>2</td>
<td>$178,700</td>
</tr>
<tr>
<td>Mayo Clinic.com TBD</td>
<td>6</td>
<td>$181,463</td>
</tr>
<tr>
<td>MedicineNet.com TBD</td>
<td>6</td>
<td>$181,463</td>
</tr>
<tr>
<td>Yahoo Health TBD</td>
<td>6</td>
<td>$181,463</td>
</tr>
<tr>
<td>AOL Health TBD</td>
<td>6</td>
<td>$181,463</td>
</tr>
<tr>
<td>Google &amp; Yahoo TBD</td>
<td>6</td>
<td>$181,463</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL UNITS</th>
<th>TOTAL COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,219,178</td>
<td>$2,718,000</td>
</tr>
</tbody>
</table>

**PLAN TOTAL** $7,937,178

Active key word search paid per click:

- **JUNE**
- **JULY**
- **AUGUST**
- **SEPTEMBER**
- **OCTOBER**
- **NOVEMBER**
- **DECEMBER**

<table>
<thead>
<tr>
<th>MONTH</th>
<th>ACTIVE KEY WORD SEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>JUNE</strong></td>
<td>600,000</td>
</tr>
<tr>
<td><strong>JULY</strong></td>
<td>600,000</td>
</tr>
<tr>
<td><strong>AUGUST</strong></td>
<td>600,000</td>
</tr>
<tr>
<td><strong>SEPTEMBER</strong></td>
<td>600,000</td>
</tr>
<tr>
<td><strong>OCTOBER</strong></td>
<td>600,000</td>
</tr>
<tr>
<td><strong>NOVEMBER</strong></td>
<td>600,000</td>
</tr>
<tr>
<td><strong>DECEMBER</strong></td>
<td>500,000</td>
</tr>
</tbody>
</table>

Online Total $2,718,000

Print Total $5,219,178

**Google & Yahoo** TBD

**PLAN TOTAL** $7,937,178
<table>
<thead>
<tr>
<th>Target: Women - Health gate Keepers</th>
<th>JUNE</th>
<th>JULY</th>
<th>AUGUST</th>
<th>SEPTEMBER</th>
<th>OCTOBER</th>
<th>NOVEMBER</th>
<th>DECEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>16</td>
<td>23</td>
<td>30</td>
<td>1</td>
<td>8</td>
<td>15</td>
<td>22</td>
</tr>
<tr>
<td>4th of July</td>
<td>Labor Day</td>
<td>Memorial Day</td>
<td>Independence Day</td>
<td>Veteran’s Day</td>
<td>Thanksgiving</td>
<td>Christmas</td>
<td></td>
</tr>
</tbody>
</table>

### NATIONAL TELEVISION

<table>
<thead>
<tr>
<th>TARGETED MEDIA</th>
<th>CREATIVE</th>
<th>TOTAL UNITS/GRP</th>
<th>EST.UNIT COST</th>
<th>TOTAL GROSS COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cable</td>
<td>50 50 50 50 50 50 50 50 50 50 50 50 550</td>
<td>$10,000</td>
<td>$5,500,000</td>
<td></td>
</tr>
<tr>
<td>Television Total</td>
<td></td>
<td></td>
<td></td>
<td>$5,500,000</td>
</tr>
</tbody>
</table>

### PRINT

<table>
<thead>
<tr>
<th>TARGETED MEDIA</th>
<th>CREATIVE</th>
<th>TOTAL UNITS/GRP</th>
<th>EST.UNIT COST</th>
<th>TOTAL GROSS COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ladies Home Journal</td>
<td>FP4CB</td>
<td>6</td>
<td>$155,000</td>
<td>$930,000</td>
</tr>
<tr>
<td>Red Book</td>
<td>FP4CB</td>
<td>6</td>
<td>$70,000</td>
<td>$420,000</td>
</tr>
<tr>
<td>Woman’s Day</td>
<td>FP4CB</td>
<td>6</td>
<td>$100,000</td>
<td>$600,000</td>
</tr>
<tr>
<td>Health</td>
<td>FP4CB</td>
<td>5</td>
<td>$100,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>Prevention</td>
<td>FP4CB</td>
<td>6</td>
<td>$121,000</td>
<td>$726,000</td>
</tr>
<tr>
<td>USA Today</td>
<td>FP4CB</td>
<td>11 2</td>
<td>$178,700</td>
<td>$357,400</td>
</tr>
<tr>
<td>New York Times</td>
<td>FP4CB</td>
<td>2</td>
<td>$181,463</td>
<td>$362,926</td>
</tr>
<tr>
<td>Print Total</td>
<td></td>
<td></td>
<td>$3,896,326</td>
<td></td>
</tr>
</tbody>
</table>

### ONLINE

<table>
<thead>
<tr>
<th>TARGETED MEDIA</th>
<th>CREATIVE</th>
<th>TOTAL UNITS/GRP</th>
<th>EST.UNIT COST</th>
<th>TOTAL GROSS COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web MD</td>
<td>TBD</td>
<td>600,000</td>
<td>$600,000</td>
<td>$360,000</td>
</tr>
<tr>
<td>TVillage</td>
<td>TBD</td>
<td>500,000</td>
<td>$500,000</td>
<td>$300,000</td>
</tr>
<tr>
<td>Revolution Health</td>
<td>TBD</td>
<td>600,000</td>
<td>$600,000</td>
<td>$360,000</td>
</tr>
<tr>
<td>Red Book</td>
<td>TBD</td>
<td>500,000</td>
<td>$500,000</td>
<td>$300,000</td>
</tr>
<tr>
<td>Health</td>
<td>TBD</td>
<td>600,000</td>
<td>$600,000</td>
<td>$360,000</td>
</tr>
<tr>
<td>Prevention</td>
<td>TBD</td>
<td>500,000</td>
<td>$500,000</td>
<td>$300,000</td>
</tr>
<tr>
<td>The Breast Cancer Site</td>
<td>TBD</td>
<td>600,000</td>
<td>$600,000</td>
<td>$360,000</td>
</tr>
<tr>
<td>Mayo Clinic.com</td>
<td>TBD</td>
<td>600,000</td>
<td>$600,000</td>
<td>$360,000</td>
</tr>
<tr>
<td>MedicineNet.com</td>
<td>TBD</td>
<td>600,000</td>
<td>$600,000</td>
<td>$360,000</td>
</tr>
<tr>
<td>Yahoo Health</td>
<td>TBD</td>
<td>800,000</td>
<td>$800,000</td>
<td>$480,000</td>
</tr>
<tr>
<td>AOL Health</td>
<td>TBD</td>
<td>600,000</td>
<td>$600,000</td>
<td>$360,000</td>
</tr>
<tr>
<td>Google &amp; Yahoo</td>
<td>TBD</td>
<td>500,000</td>
<td>$500,000</td>
<td>$300,000</td>
</tr>
<tr>
<td>Online Total</td>
<td></td>
<td></td>
<td>$2,995,000</td>
<td></td>
</tr>
</tbody>
</table>

### PLAN TOTAL

<table>
<thead>
<tr>
<th></th>
<th>EST.UNIT COST</th>
<th>TOTAL GROSS COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cable</td>
<td>$10,000</td>
<td>$5,500,000</td>
</tr>
<tr>
<td>Television Total</td>
<td></td>
<td>$5,500,000</td>
</tr>
<tr>
<td>Print Total</td>
<td></td>
<td>$3,896,326</td>
</tr>
<tr>
<td>Online Total</td>
<td></td>
<td>$2,995,000</td>
</tr>
<tr>
<td>PLAN TOTAL</td>
<td></td>
<td>$11,991,326</td>
</tr>
</tbody>
</table>

**2008 - SOCIETY OF NUCLEAR MEDICINE**  
**SAMPLE DRAFT** Costs are 2008 planning estimates, as of 1/22/08
Clinical Trials
Pharma
Other Societies
New Business
Adjournment