Front Materials

1. Speakers’ Letter
2. Registration Form
3. Directions
4. Order of Business: First Session (Vote)
5. Order of Business: Second Session (Vote)
6. Annual Meeting of the Society (Vote)
7. Speakers’ Consent Calendar (Vote)
8. Report of the Committee on Nominations: Officers and AMA Delegate and Alternate Delegate (Vote)
9. Reference Committee Members
10. House of Delegates Listing
11. Informational Report Titles (Reports Available at www.massmed.org/AM18delegateshandbook)
12. Important Reminders and Delegates’ Resources
   - Delegates’ Responsibilities
   - Acceptance of Resolutions/Reports
   - Close Debate/Vote Immediately
   - Precedence of Motions

Resolutions and Reports

- Reference Committee A – Public Health
- Reference Committee B – Health Care Systems
- Reference Committee C – MMS Administration
- Fiscal Note Components
The following information is your guide to the 2018 Annual Meeting of the House of Delegates (HOD).

Annual Meeting Website
The Annual Meeting website massmed.org/annual2018 is your complete guide to the Annual Meeting. It includes: the Delegates’ Handbook, hotel information, educational programs and special event details, and online registration.

Pre-Registration
We strongly encourage all delegates to pre-register online at massmed.org/annual2018/register for all Annual Meeting events. Pre-registering allows for faster onsite check-in, an adequate number of seats for your district in the House of Delegates, and meal counts. Pre-registration closes on Monday, April 23, at noon.

Important: Pre-registration is required for the Annual Education Program, the Networking Luncheon, and the Presidential Inauguration and Awards Reception and Dinner on Friday. On-site registrations will not be accepted.

On-site registration will open on Thursday, April 26, at 6:30 a.m. and will be available for all events with the exception of those events mentioned above.

Annual Education Program-Important Event Information
This year’s Shattuck Lecture will be delivered by Mr. Bill Gates, Co-Chair of the Bill & Melinda Gates Foundation, as part of our Annual Education Program: Epidemics Going Viral: Innovation vs. Nature. The full program features a world-renowned group of experts in global health. Please visit massmed.org/annual2018/cme for complete details and important event security and logistic information.

Family-Friendly Space
For the HOD second session on Saturday, April 28, a family-friendly space is available for attendees needing it to observe the HOD meeting. Pre-registration is required. Visit massmed.org/annual2018/hod and click on the Family-Friendly Space link.

HOD Remote Observation
Delegates and MMS members who are unable to attend the meeting may observe the HOD proceedings remotely. Please visit massmed.org/annual2018/hod for more information.

*Please note: Offsite remote observation does not count toward delegate attendance credit and does not allow for remote participation (testifying/voting) during the sessions.
HOD-Related Online Tutorials
We encourage all delegates to visit the tutorial for the online Delegates’ Handbook at massmed.org/onlinetutorial, which includes helpful information about using PDF documents. Please visit massmed.org/parliamentary for a video on parliamentary procedure.

Online-Only Meeting Materials
A-18 Committee Informational Reports (please see list of titles in front materials of this Delegates’ Handbook) and 2018–2019 MMS Committee Appointments are available online at massmed.org/annual2018/hod.

Online Testimony for Reference Committees
Members may provide testimony for all reference committees online at massmed.org/hodcommunity. Online testimony is in addition to onsite testimony at reference committee hearings. Comment as many times as you like until 8:00 a.m., Thursday, April 26.

Late-File Resolution Deadline
The deadline for late-filed resolutions is Thursday, April 12, at 5:00 p.m. For guidelines on submitting a late file, please visit massmed.org/resolutions. Late files must meet specific criteria. (Please see MMS Procedures of the House of Delegates, Procedure 4, online at massmed.org/policies.) These resolutions and reports are reviewed by the Committee on Late and Deferred Resolutions and Reports to determine the urgency of the submission.

Accommodations
The MMS room block at the Seaport Hotel is sold out. If you do not yet have hotel reservations, a small block of rooms for the evenings of April 26 and 27 are available at the Renaissance Boston Waterfront Hotel (two-minute walk to Seaport/WTC) until April 11 or until sold. To make a reservation, please call the hotel at (617) 342-5406 and ask for the MMS room block. For additional assistance, please contact Laura Bombrun at (781)434-7007 or lbombrun@mms.org.

If you are holding a reservation at the Seaport and plan to cancel prior to the start of the meeting, please contact Laura Bombrun before contacting the hotel. The MMS will manage the room block and fill rooms from the wait list. Complete check-in and cancellation policies are available at massmed.org/annual2018/hotel.

Current MMS policy allows delegates, when attending a meeting of the House of Delegates, to obtain reimbursement for up to two nights’ accommodation at the negotiated MMS group single rate and is applicable for the cost of the accommodation, self-parking, and tax. All other incidental charges are the responsibility of the individual.

District Caucus Meetings
Thursday, April 26
*Please check in at the Registration Desk, WTC, Plaza Level, prior to attending your caucus meeting.* All caucuses on Thursday will be held at the WTC.

<table>
<thead>
<tr>
<th>Time</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 a.m.</td>
<td>Berkshire, Franklin, and Hampshire Districts</td>
</tr>
<tr>
<td></td>
<td>Medical Student and Resident/Fellow Sections</td>
</tr>
<tr>
<td></td>
<td>Norfolk District</td>
</tr>
<tr>
<td></td>
<td>Suffolk District</td>
</tr>
</tbody>
</table>

Saturday, April 28

<table>
<thead>
<tr>
<th>Time</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 a.m.</td>
<td>Berkshire, Franklin, and Hampshire Districts</td>
</tr>
<tr>
<td></td>
<td>Charles River District</td>
</tr>
<tr>
<td></td>
<td>Committee on Finance</td>
</tr>
<tr>
<td></td>
<td>Essex North and Essex South Districts</td>
</tr>
<tr>
<td></td>
<td>Hampden District</td>
</tr>
<tr>
<td></td>
<td>Medical Student and Resident/Fellow Sections</td>
</tr>
<tr>
<td></td>
<td>Middlesex District</td>
</tr>
<tr>
<td></td>
<td>Middlesex Central and Middlesex North Districts</td>
</tr>
<tr>
<td></td>
<td>Middlesex West District</td>
</tr>
<tr>
<td></td>
<td>Norfolk District</td>
</tr>
<tr>
<td></td>
<td>Southeast Regional Districts</td>
</tr>
<tr>
<td></td>
<td>Suffolk District</td>
</tr>
<tr>
<td></td>
<td>Worcester and Worcester North Districts</td>
</tr>
</tbody>
</table>

We look forward to seeing you at the 2018 Annual Meeting!
**REGISTRATION FORM — MMS 2018 ANNUAL MEETING**

Save time! Register online at massmed.org/annual2018/register.

Pre-registration closes Monday, April 23, at noon. On-site registration opens Thursday, April 26, at 6:30 a.m.

Pre-registration is required for the Annual Education Program, the Networking Luncheon, and the Presidential Inauguration. On-site registrations will not be accepted. Please visit massmed.org/annual2018/cme for additional logistical notes and security information for the Annual Education Program.

**REGISTRANT INFORMATION (all fields are required):**

<table>
<thead>
<tr>
<th>MMS Member</th>
<th>Resident/Student MMS Member</th>
<th>Physician Nonmember*</th>
<th>MMS Alliance</th>
<th>Allied Health</th>
<th>Other</th>
</tr>
</thead>
</table>

**MMS MEMBER ID# (if known)**

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>LAST NAME</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>BADGE FIRST NAME</th>
<th>BADGE CREDENTIALS (2 MAX)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MAILING ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>EMAIL</th>
<th>TELEPHONE</th>
</tr>
</thead>
</table>

**GUUEST INFORMATION:**

One member guest is eligible to pay the rate of a member (i.e., 1 member + 1 guest = 2 members)

<table>
<thead>
<tr>
<th>MD</th>
<th>Alliance</th>
<th>Other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>GUEST FIRST NAME</th>
<th>LAST NAME</th>
</tr>
</thead>
</table>

**EMERGENCY CONTACT INFORMATION:**

<table>
<thead>
<tr>
<th>FULL NAME</th>
<th>TELEPHONE</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
</table>

**PRICE PER PERSON**

<table>
<thead>
<tr>
<th>THURSDAY, APRIL 26</th>
<th>NUMBER OF ATTENDEES</th>
<th>MMS MEMBER</th>
<th>RES./STUDENT MMS MEMBER</th>
<th>PHYSICIAN NONMEMBER*</th>
<th>MMS ALLIANCE</th>
<th>ALLIED HEALTH/OTHER</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegate — House of Delegates (8:30 a.m.)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
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</tr>
<tr>
<td>Non-Delegate — Opening Session (8:30 a.m.)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>MMS Awards Luncheon (12:30 p.m.)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Ethics Forum (3:00 p.m.)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>$70</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>President’s Reception and the Nancy N. Caron Annual Art Exhibit and MMS and Alliance Charitable Foundation Auction (5:30 p.m.)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>International Medical Graduates Reception (6:00 p.m.)</td>
<td>—</td>
<td>—</td>
<td>—</td>
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<td>—</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FRIDAY, APRIL 27</th>
<th>NUMBER OF ATTENDEES</th>
<th>MMS MEMBER</th>
<th>RES./STUDENT MMS MEMBER</th>
<th>PHYSICIAN NONMEMBER*</th>
<th>MMS ALLIANCE</th>
<th>ALLIED HEALTH/OTHER</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Education Program (8:00 a.m.)†</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>$380</td>
<td>—</td>
<td>—</td>
<td>$195</td>
</tr>
<tr>
<td>Annual Education Program Webcast (No CME credits) (8:00 a.m.)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
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</tr>
<tr>
<td>Networking Luncheon (12:30 p.m.)†</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>$55</td>
<td>$25</td>
<td>—</td>
<td>$55</td>
</tr>
<tr>
<td>Bleeding Control for the Injured/Stop the Bleed Training (2:30 p.m.)</td>
<td>—</td>
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<td>—</td>
</tr>
<tr>
<td>Presidential Inauguration and Awards Reception and Dinner (6:00 p.m.)†</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>$175</td>
<td>—</td>
<td>—</td>
<td>$175</td>
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</table>

<table>
<thead>
<tr>
<th>SATURDAY, APRIL 28</th>
<th>NUMBER OF ATTENDEES</th>
<th>MMS MEMBER</th>
<th>RES./STUDENT MMS MEMBER</th>
<th>PHYSICIAN NONMEMBER*</th>
<th>MMS ALLIANCE</th>
<th>ALLIED HEALTH/OTHER</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegate — House of Delegates (8:30 a.m.)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Non-Delegate — HOD Second Session (8:30 a.m.)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>70th Alliance Meeting and Luncheon (11:30 a.m.)</td>
<td>—</td>
<td>—</td>
<td>—</td>
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</tr>
<tr>
<td>HOD Luncheon/Annual Meeting of the Society Luncheon (12:30 p.m.)</td>
<td>—</td>
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</tr>
</tbody>
</table>

(Please note: educational vouchers may only be applied as payment toward the Annual Education Program.)

<table>
<thead>
<tr>
<th>EDUCATIONAL VOUCHERS REDEEMED (DEDUCT THIS AMOUNT FROM YOUR TOTAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$_________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIETARY REQUIREMENTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Gluten Free</td>
</tr>
<tr>
<td>□ Specific Allergy (please specify below):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAYMENT OPTIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Visa</td>
</tr>
<tr>
<td>CREDIT CARD NO.:</td>
</tr>
<tr>
<td>EXP. DATE:</td>
</tr>
</tbody>
</table>

*Physician nonmembers: For information on joining the MMS and qualifying for Annual Meeting member pricing, call our Member Information Center at (800) 322-2303, ext. 7312.
†The cost of self-parking is included for these programs. Parking will be validated upon check-in.

Pre-registration is required for the Annual Education Program, the Networking Luncheon, and the Presidential Inauguration. On-site registrations will not be accepted.

Fax completed registration form to (781) 893-0413. To register by mail send to:

MMS Annual Meeting, ATTN: Finance Department, 860 Winter Street, Waltham, MA 02451-1411
From points west via I-90

Follow the Massachusetts Turnpike/Interstate 90 East to Exit 25 – South Boston. At the top of the ramp, bear left toward Seaport Boulevard. At the first set of lights, proceed straight onto East Service Road. At the next set of lights, take a right onto Seaport Boulevard. The Seaport Boulevard entrance to the Seaport Garage is located ahead on the right.

From points south via I-93

Heading northbound on I-93 toward Boston, take Exit 20, which will be immediately after Exit 18. Follow the signs to “I-90 East.” Take the first tunnel exit to "South Boston." At the first set of lights at the top of the ramp, proceed straight onto East Service Road. At the next set of lights, take a right onto Seaport Boulevard. The Seaport Boulevard entrance to the Seaport Garage will be ahead on the right.

From points north via I-93

Heading southbound on Interstate 93 Boston, take Exit 23, Purchase Street and move into the left lane. At the top of the ramp, take a left turn onto the Evelyn Moakley Bridge/Seaport Boulevard. Follow Seaport Boulevard for approximately .8 miles, the Seaport Boulevard entrance to the Seaport Garage will be on the right, after the Seaport Boulevard/B Street intersection.

From Logan International Airport and Route 1A South

Follow the signs toward I-90 West - Ted Williams Tunnel. Take the Ted Williams Tunnel to Exit 25. At the top of the ramp proceed straight onto B Street. Follow B Street to the end and take a right onto Seaport Boulevard. The Seaport Boulevard entrance to the Seaport Garage will be on your right.

Public transportation

The MBTA Silver Line Waterfront (SL1) provides service from the WTC Station to Logan International Airport terminals every 10 minutes during the weekday and every 15 minutes during the weekend. The Silver Line station is located adjacent to the hotel.
ORDER OF BUSINESS
FIRST SESSION

1. Call to Order
   David Rosman, MD, MBA, Speaker
2. Quorum Report
3. Order of Business (vote)
4. Delegate Service Awards
5. Memorials
6. Committee on Late and Deferred Resolutions (vote)
7. Acceptance of Resolutions and Reports for Action
   • Withdrawals or Minor Word Changes
   • Speakers’ Consent Calendar (vote)
   • Object to Consideration
8. Consent Calendar (vote)
   a. Informational Reports
10. President’s Report
11. NEJM Group Update
12. Alliance President’s Report
13. MMS and Alliance Charitable Foundation Report
14. Massachusetts Medical Benevolent Society
15. Election of Officers and AMA Delegate and Alternate Delegate (vote)
16. MMS Committee Appointments (vote)
17. Fiscal Note Review and FY 2019 Budget Presentation (Executive Session)
18. Announcements
19. Recess

Reference committee reports will be available online Friday, April 27, at massmed.org/AM18refcommreports.

Reference Committee Report Order at the HOD Second Session, Saturday, April 28:
   • Reference Committee A — Public Health
   • Reference Committee B — Health Care Delivery
   • Reference Committee C — MMS Administration
1. Call to Order
   David Rosman, MD, MBA, Speaker

2. Quorum Report

3. Order of Business (vote)

4. Delegate Service Awards

5. Fiscal Notes Update

6. Reference Committee Reports (vote)

   * Reference Committee A — Public Health
   * Reference Committee B — Health Care Delivery
   * Reference Committee C — MMS Administration

7. Fiscal Notes Totals

8. Announcements

9. Adjournment
1. Call to Order
   Henry Dorkin, MD, FAAP, President

2. Order of Business (vote)

3. Approval of the Record of the Annual Meeting of the Society, April 29, 2017 (vote)

4. Bylaws Amendments (vote)

5. Report of the Membership

6. State of the Society Address

7. Adjournment
Per the Procedures of the House of Delegates, the speaker has the ability to place non-controversial/routine reports on a consent calendar for immediate adoption. The consent calendar will be presented for a vote at the first session of the House. Any delegate can extract an item from this calendar for discussion at a reference committee and/or for subsequent deliberation by the House.

Your speakers reviewed all items of business submitted to the HOD and determined that the following reports in this Delegates’ Handbook should be placed on the consent calendar:

Reference Committee C: MMS Administration

<table>
<thead>
<tr>
<th>Hearing Order #</th>
<th>Title</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>*12</td>
<td>Delegates-at-Large</td>
<td>BOT Report A-18 C-12</td>
</tr>
<tr>
<td>*13</td>
<td>Membership Dues for Calendar Year 2019</td>
<td>COF Report A-18 C-13</td>
</tr>
</tbody>
</table>

Rationale for report placement on consent calendar:

These are standard reports submitted annually by the Board of Trustees and Committee on Finance, respectively. Regarding the membership dues report, there have been no changes since last year’s dues report.
MEMORANDUM TO THE HOUSE OF DELEGATES

Subject: 2018–2019 Slate of Officers; New AMA Delegate and Alternate Delegate Positions

The Committee on Nominations (CON) met on Thursday, March 1, 2018, at 4:00 p.m. at Society headquarters in Waltham with several members participating remotely. Committee Chair David T. Golden, MD, presided.

There were nineteen districts represented, constituting a quorum.

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>Committee Members Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnstable</td>
<td>Kenneth A. Heisler, MD</td>
</tr>
<tr>
<td>Berkshire</td>
<td>Erwin Stuebner Jr., MD and Robert Hertzig, MD</td>
</tr>
<tr>
<td>Bristol North</td>
<td>Brett S. Stecker, MD</td>
</tr>
<tr>
<td>Bristol South</td>
<td>Walter J. Rok, MD</td>
</tr>
<tr>
<td>Charles River</td>
<td>David T. Golden, MD and Hugh I Caplan, MD</td>
</tr>
<tr>
<td>Essex North</td>
<td>Joseph M. Heyman, MD and Glenn P. Kimball, MD</td>
</tr>
<tr>
<td>Essex South</td>
<td>Keith C. Nobil, MD and Sanjay Aurora, MD</td>
</tr>
<tr>
<td>Franklin</td>
<td>None</td>
</tr>
<tr>
<td>Hampden</td>
<td>James K. Wang, MD</td>
</tr>
<tr>
<td>Hampshire</td>
<td>Peter C. Kenny, MD</td>
</tr>
<tr>
<td>Middlesex</td>
<td>George E. Ghareeb, MD and Deanna P. Ricker, MD</td>
</tr>
<tr>
<td>Middlesex Central</td>
<td>Eileen Deignan, MD</td>
</tr>
<tr>
<td>Middlesex North</td>
<td>Alan T. Kent, MD</td>
</tr>
<tr>
<td>Middlesex West</td>
<td>Cecilia M. Mikalac, MD</td>
</tr>
<tr>
<td>Norfolk</td>
<td>Francis X. Rockett, MD</td>
</tr>
<tr>
<td>Norfolk South</td>
<td>Bartley G. Cilento, MD and John J. Walsh, MD</td>
</tr>
<tr>
<td>Plymouth</td>
<td>Philip E. McCarthy, MD and Elsa J. Aguilera, MD</td>
</tr>
<tr>
<td>Suffolk</td>
<td>Marian C. Craighill, MD and Charles A. Welch, MD</td>
</tr>
<tr>
<td>Worcester</td>
<td>Thomas L. Rosenfeld, MD</td>
</tr>
<tr>
<td>Worcester North</td>
<td>Daniel J. O’Brien, MD and Robert B. Coit, MD</td>
</tr>
<tr>
<td>Resident &amp; Fellow Section</td>
<td>Eli C. Freiman, MD</td>
</tr>
<tr>
<td>Medical Student Section</td>
<td>Celeste Peay</td>
</tr>
</tbody>
</table>

A total of ten candidates submitted applications for six officer positions. In addition, four candidates submitted applications for one AMA Delegate position and four candidates for one Alternate Delegate position which became available when the Society was notified by the AMA that the number of AMA physician members from Massachusetts had increased.
The CON carefully interviewed all of the nominees, paying particular attention to each nominee’s experience and qualifications as they relate to the MMS strategic vision and programmatic priorities. The CON also reviewed the process for identifying and selecting candidates interested in leadership roles within the Society and the AMA.

After due deliberation, the CON nominates the following candidates for approval by the House of Delegates.

### 2018–2019 SLATE OF OFFICERS

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>President-Elect</td>
<td>Maryanne C. Bombaugh, MD, MSc, MBA</td>
</tr>
<tr>
<td>Vice President</td>
<td>David A. Rosman, MD, MBA</td>
</tr>
<tr>
<td>Secretary-Treasurer</td>
<td>Joseph C. Bergeron, Jr., MD</td>
</tr>
<tr>
<td>Assistant Secretary-Treasurer</td>
<td>Lynda G. Kabbash, MD</td>
</tr>
<tr>
<td>Speaker</td>
<td>Francis P. MacMillan, Jr., MD</td>
</tr>
<tr>
<td>Vice Speaker</td>
<td>McKinley Glover, IV, MD</td>
</tr>
</tbody>
</table>

### SLATE OF AMA DELEGATE AND ALTERNATE DELEGATE

**Delegate (1 new position: 2 year term – January 1, 2018 – December 31, 2019)**

Lee S. Perrin, MD

**Alternate Delegate (1 new position: 2 year term – January 1, 2018 – December 31, 2019)**

Kenath J. Shamir, MD

The chair expresses sincere appreciation to all of the candidates for their interest in the MMS and to the committee members for their active participation at the meeting.

For the Committee,

David T. Golden, MD

Chair, Committee on Nominations
# REFERENCE COMMITTEES
## ANNUAL MEETING 2018

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<td>Mr. Patrick P. Lowe</td>
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<td>Status/Implementation Chart: I-17 Resolutions &amp; Reports</td>
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IMPORTANT REMINDERS TO DElegates

DELEGATES’ HANDBOOK DISCLAIMER
A few general reminders to delegates when reviewing the Delegates’ Handbook:

- All delegates receiving this material are reminded that it refers only to items considered by the HOD.
- No action has been taken on anything herein contained, and it is informational only.
- Only those items that have been acted on finally by the HOD can be considered official.
- Only the resolve(s)/recommendation(s) portions of the resolution(s)/report(s) are considered by the HOD. The “whereas” portions or preambles and also resolution/report titles are informational and explanatory only.

INFORMATIONAL REPORTS
Informational reports are posted online (only) at www.massmed.org/am18delegateshandbook. (A list of the informational report titles is included in these front materials.) For adopted A-17 and I-17 directives due for an informational report and whose status can be provided in a “short-form” manner, these updates are provided in Report Status/Implementation Charts.

HOUSE OF DELEGATES TWO SESSION ATTENDANCE REQUIREMENT
Please note, Section 3.15 of the MMS Bylaws states that:

No delegate elected by a district shall be eligible to serve for a third consecutive Presidential Year who has not attended at least two sessions of the House of Delegates of the Massachusetts Medical Society in the two prior consecutive presidential years. In the event a delegate is elected to serve for a third consecutive presidential year, but fails to satisfy this attendance requirement, the individual shall not serve as elected, and the district shall fill the vacancy in accordance with Section 3.16. Exceptions for extenuating circumstances shall require the written consent of the delegate’s district president.

The meetings that attendance counts towards criteria for the current two-year cycle are: Interim Meeting 2016, Annual Meeting 2017, Interim Meeting 2017, and Annual Meeting 2018.

If you have questions about your status or about this bylaw, please contact houseofdelegates@mms.org.

GENERAL GOVERNANCE RESOURCES
The following governance resources are available on the MMS website:

- 2017 Interim Meeting Proceedings (www.massmed.org/recentproceedings)
- Procedures of the House of Delegates (www.massmed.org/procedures)
- Bylaws (www.massmed.org/policies)
- Policy Compendium (www.massmed.org/policies)

You must be logged on as an MMS member to access this information. If you would like to receive a printed copy, please contact the Department of Governance Meetings and Services at (800) 322-2303, extension 7332, or email to houseofdelegates@mms.org.

In addition, attached are a number Delegates’ Resources designed specifically to help delegates navigate certain procedures and parliamentary processes used at our HOD meetings. Should you have any questions about any HOD procedure, please feel free to contact your speakers at speaker@massmed.org.
Overview
The HOD is the policy-making body of the Massachusetts Medical Society (MMS) and has the authority to establish two general types of policy: health policies and directives. Health policies are statements of philosophy based on professional principles and scientific standards. These policies define what the Society stands for as an organization. Directives are action items that articulate a strategy for accomplishing an objective and/or activate the Society’s health policies. Health policies are based on a statement of philosophy or health policy. While a health policy sets forth the Society’s position, a directive instructs the Society to take some action. The HOD also sets the long-range goals of the Society. Policies of the MMS may be found in the MMS Policy Compendium.

The Speaker presides over meetings of the HOD and, along with the Vice Speaker, is responsible for appointing Reference Committees and assigning resolutions and reports to them. Questions or comments for the Speaker of the HOD may be directed to speaker@massmed.org.

Composition
The HOD is composed of delegates elected by the district medical societies and in addition:

- One delegate from each designated medical specialty society
- Two delegates from the student membership of each medical school in the Commonwealth
- Eight delegates from the Resident and Fellow Section
- One delegate from the Organized Medical Staff Section, one delegate from the Academic Physician Section, and one delegate from the International Medical Graduate Section
- The President, President-elect, Vice President, Secretary-Treasurer, Assistant Secretary-Treasurer, Speaker and Vice Speaker
- The president and secretaries from each of the district medical societies
- The trustee and alternate trustee from each of the district medical societies, for the duration of their term as such, and the Medical Student Section trustee and alternate
- Chairs of all standing committees of the Society, during their tenure.
- Past Presidents of the Society
- Delegates-at-large, as recommended by the Board of Trustees (BOT)
- The President of the MMS Alliance

Reference Committees Hearings
Reference Committees are groups of five delegates (and two alternates) selected by the Speaker to conduct open hearings on the resolutions and reports before the House for action. The Speaker schedules a number of concurrent Reference Committees to meet on the first day of the Annual and Interim meeting. Reference Committee hearings are open to all members of the Society, guests, official observers, interested outsiders, and the press. Any member of the Society may speak on a resolution or report under consideration. Nonmember physicians, guests or interested outsiders may, upon recognition by the chair, be permitted to speak.
Responsibilities of the HOD

The powers and duties of the HOD include some of the following responsibilities:

- Consideration and action on Reference Committee reports.
- Approval of standing committee chair and member appointments for standing and special committees.
- Establishment of special committees.
- Election of Officers and AMA representatives.
- Approval to establish or discontinue medical specialty society representation on the HOD.
- Authority to override BOT action on prioritization of funding a House directive with a two-thirds (2/3) vote of the delegates.
- Elect Honorary and Affiliate members of the Society.
- Act upon matters of indemnification.

Participation in the MMS Governance Process

The Society is governed by a democratic process that starts with the HOD. The Procedures of the HOD outlines the methods for handling and conducting the business before the House.

1. Resolutions and Reports

Any member of the Society—whether or not a delegate—can ask the House to consider an item of business. Those items, called resolutions, are drafted and submitted prior to each House meeting. The House also considers reports from committees, Member Interest Networks, membership sections, or MMS leadership groups; often, reports cover previous House business, information about current activities, or an item the House has assigned to a group for review and analysis.

2. Pre-Meeting Publication of House Business

All resolutions and reports for an upcoming meeting, plus any other business before the House, are published in the Delegates Handbook before each meeting. MMS members can also view this information in the members-only area of the website, under Annual and Interim Meetings or opt in for a printed copy.

3. Reference Committee Process

Before each House meeting, the Speaker appoints members of the Society to sit on Reference Committees. Reference Committees, with five members and two alternates, hold open hearings on the resolutions assigned to it by the Speaker. Reference Committees meet during the first session of the House meeting. Following the Reference Committee hearings, the committee draws up a report with recommendations to the House for disposition of its items of business.

4. House First Session

At its first session, the House determines whether to accept any late items of business and which of the timely submitted resolutions and reports for action it will accept on its agenda. After this, the Reference Committees meet to begin hearing testimony on the resolutions/reports for action. (Resolutions and reports are often grouped into a single Reference Committee by general subject, e.g., new policies/programs). Any member of the Society may testify before a Reference Committee and the hearings are open to all members, the public, and the media.

After all testimony is heard, Reference Committees deliberate in executive session and determine whether to recommend that the House accept or reject its
resolutions/reports for action. A written report of the Reference Committee’s recommendations is prepared for the House.

5. House Second Session
During its second session, the House considers each Reference Committee’s report and votes whether to accept or reject the committee’s recommendation on each resolution. Once all committee reports are heard and voted upon, the House adjourns. A report of the House’s decisions is sent to the MMS Board of Trustees (BOT).

6. BOT implements the will of the HOD
The BOT prioritizes and assigns resolutions or reports from the House to committees for implementation or report back. A report is provided to the House upon completion of each item.

Delegate Roles and Responsibilities
Members of the MMS HOD serve as an important communications, policy, and membership link between the MMS and grassroots physicians. The delegate is a key source of information on activities, programs, and policies of the MMS.

Qualifications
- MMS member.
- District delegates must have been members of the MMS for one year and meet the attendance requirement as outlined on page two.
- Elected or selected by the principal governing body.
- Completion of a “Confirmation of Compliance with the MMS Conflicts of Interest Policy” form. Every delegate is required to update and resubmit this Form at the beginning of each MMS Presidential Year.

The Department of Governance Meetings and Services
For additional information, please contact the Department of Governance Meetings and Services. If you have questions on this material or would like to make suggestions for further resource information, please email houseofdelegates@mms.org.

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Section 2: Acceptance of Resolutions and Reports: House First Session

The procedure regarding the presentation of resolutions and reports was recently updated by the House of Delegates to help facilitate House meetings. It allows for resolutions/reports for action that do not require debate, whether because they are non-controversial, or, because the content is objectionable, to be handled immediately. Any delegate can object to the proposed immediate action on a resolution/report for action, and the item will be referred to a reference committee for discussion.

We ask that delegates please review this information prior to the House meeting.

Presentation of Late Resolutions and Reports
Late resolutions/reports are posted online and distributed at the meeting (resolutions/action reports). The Committee on Late and Deferred Resolutions, if convened by the Speaker, will submit its recommendations on each late resolution/report. The House will then be asked to vote on the acceptance of each resolution/report. A two-thirds affirmative vote is required for acceptance of late resolutions/reports as official business of the House.

Withdrawal or One- or Two-Word Change by Resolution/Report Sponsor
Resolution/report sponsors to may present a one- or two-word change in any resolution/report for action. Sponsors may also withdraw their resolution/report.

Speakers’ Consent Calendar
Enclosed is the speakers’ consent calendar. The speakers have carefully reviewed resolutions/reports submitted for the meeting and have placed non-controversial/routine reports on this consent calendar for immediate adoption. These reports are still included in the Delegates’ Handbook for your review. Any delegate may extract an item from this consent calendar for discussion at a reference committee and the House. (See steps on next page.)

Objection to Consideration
At the time of introduction of any resolution/report, including the late and deferred resolutions/reports, it is possible for any delegate to object to its consideration. (See steps on next page.) In the event that the House sustains such objection by a two-thirds vote, the resolution/report will not be referred to a reference committee and will not be considered by the House.

Steps for Delegates to Objection to Consideration
Any delegate who believes that the subject matter of any resolution/report presented, including the late and deferred resolutions/reports, is not germane to the mission of the MMS may make a motion to “object to consideration.”

1. Delegate should proceed to the microphone. Upon acknowledgement from the Speaker, the delegate should state that they “object to consideration of [in reference committee _] item number _ and title.

2. A second is not required, and there will be no debate. The Speaker will acknowledge that an objection to consideration of resolution/report(s) has been proposed.
To sustain the objection to consideration, a two-thirds vote in the negative is required. The Speaker will state that those in favor of consideration of the resolution/report for action should say “aye.” All those objecting to consideration of the resolution/report should say “no.”

**Steps for Delegates to Extract a Resolution/Report from Speakers’ Consent Calendar and Refer to a Reference Committee**

The speaker will present this consent calendar for a vote of acceptance by the House. Any delegate who believes a resolution/report on the calendar should not be accepted immediately and should be sent to a reference committee may extract the item(s) from the consent calendar.

1. Delegate should proceed to the microphone. Upon acknowledgement from the Speaker, the delegate should state that they “wish to extract item number _ [title] from the speakers’ consent calendar.”

2. A second is not required, and there will be no debate. The Speaker will acknowledge that the item(s) have been extracted and will be sent to a reference committee.
Section 3: Request to Close Debate and Vote Immediately

The following is a guide for delegates to use when they would like to make a motion to close debate and vote immediately. The MMS generally follows the procedure as outlined in *The American Institute of Parliamentarians Standard Code of Parliamentary Procedure* and the MMS Procedures of the HOD.

**Step 1: Obtain the Floor**
Delegate should proceed to any microphone. (Motion cannot interrupt a speaker.)

**Step 2: Make Motion to Close Debate and Vote Immediately and Specify Which Pending Motion(s) This Applies To**
After being recognized by the Speaker, the delegate should state that (he/she) would like to “make a motion to close debate and vote immediately.” If more than one motion is pending (for example, a primary and secondary amendment, plus the main motion) specify which motion(s) you are requesting to close debate on: “… on all pending motions,” or “… on the immediately pending motion – the secondary amendment.”

**Consider Any Pending Amendments:** If the main motion includes first and second degree amendments, the person making the motion should take into consideration which portions have been fully discussed and qualify their motion appropriately so as not to terminate discussion on the items that have not been adequately and fully discussed.

**The speaker will announce the motion** “It has been moved that we close debate on___. Is there a second?”

**The speaker will take the vote.** (Requires a two-thirds vote.)

**Closing Debate and Vote Immediately on “All Pending Matters”**
If the pending amendments in addition to the main motion have been fully heard, then the appropriate motion is to “close debate on this and all pending matters.” According to the MMS HOD procedures (17 E), “A motion to vote immediately on all pending matters will only be accepted if the Speaker rules that both sides have been heard on all pending matters. In the event such latter motion prevails, the House must act without further debate on the item of business and all pending amendments in proper order of precedence. The Speaker will not recognize the motion to vote immediately or terminate debate as being “in order” if it is added at the conclusion of the significant discussion of the immediately pending question. At the option of the Speaker, a motion to vote immediately will not be accepted until the House has heard at least one speaker representing each side of the issue.

For additional information, please also see Procedure 17 (E) of the *MMS Procedures of the House of Delegates* ([www.massmed.org/policies](http://www.massmed.org/policies)) and *The American Institute of Parliamentarians Standard Code of Parliamentary Procedure*, 2012, McGraw-Hill Companies, Inc. On the following page, please see MMS HOD Procedure 15, Precedence of Motions.
Procedure 15: Precedence of Motions

Motions are made so that those that are lower on the list can be modified by those that are higher. It is perfectly acceptable to skip a step in the list when making motions (for example, it is not required to amend a motion in order to move to limit debate). Votes are taken, starting from those higher on the list toward those lower on the list, until a complete disposition has been made of the matter at hand. It is not uncommon to move up the list in making motions, then to move partway down the list in voting, and again to repeat the procedure before completely disposing of the matter at hand.

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<tr>
<th>Type of Motion</th>
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<th>Vote Required</th>
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<td>10) Table</td>
<td>No</td>
<td>No</td>
<td>2/3*</td>
</tr>
<tr>
<td>9) Vote Immediately</td>
<td>No</td>
<td>No</td>
<td>2/3*</td>
</tr>
<tr>
<td>8) Limit Debate</td>
<td>Limited</td>
<td>Limited</td>
<td>2/3</td>
</tr>
<tr>
<td>7) Postpone Definitely</td>
<td>Limited</td>
<td>Limited</td>
<td>Majority</td>
</tr>
<tr>
<td>6) Refer to the Committee on Ethics, Grievances, and Prof Standards</td>
<td>Limited</td>
<td>Limited</td>
<td>Majority</td>
</tr>
<tr>
<td>5) Refer for Decision</td>
<td>Limited</td>
<td>Limited</td>
<td>Majority</td>
</tr>
<tr>
<td>4) Refer</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>3) Amend: Second Order</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
</tr>
<tr>
<td>2) Amend</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
</tr>
<tr>
<td>1) Main Motion</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
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*Not debatable
### Reference Committee A — Public Health

#### Hearing Order

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<td>Opposition to “Concealed Carry Reciprocity”</td>
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Whereas, The Massachusetts Medical Society (MMS) strategic priorities for 2017–2020 include promoting the integration of public health, behavioral health, and the social determinants of health; and

Whereas, The MMS strategic priorities for 2017–2018 include ensuring the Society is a productive and credible voice for physicians and patients at the state and federal level...” and providing “a leadership voice through its advocacy, collaboration, and public health efforts...; and

Whereas, The MMS has an extensive history of promoting public health through accident and violence prevention addressing varied public health concerns from helmets and mouth guards to impaired driving and firearm violence reduction; and

Whereas, The MMS currently supports the following two firearm safety policies, “reducing the number of deaths, disabilities, and injuries attributable to guns” and “encouraging health care providers to review gun safety as a routine component of preventive care”;¹ and

Whereas, The MMS already supports the prohibition of firearm ownership by convicted felons and spouse and child abusers (Amended and Reaffirmed MMS House of Delegates, 5/19/12); and

Whereas, The Commonwealth’s strong gun safety laws have yielded significant results,² including a gun-related mortality of 3.4 per 100,000 compared to the national average of 11.8 per 100,000;³ and

¹Massachusetts Medical Society Policies, 2018
Whereas, Extreme Risk Protection Orders (ERPOs) are civil court orders issued by a judge after consideration of evidence from the petitions of various entities such as a family member, healthcare provider, or law enforcement officer. ERPOs are a formal legal process to temporarily withdraw an individual’s access to firearms and ammunition if the court determines that the individual poses a danger to themselves or others. ERPO laws provide liability protections to those who choose not to pursue an ERPO; and

Whereas, ERPOs have been implemented in some form in 5 states (Connecticut, Indiana, California, Oregon, and Washington), while 30 other states are considering such bills in a national effort; and

Whereas, In Connecticut, for every 10–20 firearm interventions, 1 life has been saved; and

Whereas, In the Commonwealth, The Duty to Warn Law poses a legal obligation of a clinician (specifically mental health professionals) to take reasonable precautions such as disclosure of information about an individual if there is an explicit threat to kill or inflict serious bodily injury upon reasonably identified persons and the individual has apparent intent and ability to implement the threat. It is incumbent on a clinician to balance ethical responsibility to protect their patient confidentiality with a legal obligation of reporting threats and harm reduction; and

Whereas, Currently, in the Commonwealth, there is no statute in place for ERPOs. Local police chiefs have the authority to suspend or repeal an individual’s gun permit, but not previously purchased guns. No law exists at this time that imparts due process for the suspension of an individual’s permit; rather, the determination is based solely on the authority of the local police chief, with significant variation across the Commonwealth; and

Whereas, ERPO legislation offers a solution to provide due process and a coordinated court proceeding, similar to that of the restraining order process in Massachusetts, that can serve to ensure the rights of the patient when a report has been made of a threat of violence; and
Whereas, Two Extreme Risk Protection Order bills are pending favorable report from the Massachusetts Joint Committee on the Judiciary\textsuperscript{14,15}; therefore, be it

1. RESOLVED, That the MMS advocate to appropriate State and Federal policymakers for Extreme Risk Protection Order policies that establish a civil-court mediated due process by which access to and purchase of firearms may be temporarily withheld from individuals who are deemed an imminent danger to themselves or others; and, be it further (D)

2. RESOLVED, That the MMS advocate for Extreme Risk Protection Order preventive procedures (that establish a civil-court mediated due process by which access to and purchase of firearms may be temporarily withheld from individuals who are deemed an imminent danger to themselves or others) that do not alter the current legal liability and standard by which health care providers are required to report if a person is an imminent danger to themselves or others, thereby preserving current provider-patient relationship expectations. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

\textsuperscript{14} MA Bill H. 3081, 2018, \url{https://malegislature.gov/Bills/190/H3081}.
\textsuperscript{15} MA Bill H. 3610, 2018, \url{https://malegislature.gov/Bills/190/H3610}.
Whereas, An MMS strategic priority is to “Ensure that the Society is a productive and credible voice for physicians and patients at the state and federal level, as well as local and national health care organizations” and to “provide a leadership voice through its advocacy, collaboration, and public health efforts”; and

Whereas, The MMS has the following relevant policy which pledges to reduce gun violence and supports this topic:

**Handguns**

*Public Policy*

1. The Massachusetts Medical Society supports the continued prohibiting of handgun sales to or transport by persons under the age of 21.

2. The Massachusetts Medical Society supports penalties for adults who leave guns accessible to children under the age of 18.

**Education**

1. The Massachusetts Medical Society supports the education of physicians about the epidemic of gun violence in all its forms and will work with local agencies and organizations who share goals of eliminating or reducing violence through education and comprehensive regulatory and legislative measures.

3. The Massachusetts Medical Society supports efforts to educate licensed firearms dealers on the health implications of firearm injuries and violence.

**Collaboration**

9. The Massachusetts Medical Society supports adding two new categories of prohibited buyers — spouse and child abusers.

10. The Massachusetts Medical Society supports prohibiting handgun possession by persons under the age of 18.

Reaffirmed MMS House of Delegates, 5/14/04

(Items 1, 3, 4, Education) Amended and Reaffirmed MMS House of Delegates, 5/21/11

(Item 1, Public Policy) Amended and Reaffirmed MMS House of Delegates, 5/19/12

(Item 2, Education) Amended and Reaffirmed MMS House of Delegates, 5/19/12

; and
Whereas, Gun violence is a major public health problem, resulting in over 200 deaths annually from intentional homicides and suicides in MA;¹ and

Whereas, Nationally among children and youth under 19 in 2015, more than 70 percent of all homicide deaths and over 40 percent of suicide deaths were the result of a firearm, and most firearm-related injuries and deaths of children and adolescents involve a handgun;² and

Whereas, The rate of gun deaths and injuries in MA and other states with strict licensing regulations and background check requirements is lower than that of states with lax rules. In fact, Massachusetts has the lowest rate of gun-related deaths in the country at 3.4 deaths per 100,000 population in 2016 according to the CDC;³ and

Whereas, Federal legislation to permit “concealed carry reciprocity” across state lines would lower standards across the country to the lowest common denominator by requiring all states to recognize concealed carry permits granted by other states and by allowing citizens with concealed carry permits in one state to carry guns into states that have stricter laws;⁴ and

Whereas, Attorneys General from 16 states and the District of Columbia as well as law enforcement officials across the nation have opposed “concealed carry reciprocity” because of the danger it poses to law enforcement agents, to victims of domestic violence, and to the public;⁵,⁶ and

Whereas, Twelve states have no requirements for background checks, firearms training, or a proven need to carry a weapon⁷ and, according to the Guns to Carry website, 14 states allow “permitless carry”;⁸ and

Whereas, MMS policy supports universal licensing requirements and background checks for firearm sales and encourages the AMA to support the same;⁹ and

Whereas, The MMS has committed to work to diminish gun violence in the US; therefore, be it

1. RESOLVED, That the MMS opposes all forms of “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry permits granted by other states and allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws; and, be it further (D)

2. RESOLVED, That the MMS, in the interest of safety for all citizens, encourage the AMA to oppose “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry permits granted by other states and allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 3  
Code: Resolution A-18 A-103  
Title: Opposition to the Criminalization of Self-Induced Abortion  
Sponsors: Rebekah Rollston, MD, MPH  
Wayne Altman, MD  
James Broadhurst, MD, MHA  

Referred to: Reference Committee A  
Marian Craighill, MD, MPH, Chair

Whereas, MMS strategic priorities include a leadership voice in patient advocacy and addressing barriers that impede access to quality care; and

Whereas, The MMS and the AMA have the following policies on this topic:

ABORTION
The Massachusetts Medical Society adopts the AMA Policy on abortion which reads:

The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.


Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state and (2) Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

AMA: Reaffirmed I-96, Reaffirmed: A-97 Reaffirmed I-00, Reaffirmed I-96, Reaffirmed A-97 Reaffirmed I-00,  
MMS Council, 10/11/89  
Reaffirmed MMS House of Delegates, 5/7/99  
Reaffirmed MMS House of Delegates, 5/12/06  
Reaffirmed MMS House of Delegates, 5/11/13

; and

Whereas, Barriers to abortion care are widespread and multifactorial, including but not limited to: lack of access to clinics or providers, limited clinic capacity, the need for multiple appointments, state-imposed waiting periods, lack of insurance coverage, cost, gestational age limits, parental notification laws, stigma, and misinformation;¹ and

Whereas, Anti-abortion protesters employ tactics to intimidate, shame, and violate the privacy of women who present for reproductive health services, which further inhibits access to care;² and

Whereas, From the beginning of 2011 through July 2016, states enacted 334 new legal restrictions on abortion, further limiting access to abortion care. In 2018 alone, 695 provisions have already been introduced to further restrict abortion;³ and

Whereas, These barriers are some of the many factors that cause patients to consider self-induced abortion. In 2015, there were more than 700,000 google searches for information regarding self-induced abortion in the United States, suggesting that many patients consider this option. National studies of abortion patients have shown that approximately 2% of patients attempted to self-induce an abortion at some point in their lives. That number is higher in states such as Texas with stricter legal restrictions on abortion, where one study showed that 7% of patients attempted some method to end their pregnancy before presenting to the clinic;⁴ and

Whereas, Laws criminalizing self-induced abortion increase health risks and deter patients from seeking necessary health care services related to self-induced abortion or miscarriage;⁵ and

Whereas, Laws criminalizing patients who self-induce abortion lead to increased suspicion towards patients presenting to health care providers for miscarriage;⁶ and

Whereas, People of color are disproportionately targeted for prosecution and criminalization related to pregnancy outcomes;⁷ and

Whereas, The effect of a criminal record resulting from such criminalization of self-induced abortion can limit employment opportunities for women and therefore economic self-sustainability;⁸ and

Whereas, The Academy of Obstetricians and Gynecologists (ACOG) has taken a very strong position that patients should not be prosecuted for trying to end their own pregnancies and opposes forcing physicians to share information about patients due to its burdensome interference in the patient-provider relationship;⁹ and

Whereas, The ability and willingness to access medical care if complications relating to self-induced abortion arise is essential for patient safety;¹⁰ and

³ https://www.guttmacher.org/united-states/abortion.
⁶ Ibid.
Whereas, The criminalization of self-induced abortion does not help to address underlying societal and public health issues, nor does it benefit women’s health\textsuperscript{11}; and

Whereas, The reproductive decision-making within the context of race, class, and income status is experienced uniquely by all women and, particularly, women of color who are more likely to be targeted for prosecution and investigation of self-induced abortion due to disproportionate law enforcement of African American communities in general, and

Whereas, Fear of prosecution and potential incarceration undermines public health endorsement of open communication with primary care providers as well as promotion of early feto-maternal care;\textsuperscript{12} therefore be it,

1. RESOLVED, That the MMS will advocate against any legislative efforts or laws in Massachusetts or federally to criminalize self-induced abortion; and, be it further (D)

2. RESOLVED, That the MMS encourage the MMS AMA Delegation to submit a resolution to the AMA stating that the AMA will advocate against any legislative efforts or laws to criminalize self-induced abortion. (HP)

Fiscal Note: No Significant Impact

(Out-of-Pocket Expenses)

FTE: Existing Staff

(Staff Effort to Complete Project)


Whereas, Involuntary civil commitment is defined by law as the commitment of a person who is ill, incompetent, drug-addicted, or the like, without the consent of the person being committed; and

Whereas, In response to the opioid crisis, the scope of these laws has rapidly expanded, as the number of states with such laws went from 18 in 1991 to 38 jurisdictions and counting;¹ and

Whereas, Existing data on both the short- and long-term outcomes following involuntary civil commitment for reasons related to substance-use disorder does not support its broad utilization,² including recent data suggesting coercive treatment puts patients at higher risk of fatal overdose;³ and

Whereas, Current Massachusetts state law⁴ authorizes the state to involuntarily civilly commit someone with an alcohol or substance-use disorder for up to 90 days; and

Whereas, The legal standards and procedures for involuntary civil commitment in Massachusetts are very broad and allow for the presiding judge to over-rule the clinical determination of the commitment’s appropriateness; and

Whereas, Massachusetts Governor Charlie Baker introduced “An Act Relative to Combatting Addiction, Accessing Treatment, Reducing Prescriptions, and Enhancing Prevention” (CARE Act),⁵ which proposes to expand involuntary civil commitment in Massachusetts to include a second, short-term civil commitment option without judicial involvement; and

Whereas, Involuntary civil commitment of persons for reasons related to substance-use disorder has already been implicated in a number of human rights abuses and suicides in Massachusetts;⁶ and

¹ http://www.namsdl.org/IssuesandEvents/NEW%20Involuntary%20Commitment%20for%20Individuals%20with%20a%20Substance%20Use%20Disorder%20or%20Alcoholism%20August%202016%2009092016.pdf
² http://jaapl.org/content/43/3/313.long
⁴ Section 35 of Massachusetts General Law chapter 123
Whereas, Some contend Governor Baker’s proposal is part of a misguided national trend to use involuntary civil commitment or other coercive treatment mechanisms to address the country’s opioid crisis; and

Whereas, Massachusetts’s own mandated evaluation of overdose data has found that people who were involuntarily committed were more than twice as likely to experience a fatal overdose as those who completed voluntary treatment;⁷ and

Whereas, MMS strategic priorities include providing a leadership voice through... advocacy, collaboration, and public health efforts and developing resources and tools on... opioid use, misuse, dependence and abuse; and

Whereas, The MMS has no policy on this topic; therefore, be it

1. RESOLVED, That the MMS advocate to limit the practice of involuntary civil commitment for reasons related to substance-use disorder in Massachusetts and nationally in furtherance of health, ethical, and patient rights imperatives; and, be it further (D)

2. RESOLVED, That the MMS oppose further expansions of authority to involuntarily civilly committed persons for reasons related to substance-use disorder in Massachusetts and nationally; and, be it further (D)

3. RESOLVED, That the MMS work to advance policy and programmatic efforts to address gaps in voluntary substance-use treatment services; and, be it further (D)

4. RESOLVED, That the MMS advocate that the American Medical Association work to limit, and oppose further expansions of authority in, the practice of involuntary civil commitment of persons for reasons related to substance-use disorder; and be it further (D)

5. RESOLVED, That the MMS advocate that the American Medical Association work to advance policy and programmatic efforts to address gaps in voluntary substance-use treatment services. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

Whereas, MMS strategic priorities are to provide a leadership voice through its advocacy, collaboration, and public health efforts and to work toward improved patient care and outcomes; and

Whereas, The MMS has no policy on this topic; and

Whereas, Under Massachusetts state law a judge may forcibly commit to treatment any person with reasons related to substance-use disorder who is deemed a danger to themselves or others;¹ and

Whereas, Massachusetts is the only state that places persons involuntarily civilly committed for reasons related to substance-use disorder into the care of the penal system;² and

Whereas, Massachusetts state law was amended in 2016 to require that women involuntarily civilly committed for reasons related to substance-use disorder be treated at facilities licensed by the state Department of Public Health or Department of Mental Health;³ and

Whereas, Current Massachusetts state law, adopted in 2016, reads “the person may be committed to: (i) a secure facility for women approved by the department of public health or the department of mental health, if a female; or (ii) the Massachusetts correctional institution at Bridgewater, if a male;” creating a clear difference in the settings of care extended to men and women; and

Whereas, The facility at Bridgewater has since been replaced for this use by the Massachusetts Alcohol and Substance Abuse Center (MASAC) at a minimum-security correctional facility at Plymouth run by the Department of Corrections; and

Whereas, The Boston Globe has described conditions at the Plymouth MASAC facility as “a mere jail,” and describes unsanitary conditions, poor treatment of mental health problems, and abusive corrections officers;⁴ and

¹ M.G.L ch.123 §35.
³ M.G.L ch.123 §35
⁴ Ibid Cramer and Freyer.
Whereas, One inmate suicide\textsuperscript{5} and multiple attempted suicides have been reported at the facility within its first half-year of operation; and

Whereas, The burden of requiring that the state Department of Public Health or the Department of Mental Health approve of specific facilities and treatment programs for persons involuntarily civilly committed for reasons related to substance-use disorder is a relatively small one; and

Whereas, Effective and humane treatment of persons involuntarily civilly committed for reasons related to substance-use disorder is of urgent importance in the current opioid crisis in Massachusetts; and

Whereas, The MMS, as the representative of physicians in Massachusetts, ought to play a role in shaping the treatment of persons with substance-use disorders in any facility in the state; therefore, be it

1. RESOLVED, That the MMS advocate that all persons involuntarily civilly committed in Massachusetts for reasons related to substance-use disorder be confined only in facilities monitored and approved of by the Department of Public Health or Department of Mental Health, and be subject only to treatment programs approved by the same; and, be it further (D)

2. RESOLVED, That the MMS advocate to the Department of Public Health and Department of Mental Health to standardize and increase the effectiveness and quality of the treatment of persons involuntarily civilly committed for reasons related to substance-use disorder, in accordance with the best evidence-based standards of care. (D)

Fiscal Note: No Significant Impact (Out-of-Pocket Expenses)

FTE: Existing Staff (Staff Effort to Complete Project)

Whereas, MMS strategic priorities include providing a leadership voice through... advocacy, collaboration, and public health efforts... and developing resources and tools on... opioid use, misuse, dependence, and abuse; and

Whereas, The MMS has as Our Mission..."to do all things as may be necessary and appropriate ...to promote medical institutions formed on liberal principles for the health, benefit and welfare of the citizens of the Commonwealth"; and

Whereas, Unintentional overdose deaths of American citizens caused by non-prescribed opioids in 2016 exceeded 60,000 as a result of the desired heroin being either laced with fentanyl or replaced entirely with fentanyl, a more powerful opioid than heroin; and

Whereas, Quality control is unknown in the “black market” so customers are at the mercy of dealers who themselves may be ignorant of the ingredients being sold as heroin; and

Whereas, Those addicted to heroin are afraid to come forward for treatment because they fear arrest for possession under current laws; and

Whereas, The numbers of deaths attributed to unintentional overdoses of opioids plummeted after Portugal decriminalized possession of opioids in 2001 and arranged for treatment options for those addicted;¹ and

Whereas, In order to justify full legalization one must establish clearly that every citizen currently has a right to use and possess dangerous yet legal substances which they might inhale, ingest, imbibe, snort, or inject, such as dangerous drugs often used in suicide attempts, e.g., acetaminophen (Tylenol), which is available without prescription in any pharmacy; tobacco smoked freely despite it being responsible for emphysema and causes deaths of hundreds of thousands of people each year in the US; and alcohol used widely, once prohibited by Constitutional Amendment, repealed 14 years later, and still responsible for tens of thousands of deaths annually in the US;² and

Whereas, It remains the position of the MMS that we do not recommend use of any
drugs which are potentially harmful, such as nicotine or opioids, for non-therapeutic
purposes; and

Whereas, Our advocacy of legalization should not be misconstrued as encouragement
for these drugs to be used recreationally. Instead we understand that users who avail
themselves of these drugs — opioids in particular — through the black market, risk that
they will receive stronger dosages or drugs laced with or replaced in full by far stronger
and more potent drugs such as fentanyl, which are known to cause respiratory
suppression and death; therefore, be it

1. RESOLVED, That the MMS advocate for the repeal of state laws that make
possession of small amounts of illicit opioids, such as heroin and fentanyl, a
criminal offense and instead urge public policy to promote the offering of
treatment options; and, be it further (D)

2. RESOLVED, That the MMS advocate to state and federal legislators to repeal
laws or regulations which prohibit the possession, distribution, or use of illicit
opioids, due to the lethality of these variable, unpredictable, unregulated
substances, such as fentanyl and heroin, bought in the black market. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Background

At I-06, the House of Delegates adopted the following policy, which was most recently reaffirmed at A-13:

**Capital Punishment**

The Massachusetts Medical Society adopts the American Medical Association Council on Ethical and Judicial Affairs Opinion E-2.06, “Capital Punishment,” adopted in June 2000, with the exclusion of the provision of the opinion regarding organ donation by prisoners, to read as follows:

An individual’s opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure, monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution: (1) testifying as to medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial,
testifying as to medical aspects of aggravating or mitigating circumstances during
the penalty phase of a capital case, or testifying as to medical diagnoses as they
relate to the legal assessment of competence for execution; (2) certifying death,
provided that the condemned has been declared dead by another person; (3)
witnessing an execution in a totally nonprofessional capacity; (4) witnessing an
execution at the specific voluntary request of the condemned person, provided
that the physician observes the execution in a nonprofessional capacity; and (5)
relieving the acute suffering of a condemned person while awaiting execution,
including providing tranquilizers at the specific voluntary request of the
condemned person to help relieve pain or anxiety in anticipation of the execution.

Physicians should not determine legal competence to be executed. A physician’s
medical opinion should be merely one aspect of the information taken into
account by a legal decision maker such as a judge or hearing officer. When a
condemned prisoner has been declared incompetent to be executed, physicians
should not treat the prisoner for the purpose of restoring competence unless a
commutation order is issued before treatment begins. The task of reevaluating
the prisoner should be performed by an independent physician examiner. If the
incompetent prisoner is undergoing extreme suffering as a result of psychosis or
any other illness, medical intervention intended to mitigate the level of suffering is
ethically permissible. No physician should be compelled to participate in the
process of establishing a prisoner’s competence or be involved with treatment of
an incompetent, condemned prisoner if such activity is contrary to the physician’s
personal beliefs. Under those circumstances, physicians should be permitted to
transfer care of the prisoner to another physician. (HP)

MMS House of Delegates, 11/04/06
Reaffirmed MMS House of Delegates, 5/11/13

Relevance to MMS Strategic Priorities
MMS’s Capital Punishment policy supports the MMS’s strategic priority on physician and
patient advocacy. Having policy that clearly defines physicians’ roles with regard to legal
executions allows the MMS to provide a leadership voice through its advocacy when the
issue arises at the state or national level.

Discussion
At A-14, the House of Delegates adopted OMSS Report A-14 A-103, Review of
Positions on Medical Ethics, which requires the MMS to monitor the statements related
to medical ethics adopted by the American Medical Association (AMA) and other
sources periodically, as events and circumstances demand.

As directed by OMSS Report A-14 A-103, Review of Positions on Medical Ethics, the
Committee on Ethics, Grievances, and Professional Standards (EGPS) monitors
statements related to medical ethics adopted by the AMA and other sources. On June
13, 2016, the AMA completed its first comprehensive update to the AMA Code of
Medical Ethics in more than 50 years. According to the AMA, this update was
undertaken to improve the code’s (1) relevance (by ensuring that the language applies to
contemporary medical practice), (2) clarity (by improving structure and formatting to
ensure that foundational ethical principles and specific physician responsibilities are
easy to find, read and apply), and (3) consistency (by consolidating related issues into a
single, comprehensive statement).
In 2006, the MMS adopted the CEJA Opinion E-2.06 *Capital Punishment*, with the exclusion of the provision of the opinion regarding organ donation by prisoners. The current version of the AMA’s Code of Medical Ethics includes an updated policy on Capital Punishment (CEJA Opinion 9.7.3). The updated CEJA Opinion adds language regarding the treatment of incompetent condemned prisoners, but is otherwise substantively similar to the opinion it replaced.

**Conclusion**
EGPS voted at its October 11, 2017, meeting to recommend adoption of the CEJA Opinion 9.7.3 *Capital Punishment*, with the exclusion of the provision of the opinion regarding organ donation by prisoners, to replace the MMS’s current policy on capital punishment.

**Recommendation:**
That the Massachusetts Medical Society adopt-in-lieu of the Capital Punishment policy adopted at I-13 and reaffirmed at A-13 the following:

The Massachusetts Medical Society adopts the American Medical Association Council on Ethical and Judicial Affairs Opinion E-9.7.3 *Capital Punishment*, adopted in 2016, with the exclusion of the provision of the opinion regarding organ donation by prisoners, to read as follows:

Debate over capital punishment has occurred for centuries and remains a volatile social, political, and legal issue. An individual’s opinion on capital punishment is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution.

Physician participation in execution is defined as actions that fall into one or more of the following categories:
(a) would directly cause the death of the condemned;
(b) would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; and
(c) could automatically cause an execution to be carried out on a condemned prisoner.

These actions include, but are not limited to:
(d) determining a prisoner’s competence to be executed. A physician’s medical opinion should be merely one aspect of the information taken into account by a legal decision maker, such as a judge or hearing officer;
(e) treating a condemned prisoner who has been declared incompetent to be executed for the purpose of restoring competence, unless a commutation order is issued before treatment begins. The task of re-evaluating the prisoner should be performed by an independent medical examiner;
(f) prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure;
(g) monitoring vital signs on site or remotely (including monitoring electrocardiograms);
(h) attending or observing an execution as a physician;
(i) rendering of technical advice regarding execution.
And, when the method of execution is lethal injection:

(j) selecting injection sites;
(k) starting intravenous lines as a port for a lethal injection device;
(l) prescribing, preparing, administering, or supervising injection drugs or their
doses or types;
(m) inspecting, testing, or maintaining lethal injection devices; and
(n) consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution:
(o) testifying as to the prisoner’s medical history and diagnoses or mental state as
they relate to competence to stand trial, testifying as to relevant medical evidence
during trial, testifying as to medical aspects of aggravating or mitigating
circumstances during the penalty phase of a capital case, or testifying as to
medical diagnoses as they relate to the legal assessment of competence for
execution;
(p) certifying death, provided that the condemned has been declared dead by
another person;
(q) witnessing an execution in a totally nonprofessional capacity;
(r) witnessing an execution at the specific voluntary request of the condemned
person, provided that the physician observes the execution in a nonprofessional
capacity;
(s) relieving the acute suffering of a condemned person while awaiting execution,
including providing tranquilizers at the specific voluntary request of the
condemned person to help relieve pain or anxiety in anticipation of the execution;
(t) providing medical intervention to mitigate suffering when an incompetent
prisoner is undergoing extreme suffering as a result of psychosis or any other
illness.

No physician should be compelled to participate in the process of establishing a
prisoner’s competence or be involved with treatment of an incompetent,
condemned prisoner if such activity is contrary to the physician’s personal
beliefs. Under those circumstances, physicians should be permitted to transfer
care of the prisoner to another physician.

(HP)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Whereas: The Massachusetts Medical Society (MMS) 2017–18 Strategic Priorities state that the MMS shall “Provide a leadership voice through its advocacy, collaboration, and public health efforts”; and

Whereas, Currently the MMS has no policy regarding the health impacts of neonicotinoids, a widely used pesticide in the United States; and

Whereas, American Medical Association (AMA) Policy states:

Pollution Control and Environmental Health H-135.996
Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in Pollution Control and Environmental Health H-135.996

; and

Whereas, According to the United States Geological Survey (the sole science agency for the Department of the US Interior), neonicotinoids, agricultural pesticides linked to the deaths of bee colonies and the most commonly used pesticides today on the American market, were developed in the 1990s to replace organophosphates;¹ and

Whereas, Neonicotinoids, chemically similar to nicotine bind to the nicotine acetylcholine receptor, leading to disorientation, paralysis, and death within a few hours in the target species;² and

Whereas, Since the acetylcholine receptor is found in many species, these chemicals are producing unintended health effects in non-target species;³⁴⁵ and

¹ Pesticide National Synthesis Project of National Water-Quality Assessment Program (USGS).
Whereas, Since neonicotinoids are used to treat seeds prior to planting; they infiltrate every part of the growing plant and fruit; importantly for humans. The pesticide residue cannot be washed away with water;\textsuperscript{6,7} and

Whereas, Because neonicotinoids are highly water soluble and only two percent of the pesticide is absorbed by crops, their use has led to widespread contamination of the soil, surface water, deep aquifers,\textsuperscript{7} and drinking water\textsuperscript{8} and persist in the environment both in Massachusetts and worldwide; and

Whereas, Neonicotinoids are found in 86 percent of US honey, as well as in fruits, vegetables, and infant formula, often at levels over the regulatory limit;\textsuperscript{9} and

Whereas, These neurotoxins are not selective for insects responsible for crop blights but also kill beneficial insects, such as honeybees, where the link to colony collapse disorder has now been decisively shown; and are leading to declines in other species such as bats, birds, and earthworms;\textsuperscript{10,345} and

Whereas, The $15 billion US agricultural sector depends on pollinators\textsuperscript{11}; insect pollination is integral to food security in the United States; bees are essential to the production of at least 90 commercially grown crops in North America and 87 of the leading 115 crops globally (35 percent of global food production);\textsuperscript{11} and

Whereas, The number of managed honeybee colonies has declined precipitously from 6 million colonies in 1947 to 2.5 million today; given the heavy dependence of certain crops on commercial pollination, reduced honeybee populations present an immense threat to domestic agriculture. This threat to pollinators, represents, implicitly, a threat to our food supply;\textsuperscript{11} and

Whereas, Because humans, birds, invertebrates, and fish are exposed through inhalation or ingestion via air, pollen, food, or water, the effects of these chemicals have implications for all species;\textsuperscript{12} and

\textsuperscript{10}“EPA: Neonicotinoid Pesticides Pose Serious Risks to Birds, Aquatic Life.” EcoWatch, 18 Dec. 2017
\textsuperscript{11}“Fact Sheet: The Economic Challenge Posed by Declining Pollinator Populations.” \textit{National Archives and Records Administration}, National Archives and Records Administration, 20 June 2014
\textsuperscript{12}Michelle L. Hladik, Dana W. Kolpin, Kathryn M. Kuivila, Widespread occurrence of neonicotinoid insecticides in streams in a high corn and soybean producing region, USA, Environmental Pollution, Volume 193, 2014, Pages 189-196, ISSN 0269-7491, \url{https://doi.org/10.1016/j.envpol.2014.06.033}. 
Whereas, Acute exposure in humans is reported to cause tremor, short term memory loss, slurred speech, and prolonged QT interval, among other side effects; and

Whereas, Because neonicotinoids are neurotoxins, there is concern that in humans this may translate to an increased risk of central nervous system disorders (i.e., Parkinson’s disease, Alzheimer’s disease, schizophrenia, and depression), alterations to the developing brain, and reproductive and developmental effects; and

Whereas, In addition to being neurotoxic, these persistent chemicals are endocrine disruptors and have been demonstrated to lead to hyperthyroidism in mouse models; and

Whereas, These chemicals are carcinogenic and mutagenic to mammalian cells; and hepatotoxic and hepatocarcinogenic in mice; and

Whereas, Neonicotinoids are associated with decreased fertility in animal models and with birth defects in humans; in the San Joaquin valley where these pesticides are used extensively, studies show an association with cardiac birth defects such as Tetralogy of Fallot; and

Whereas, Based on the body of scientific evidence, the European Commission banned three neonicotinoid insecticides in 2013 and expanded this ban to include all five neonicotinoids in January 2018; the European Food Safety Authority (EFSA) cited evidence that neonicotinoids “may adversely affect the development of neurons and brain structures associated with learning and memory”; and

Whereas, Other organizations advocating for a ban include the Canadian Association of Physicians for the Environment and the Registered Nurses of Ontario; and


17 Swenson TL. “Neonicotinoid Insecticide Metabolism and Mechanisms of Toxicity in Mammals.” University of California, Berkeley, UCB Libraries, Apr. 9, 2013.


Whereas, Quebec has recently imposed a ban on five common pesticides: atrazine, chlorpyrifos, and three neonicotinoids (clothianidin, imidacloprid, and thiamethoxam) (Feb 19, 2018); and

Whereas, Maryland is the first state in the US to adopt a ban on use of neonicotinoid pesticides (Jan 1, 2018); and

Whereas, Representatives Earl Blumenauer (OR-03) and Jim McGovern (MA-02) introduced the Saving America’s Pollinators Act in early 2018 to protect the health of critical pollinators, such as honeybees, and urges the EPA to fully investigate the effect of harmful pesticides on bees; therefore, be it

1. RESOLVED, That the MMS advocate for non-hazardous alternatives to neonicotinoids, such as those used in Europe since 2013, including but not limited to: biopesticides, integrated pest management, and eco-engineering; and, be it further (D)

2. RESOLVED, That the MMS advocate for passage of legislation in Massachusetts to regulate the use of neonicotinoids in Massachusetts due to the direct and indirect public health effects. (D)

Fiscal Note: No Significant Impact (Out-of-Pocket Expenses)

FTE: Existing Staff (Staff Effort to Complete Project)

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 9
Code: Resolution A-18 A-108
Title: Gaming Addiction Now a Mental Health Disorder
Sponsor: Ihor Bilyk, MD

Referred to: Reference Committee A
Marian Craighill, MD, MPH, Chair

Whereas, An MMS strategic priority is to work toward improved patient care and outcomes; and

Whereas, The MMS has no policy on the topic of gaming addiction or disorder; and

Whereas, The World Health Organization (WHO) is adding “gaming disorder” to the 11th edition of its International Classification of Diseases, known as ICD-11 (scheduled for publication in mid-2018); and

Whereas, The WHO defines gaming disorder as “a pattern of gaming behavior (‘digital-gaming’ or ‘video-gaming’) characterized by impaired control over gaming, increasing priority given to gaming over other activities to the extent that gaming takes precedence over other interests and daily activities, and continuation or escalation of gaming despite the occurrence of negative consequences”; 1 and

Whereas, A diagnosis of gaming disorder is based on behavior that causes “significant impairment in personal, family, social, educational, occupational, or other important areas of functioning and would normally have been evident for at least 12 months”; and

Whereas, Gaming disorder commonly affects the young and male population; adults may be affected as well and the disorder may occur in up to 15% of the general population.2 Gaming disorder can cause significant harm to people’s lives and may include social isolation, poor sleep habits, a decline in school grades, or dropping out of school entirely, with possible overlap with attention deficit disorder, anxiety, and depression;3 and

Whereas, Sometimes when the pathological addictive state of gaming disorder may be difficult to differentiate from somewhat excessive but otherwise normal recreational activity of gaming, a mental health professional or a specialist in addiction psychiatry may need to be consulted for proper diagnosis; therefore, be it

1. RESOLVED, That the MMS will advocate and educate regarding the adverse public health effects of gaming disorder as a service to our legislators and other parties interested in objective and factual data; and, be it further (D)

1 www.who.int/features/qa/gaming-disorder/en
3 Ibid.
2. RESOLVED, That the MMS encourage physicians to advise their patients and parents of their patients of the addictive potential of gaming; and, be it further (D)

3. RESOLVED, That the MMS encourage physicians to advise specific prevention measures that parents can use for their children, which may include monitoring what and how much their children play video games, keeping the gaming activity in a public place to allow better control, setting up rules, and limiting where gaming devices are kept and the times they are used (for example, no gaming two hours before bedtime and only after chores and homework are done). (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Whereas, An MMS strategic priority is to work toward improved patient care and outcomes; and

Whereas, The MMS has a general policy on child abuse, sexual harassment/misconduct, and sexual assault (see appendix), but it does not address the specific situation of child abuse occurring within the fashion industry; and

Whereas, Sexual exploitation and abuse of men and women of all ages in many industries have been recently reported on a frequent basis in the news; and

Whereas, There have been many instances of abuse and exploitation of children of both sexes under 18 years of age as expressed by the victims within the fashion industry as described in a recent article in the *Boston Globe*;¹ and

Whereas, A sampling of some of the repulsive behaviors include the following: groping and fondling of the models by the photographer; a photographer masturbating in front of a model while threatening to ruin their family if they told anyone; agents providing drugs and alcohol to child models; withholding earnings and coercing models into sexual relationships as teenagers; failing to inform models that photo shoots would require nudity; encouraging models to sleep with photographers to advance their careers; models being sent to sets with known predators; sexual misconduct by agents, stylists, casting directors, and other industry professionals which include violations ranging from unwanted kissing to rape; and models being told not to tell anyone of their abuses because complaining about the perpetrator would hurt the model’s chances of making it big;² therefore, be it

1. RESOLVED, That the MMS will advocate to the AMA, requesting exploration of ways to increase the physicians’ and public’s awareness of the potential for child sexual exploitation and abuse within the fashion industry; and, be it further (D)

2. RESOLVED, That the MMS discuss with legislators about how to further study and possibly prevent the potential for child sexual exploitation and abuse within the fashion industry, as published in recent news outlets. In particular, issues that may be addressed with legislators may include the possibility of providing legal protections and reform of the youth-obsessed fashion industry to include basic safeguards such as private dressing rooms, if not currently


² Ibid.
available (so models don’t have to get naked in public); to require the presence of a parent/guardian and an additional non–industry-related adult on the set at all photo shoots, if not currently available (to prevent having the underage model alone in the room with a photographer or other industry professional); and to require having a work contract, if not currently available, to include a parent/guardian and the underage model that details exactly what type of photo shoot would be done and whether any nudity would be involved. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Appendix

CHILDREN
Abuse and Neglect
The Massachusetts Medical Society will continue to support initiatives to increase physicians', other health workers', and the public's knowledge of child abuse to improve education and training methods for the prevention, diagnosis, and treatment of child abuse; to promote development of evidence-based programs that continue to advance medical knowledge and competence in the control of this public health problem; and engage in collaborative work with professionals, especially in fields such as child welfare, law, social work, psychology, education, and religion in the management of child abuse. (HP)

MMS Council, 5/10/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/11/13

The Massachusetts Medical Society, in cooperation with the American Medical Association, various medical specialty societies, and other concerned health organizations, will take immediate initiatives: in increasing physicians', other health workers', and the public's awareness of the nature and extent of the child abuse problem; in improving education and training in the use of existing resources and methods for the prevention, diagnosis, and treatment of child abuse; in promoting the development of innovative programs to advance medical knowledge and competence in the control of this significant health problem; and in encouraging physicians to work with concerned community agencies and as essential components of child protection teams drawn from such fields as law, social work, psychology, and education and religion. (D)

MMS Council, 5/10/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/11/13

ETHICS
Sexual Harassment/Misconduct
The Massachusetts Medical Society unequivocally disapproves and rejects any and all forms of sexual harassment. (HP)

MMS Council, 5/10/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 11/4/06
Amended and Reaffirmed MMS House of Delegates, 5/11/13

Sexual Assault
The Massachusetts Medical Society (MMS) affirms its commitment to addressing and preventing sexual assault. (HP)

The MMS supports the development of physician educational programs and resources, as well as patient education materials, pertaining to sexual assault. (HP)

The MMS strongly encourages and facilitates the participation of physicians, physicians-in-training, and medical students in educational programs that address sexual assault. (HP)

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Items 2 and 3: Reaffirmed MMS House of Delegates, 5/17/14
Item 1 of 3: Amended and Reaffirmed MMS House of Delegates, 5/17/14
Background

“Infant mortality is the best indicator of the health and well-being of a community or state, because the same biological, social, economic, and environmental risk factors that contribute to infant health also affect the health of the broader population.”1 Although Massachusetts had the third lowest infant mortality rate in the country (3.9 deaths per thousand live births compared to a rate of 5.8 nationally as of 2016),2 this low rate is not equally distributed across counties. Low-income communities and communities of color tend to have much higher infant mortality rates with rates varying geographically according to the most recent data available (see Table 1).3

Table 1: Select Infant Mortality Rates in Massachusetts by City, 2014

<table>
<thead>
<tr>
<th>City</th>
<th>Infant Mortality Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts Overall</td>
<td>4.4 (2014 data)</td>
</tr>
<tr>
<td>Fitchburg</td>
<td>9.9</td>
</tr>
<tr>
<td>Chelsea</td>
<td>8.5</td>
</tr>
<tr>
<td>Worcester</td>
<td>7.4</td>
</tr>
</tbody>
</table>

*Infant Mortality Rate: Number of infant deaths per 1,000 live births

Source: Massachusetts Department of Public Health. 2017 State Health Assessment.

Findings in Table 2 demonstrate that rates of infant mortality among blacks were more than two times that of whites, while Hispanic infant mortality rates were 1.5 times higher than whites geographically according to the most recent data available.4

4 Ibid.
### Table 2: Select Infant Mortality Rates in Massachusetts by Race/Ethnicity, 2014

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Infant Mortality Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic Black</td>
<td>7.3</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>5.0</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>3.4</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>2.9</td>
</tr>
</tbody>
</table>

*Infant Mortality Rate: Number of infant deaths per 1,000 live births based on linked birth and death records.

Source: Massachusetts Department of Public Health. 2017 State Health Assessment.

One way to identify and help address the issue of unequal rates of fetal and infant death is via Fetal Infant Mortality Reviews (FIMRs), a public health multi-part process that supplements state birth records with detailed information from individual record reviews by medical professionals and in-home interviews with mothers about their experiences. “Currently there are 200 FIMR programs conducted in 40 states and have proven to be beneficial. For example, one FIMR program saw deaths of infants under four months of age from pertussis. That FIMR program responded by offering Tdap vaccines to family members of pregnant women to minimize potential exposure to pertussis.”

Currently the Massachusetts Department of Public Health oversees monitoring of fetal and infant deaths in the state using the following process:

- Death occurs
- Death certificates issued to local probate registrar
- No notification to local public health entities with the exception of Sudden Unexpected Infant Death (SUID) or Sudden Infant Death Syndrome (SIDS) currently occurs

The following steps are conducted in an FIMR process:

- Death occurs
- Massachusetts Dept. Public Health (DPH) notifies approved local public health departments within time period determined by DPH
  - Notification would include information determined by the DPH. Likely to be included are:
    - Hospital/location of death
    - Details of death
    - Mother’s identity and contact information
- Cases to be reviewed are identified
- Hospital charts reviewed to determine cause of death
- Mother is contacted and asked to be interviewed
- Case record created by combining medical information and mother’s interview

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7 Ibid.
• Clinical Review Team (CRT) reviews case record
  o for medical, system, and cultural opportunities for prevention and make recommendations
• Community Action Team (CAT) take community actions based on opportunities identified by CRT
• Ability to improved health outcomes

The National FIMR Program estimates costs to implement FIMR for local health organizations at $400–$700 per FIMR while infrastructure costs will vary based on current personnel at local public health entities.8

Although some hospitals conduct chart reviews on fetal and infant deaths in Massachusetts, no Massachusetts communities are conducting processes aligned with FIMR guidelines.9 Therefore, Massachusetts legislators have sponsored a bill, H.1219, An act to establish fetal and infant mortality review10, seeking to establish an FIMR in Massachusetts under the direction of the Massachusetts Department of Public Health (DPH). H.1219 would direct the DPH to notify local public health organizations of an infant’s death in a timely manner. The process is voluntary in that H.1219 authorizes, not requires, local public health to conduct FIMR should they desire. Passage of bill would require the DPH to establish a process and criteria for local public health entities to become “FIMR approved.” Approved communities would then have access to vital statistics data and other information, such as physician and hospital records, required for the FIMR process.

With the passage of the FIMR bill, the DPH would need to notify the local public health entity of all individual infant deaths in a timely manner. Without such notification it is often difficult for the local public health entities who wish to conduct FIMR to do so. Core to the FIMR review is the family member interview which is typically with the mother. This is a unique element to the review that brings voice to the personal experience of the death and provides important insights to uncover actionable opportunities to improve health outcomes.11

The Worcester Healthy Baby Collaborative, a volunteer group of community agencies and health care organizations working to reduce disparities in Worcester's infant mortality rate (IMR), described the important role an FIMR would serve in addressing health inequities associated with fetal and infant deaths in that city:

“Here in Worcester, where our volunteer public health physicians do real time chart reviews allowing us to be ahead of the state data, Worcester's IMR in the three-year period 2013–2015 is 5–6 per thousand live births with our Hispanic infant mortality above 10 per thousand live births in the same time period. We have struggled for over 20 years to consider the potential causes of the disparities in Worcester's IMR. We have always wanted more timely data and

8 Boston Public Health Commission. An Act to Establish Fetal Infant Mortality Review (FIMR) H.1219
9 Ibid.
more opportunity to dig deeper into the individual stories in a timely way that, if performed sensitively and professionally, will add richness to our understanding of the factors related to infant loss through the voices that comes directly from grieving families, not through the filter of medical chart audits.”

Boston embarked on an FIMR process twice in the past with short-term grant-funded programs. Although both ended with loss of funding and relied primarily on a review of burial permit applications no longer possible given changes in regulations, these efforts yielded useful insights. According to the Boston Public Health Commission, “Allowing Massachusetts communities to carry out FIMR processes in line with best practices will bring new insight, helping us lower the mortality rate in communities whose rates now exceed the state average.” The FIMR includes a community engagement process whereby the maternal voice and community voice are heard as well as a process where the social determinants of health are also considered.

Current MMS Policy
The MMS does not have current policy on the monitoring or review of infant mortality in the Commonwealth.

Relevance to MMS Strategic Priorities
An MMS strategic priority is physician and patient advocacy as the FIMR seeks to monitor the impact of the rapidly transforming health care landscape on Massachusetts physicians and patients. The MMS also seeks to improve patient care and outcomes. Lastly, the FIMR is important to the MMS’s priority to play a leadership role in developing a sustainable health care delivery system by promoting the integration of public health, behavioral health, and the social determinants of health across physician practices.

Discussion
The FIMR is important as it highlights the service gaps and system breakdowns that can occur in the areas of fetal and infant health while monitoring emerging birth outcome trends in an effort to proactively bring about system change and improve the quality of health care in the Commonwealth. Currently, no such mechanism or process is in place in Massachusetts. Without one, it is unlikely that the Commonwealth will be able to uncover and address the systemic causes and social determinants of health factors impacting unequal rates of fetal and infant death that vary by geography, race/ethnicity, and socioeconomic factors across Massachusetts.

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Conclusion
The Committee on Maternal and Perinatal Welfare (CMPW) supports the introduction of a timely, voluntary, systematic FIMR process for Massachusetts in order to address health inequities. To that end, the CMPW proposes the following recommendations.

Recommendations:
1. That the MMS supports the timely, voluntary, systematic monitoring of fetal and infant mortality in Massachusetts. *(HP)*

2. That the MMS will work with the appropriate stakeholders, regulators, and/or policymakers to advocate for the establishment of a timely, voluntary, systematic monitoring of fetal and infant mortality in Massachusetts. *(D)*

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Item #: 12
Title: Ensuring Oral Health as a Component of Accountable Care Organizations
Sponsors: Committee on Oral Health
Hugh Silk, MD, Chair
Michelle Dalal, MD

Referred to: Reference Committee A
Marian Craighill, MD, MPH, Chair

Background
Oral health is essential to overall health. While periodontal disease is largely preventable, it remains the most common chronic disease in the United States. As they do with physical and behavioral health services, all patients should also have access to patient-centered, integrated, and continuous quality oral health care.

Current Relevant MMS Policy
While the MMS has much policy on accountable care organizations (ACOs), the first listed below is the only one relevant to this report.

ACCOUNTABLE CARE ORGANIZATIONS
That the MMS adopts the principles concerning accountable care organizations (ACOs) adopted by the American Medical Association (AMA) at their 2010 Interim Meeting, with MMS amendments as follows:

1. Guiding Principle — The goal of an Accountable Care Organization (ACO) is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician’s primary ethical and professional obligation is the well-being and safety of the patient.

MMS House of Delegates, 5/19/12

PUBLIC HEALTH

Oral Health

The Massachusetts Medical Society will support efforts to make basic dental care accessible and affordable for all and available to homebound and nursing home patients as well as ambulatory patients. (D)

MMS House of Delegates, 5/7/16

Relevance to MMS Strategic Priorities

An MMS strategic priority is to play a leadership role in developing a sustainable model of health care delivery by promoting the integration of public health, behavioral health, and the social determinants of health across physician practices.

Further, a relevant MMS strategic priority is to provide a leadership voice through its advocacy, collaboration, and public health efforts, and will continue to carefully monitor the impact of the rapidly transforming health care landscape on Massachusetts physicians and patient.

Discussion

Data from current national and state health care reform efforts strongly suggest that integrating oral health into primary care delivery improves patient outcomes and lowers overall health care costs. In fact, evidence available from commercial insurers such as United Concordia and Kaiser Permanente have shown remarkable results, particularly for patients with chronic diseases, such as coronary heart disease and diabetes, who received dental treatment and maintenance.

The Medicaid program in Massachusetts, known as MassHealth, launched an ACO program on March 1, 2018, to restructure MassHealth to be more patient-centered, integrated, accountable, and value-driven over the next five years. This program presents a tremendous opportunity to elevate oral health through the health care system more broadly as well as improve the way that oral health care is financed and delivered. Importantly, an oral health quality measure has been approved by the Centers for Medicare and Medicaid Services (CMS) to be

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included in the ACO quality measure slate for which all 17 ACOs will be held accountable to meet during each year of the ACO program. The inclusion of this quality measure establishes a formal incentive for primary care providers in the ACOs to obtain training on oral health to better understand the oral health needs of their patients and to build structured bi-directional, closed-loop referral networks with community-based dental providers.

Conclusion

Integrating dental services back into the rest of the health care system incentivizes medical and dental providers to communicate with each other to provide effective care coordination in areas such as pain and/or chronic disease care management. Improving interprofessional collaboration encourages patients to seek community-based dental treatment to appropriately address their oral health needs without turning to hospital emergency departments and/or opioid use to manage dental pain.

Recommendations:

1. That the MMS collaborate with and advocate to appropriate stakeholders for comprehensive integration of oral health services into all Accountable Care Organization models in Massachusetts. (D)

2. That the MMS support the development of oral health quality metrics for Accountable Care Organization models. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

6 Ibid.
Background

One in 10 people in Massachusetts are food insecure\(^1\), which is defined as “a household-level economic and social condition of limited or uncertain access to adequate food.”\(^2\) The Massachusetts Medical Society (MMS) has consistently supported full funding for the Supplemental Nutrition Assistance Program (SNAP) and is on the Massachusetts Food is Medicine State Plan Initiative,\(^3\) which addresses food insecurity as a health issue and seeks to improve access to food and nutrition services. The MMS can further its commitment to this issue by adopting a food insecurity screening policy.

Current MMS Policy

The MMS has no policy on food insecurity screenings in clinical settings.

Relevance to MMS Strategic Priorities

MMS strategic priorities include physician and patient advocacy to improve patient care and outcomes, and sustainable health care delivery by integrating public health, behavioral health, and the social determinants of health across physician practices.

Discussion

Poor nutrition has been associated with negative health outcomes across age groups: children, adults, and seniors. Consumption of unhealthy foods, such as sweets and processed meats, is associated with weight gain and increased risk of diet-related chronic disease. Further, economical processed foods that are energy dense and nutrient poor can contribute to the double burden of malnutrition. Consumption of healthy foods, such as fruits and vegetables, is associated with weight reduction and decreased risk of diet-related chronic disease.\(^4,5,6\)

Food insecurity is associated with inadequate nutrition and is also associated with poor health in children, adults, and seniors. In adults, food insecurity is associated with

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increased risk for diseases and conditions like diabetes, hypertension, and depression. In children, food insecurity is associated with increased risk for impaired brain development, hospitalizations, iron-deficiency anemia, mental health and behavioral disorders. In children, food insecurity is associated with increased risk for impaired brain development, hospitalizations, iron-deficiency anemia, mental health and behavioral disorders. Food insecurity is also associated with great economic costs to the state of Massachusetts. A recent study conducted by Children’s Health Watch estimated the health-related costs of food insecurity and hunger in Massachusetts to be at least $2.4 billion in the year 2016. Despite its clinical significance, preliminary research indicates that routine screenings for food insecurity by health providers are as low as 12.7 percent in some areas. A validated and efficient food insecurity screening tool, the Hunger Vital Sign™, identifies individuals and families as being at risk for food insecurity if they answer that either or both of the following two statements is ‘often true’ or ‘sometimes true’ (vs. ‘never true’):

1. "Within the past 12 months we worried whether our food would run out before we got money to buy more."
2. "Within the past 12 months the food we bought just didn't last and we didn't have money to get more."

The significance of addressing food insecurity is supported by several medical organizations. For example, the American Medical Association (AMA) approved a program to support "improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity." Additionally, many other organizations support food insecurity screening and intervening, such as the American Academy of Pediatrics (AAP), which recommends screening for “food insecurity at scheduled health maintenance visits or sooner”\(^1\), the Nutrition and Obesity Network Policy Research and Evaluation (NOPREN), which created an algorithm for conducting food insecurity screenings on adults and recommends screening all adult patients at least once and screening high-

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risk patients annually, and Healthy People 2020, whose objectives include to “eliminate very low food security among children” and to “reduce household food insecurity and in doing so reduce hunger.”

Conclusion
Food insecurity presents a significant health and financial burden in Massachusetts. Physicians and health care providers can help address this problem by screening patients in health care settings and referring food insecure patients to appropriate resources.

Recommendations:
1. The MMS recommends routine food insecurity screening by health care providers using the Hunger Vital Sign™, a screening tool that can identify individuals and families as being at risk for food insecurity. (HP)
2. The MMS encourages health practices to adopt as policy screening all patients for food insecurity as a critical component of clinical care, especially in underserved communities. (HP)
3. The MMS will communicate its policy regarding support for routine food insecurity screenings in all clinical settings to appropriate Massachusetts organizations, including, but not limited to: the Massachusetts Public Health Association, Massachusetts Association of Health Boards, Massachusetts Board of Allied Health Professionals, Massachusetts Board of Nursing, Massachusetts Department of Public Health, Massachusetts Health Council, Massachusetts Health and Hospital Association, and the Massachusetts League of Community Health Centers. (HP)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 14
Title: Streamlining Human Immunodeficiency Virus Testing of Source Patients following an Occupational Exposure
Sponsors: Committee on Public Health
Steven Ringer, MD, Chair
Committee on Legislation
Theodore Callanos, MD, Chair
MA AMA Delegation
Alain Chaoui, MD, FAAFP, Chair
Organized Medical Staff Section
Frank Carbone Jr., MD, Chair

Report History: Resolution: A-17 A-103
Original Sponsors: Brandon Wojcik, MD, Jennifer Singleton, MD, and Resident and Fellow Section

Referred to: Reference Committee A
Marian Craighill, MD, MPH, Chair

Background
At A-17, the House of Delegates (HOD) referred Resolution A-17 A-103, Streamlining Human Immunodeficiency Virus Testing of Source Patients Following an Occupational Exposure, to the Board of Trustees (BOT) for report back with recommendations at A-18. The BOT referred items 1 and 2 to the Committee on Public Health in consultation with the Committee on Environmental and Occupational Health and Organized Medical Staff Section, and item 3 to the Committee on Legislation, MA AMA Delegation, and Organized Medical Staff Section. The resolution states the following:

1. That the MMS work with appropriate organizations to promote hospital adoption of admission and procedural consent documents that inform the patient that undisclosed HIV testing will be performed in the event of an occupational exposure and results will only be released with further counseling and written consent, with report back of hospital implementation at A-18. (D)

2. That the MMS supports HIV testing of a patient while maintaining privacy, but without mandated explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids. (HP)

3. That the MMS work with appropriate organizations, including the AMA, to draft and promote the adoption of legislation and hospital staff guidelines to allow HIV testing of a patient while maintaining privacy, but without mandated explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids with report back at A-18. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)
FTE: Existing Staff

(Staff Effort to Complete Project)

Reference Committee Testimony
At A-17, the reference committee recommended that this resolution/report be Referred for Report Back at A-18. The following is the reference committee’s rationale:

Your reference committee heard testimony both online and in person that was largely supportive of the concept of amending laws and policies to promote HIV testing upon exposure to protect the health of health care workers and patients. As testimony progressed, several fundamental questions were raised about this resolution indicating that, while incredibly important, this issue is more complex than it may first appear. Testimony raised legal and ethical questions such as how to handle HIV testing in the absence of patient consent, and about the variability of the 36 other state laws referenced in the resolution.

There remained confusion about the intent of “undisclosed HIV testing” in Resolved 1, leading to disparate interpretations about whether this implied a lack of disclosure to the patient, to the health care worker, or to the institution. Testimony also indicated substantial variability of relevant hospital policy in Massachusetts, indicating confusion even about settled Massachusetts laws. Additionally, testimony highlighted the need to protect patients who may be exposed by health care workers, and to expand the policy to all health care facilities and not just hospitals.

Ultimately, in recognizing the importance and complexity of this issue, your reference committee recommends that this resolution be referred to the Board of Trustees for report back at A-18.

Current MMS Policy
The MMS has the following policy:

Control of HIV in Healthcare Settings
The MMS encourages further research to assess the risk of HIV transmission from patients to physicians and other healthcare workers. The MMS will advocate for legislative/regulatory changes to ensure immediate testing of the source individual for human immunodeficiency virus (HIV) and hepatitis B and C viruses in any occupational setting (including but not limited to needle-stick injuries) where an exposure to blood or other potentially infectious material has occurred, and for the release of those test results to the exposed individual. (HP)

Screening and Testing Standards
The MMS approves of HIV screening/testing upon admission to a healthcare facility as deemed appropriate by the attending physician. Screening should be voluntary, such that the patient has the option to opt out of such screening or testing. Permission to screen or release information that HIV testing was performed or the results of such testing should not require separate written consent; general healthcare consent forms should incorporate consent to HIV screening and release of HIV-related information. Prevention counseling should not be part of such a screening/testing program. Positive HIV test results should be appropriately reported to the relevant public health agencies. (HP)

MMS House of Delegates, 11/4/06
Amended and Reaffirmed, 5/17/14
HIV/AIDS Reporting and Confidentiality

Information regarding an individual’s HIV serostatus or related information collected in accordance with public health surveillance must not be disclosed for other purposes. There must be uniform protection at all levels of government of the identity of those with HIV infection or disease. Information collected about an individual’s HIV status in the clinical setting should be used only for appropriate medical care.

MMS House of Delegates, 11/4/06
Amended and Reaffirmed, 5/17/14

Discrimination Based on HIV Seropositivity

(a) The MMS recognizes the continued discrimination against HIV-infected individuals and condemns any act and opposes any legislation of categorical discrimination based on an individual’s actual or presumed disease, including HIV infection. There should be vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV health status in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate based on disease.

MMS House of Delegates, 11/4/06
Amended and Reaffirmed, 5/17/14

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Amended and Reaffirmed MMS House of Delegates, 5/17/14

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MMS House of Delegates, 11/4/06
Amended and Reaffirmed MMS House of Delegates, 5/17/14

Relevance to MMS Strategic Priorities

The resolution relates to the MMS strategic priority of physician and patient advocacy: advocate to improve the physician practice environment and work toward improved patient care and outcomes.
Discussion
The Committee on Environmental and Occupational Health and the Committee on Public
Health reviewed MMS policy and Massachusetts Law related to HIV testing and informed
consent, the original resolution, and the reference committee report. Additionally, the
committee spoke with the sponsors of the original resolution, reviewed policies of the AMA
and other professional associations, and was in touch with the state department of public
health, hospital/health system attorneys, and patient advocacy organizations for input. The
Committee on Legislation, the MA AMA Delegation and the OMSS also discussed the
resolution.

The MA AMA Delegation met on September 5, 2017, and reviewed item #3 as directed.
“That the MMS work with appropriate organizations, including the AMA, to draft and promote
the adoption of legislation and hospital staff guidelines to allow HIV testing of a patient while
maintaining privacy, but without mandated explicit consent, where a health care worker has
been placed at risk by exposure to potentially infected body fluids with report back at A-18.”

Following a lengthy discussion, the delegation agreed that there is sufficient AMA policy and
a CEJA Opinion regarding this topic and voted for no further action.
Specific policies include: HIV/AIDS Reporting, Confidentiality, and Notification H-20.915 and
Code of Medical Ethics Opinion 8.1 specifically item (d).

MMS Government Relations staff continues to monitor relevant HIV laws in Massachusetts.

HIV in Massachusetts
There are an estimated 26–27,000 residents living with HIV/AIDS in Massachusetts,
including approximately 21,000 people with known HIV. Deaths in people with HIV/AIDS,
and progression of HIV infection to AIDS, have been declining significantly. New HIV
diagnoses decreased by about half from 2000 to 2014, which the state attributes to its
prevention and care infrastructure. Most infections result from sexual activity.¹

Occupational exposures in health care facilities
The risk of occupational exposure is relatively very low. The Massachusetts Department of
Public Health (MDPH) receives reports of every test indicative of HIV infection among
Massachusetts residents and follows up on all newly diagnosed infections. The last
occupational HIV infection the MDPH identified based on HIV reports in health care workers
and on direct reports from health care workers was in 1998, resulting from an injury from a
needle sticking out of a sharps container, with unknown source patient.

For HIV transmission to occur, the exposure must include both infectious body fluid and
percutaneous, mucous membrane, or cutaneous entry with non-intact skin. When the
source is HIV positive, percutaneous exposure have been shown to carry an average 0.23%
risk of transmission, mucous membrane 0.09%; cutaneous exposure with non-intact skin
0.09%.² Factors that might increase health care worker risk for HIV infection include
exposure to a larger quantity of blood from the source, for example, if a device was visibly
contaminated with the patient’s blood, and was placed directly in a vein or artery, or a deep
injury. Risk was also increased for exposure to blood from source persons with terminal

¹ Massachusetts Integrated HIV/AIDS Prevention and Care Plan. Massachusetts Department of
² PEP quick guide for occupational exposures. Published January 1, 2018.
http://nccc.ucsf.edu/clinical-resources/pep-resources/pep-quick-guide.
illness. The most recent study of health care worker percutaneous or mucotaneous
exposures to HIV, published in 2016, found 0% seroconversion.  

Approximately 3100 percutaneous injuries are reported by hospitals each year to the 
Massachusetts Sharps Injury Surveillance System (MSISS). After eight years of decline, the 
number of sharps injuries has remained steady since 2010. The most recent MSISS report 
suggests that many of these injuries may have been prevented with the use of available 
sharps injury prevention features (37%), improved training and product design (45%), 
improved disposal practices (49%), and safer work practices in operating and procedure 
rooms.  

The US Preventive Health Service Guidelines recommend occupational management of HIV 
risk through “(1) primary prevention of occupational exposures; prompt management of 
occupational exposures and, if indicated, initiation of PEP [post-exposure prophylaxis] as 
soon as possible after exposure; (3) selection of PEP regimens that have the fewest side 
effects and that are best tolerated by prophylaxis recipients; (4) anticipating and 
preemptively treating side effects commonly associated with taking antiretroviral drugs; (5) 
attention to potential interactions involving both drugs that could be included in HIV PEP 
regimens and other medications that PEP recipients might be taking; (6) consultation with 
experts on post-exposure management strategies (especially determining whether an 
exposure has actually occurred and selecting HIV PEP regimens, particularly when the 
source patient is antiretroviral treatment experienced); (7) HIV testing of source patients 
(without delaying PEP initiation in the exposed provider) using methods that produce rapid 
results; and (8) counseling and follow-up of exposed HCP.”  

Post-exposure prophylaxis (PEP) is generally recommended when an exposure is known to 
be HIV positive or at high risk of being HIV positive. However, in cases of unknown status, 
PEP is generally not warranted.  

Concerns have been noted that sources may test negative for HIV, but may be in a 
“window,” a period of weeks after infection but before detectable HIV antibodies develop, 
and should therefore still take PEP. However, according to the USPTF, no cases of 
occupational transmission have been reported in the United States when a source has

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3 Kuhar DT, Henderson DK, Struble KA, et al. Updated US Public Health Service guidelines for the 
management of occupational exposures to human immunodeficiency virus and recommendations for 
postexposure prophylaxis. *Infection Control and Hospital Epidemiology*. 2013; 34(9): 875–892. 
HIV contaminated body fluids: The University of Pittsburgh 13-year experience. *American Journal of 
5 Davis LK, DeMaria A. Sharps Injuries among Hospital Workers in Massachusetts (Rep). 
Massachusetts Sharps Injury Surveillance System. Massachusetts Department of Public Health. 
Published 2012.  
6 Kuhar DT, Henderson DK, Struble KA, et al. Updated US Public Health Service guidelines for the 
management of occupational exposures to human immunodeficiency virus and recommendations for 
postexposure prophylaxis. *Infection Control and Hospital Epidemiology*. 2013; 34(9): 875–892. 
7 PEP quick guide for occupational exposures. Published January 1, 2018. 
http://nccc.ucsf.edu/clinical-resources/pep-resources/pep-quick-guide.  
www.acep.org/Physician-Resources/Clinical/Hematologic/Post-Exposure-Prophylaxis-for-Bloodborne- 
Pathogens/#sm.0000s5ggbtzgfezes1v1xmb7rdu9l. Published June 2009.
tested negative during this window, and PEP is not recommended if the source tests negative.\(^9\)

Sharps exposures can be a distressing experience regardless of disease transmission occurring; counseling may be recommended for the exposed health care worker.\(^{10,11}\)

**Testing of patients for HIV**

Where HIV status is unknown, in addition to reducing anxiety and informing the need for PEP in the exposed individual if the source tests negative for HIV, HIV testing can benefit source patients. In 2013, the US Preventive Services Task Force issued recommendations for the screening of adolescents and adults aged 15 to 65 years for HIV infection, and for younger and older people who are at increased risk.\(^{12,13}\) For patients who do not know their HIV status, testing can lead to knowledge of status, and, if positive, referral to treatment.

Most source patients (estimated to be 95% or more) who are asked give consent to testing for HIV in the event of an occupational exposure. Communication strategies and best practices can be employed to increase the likelihood of a patient’s consent.

Other cases where consent cannot be obtained include an incapacitated or an unknown source patient. In cases where the patient is incapacitated and unable to give consent, a valid health care proxy may be invoked, or temporary guardianship may be sought to obtain consent.\(^{14}\)

In rare instances, source patients refuse to consent to be tested. A patient’s reasons for refusing consent to HIV testing may include fear, misinformation about HIV, mistrust in the medical community, cultural barriers, concerns about personal or relationship consequences, or fear of HIV status being recorded in health care or public health.\(^{15,16}\)

While some may feel HIV is no longer stigmatized in health care, and exceptional policies should not be employed, reports show stigma remains. Massachusetts advocacy groups and case managers indicate stigma and discrimination persist in the community and in health care; individuals with HIV have experienced negative consequences in the workplace, in housing, in health care, and in personal relationships. Nearly 8 in 10

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Americans being treated for HIV experience internalized stigma around HIV.\textsuperscript{17} Stigma associated with HIV can prevent individuals from receiving proper health care, reduce chances of beginning treatment, and be complicated with the compounded elements of stigma associated with substance use, mental health, or sexual orientation.\textsuperscript{18}

There are currently 35 states that have laws allowing for some kind of unconsented HIV testing following an occupational exposure.\textsuperscript{19}

The Massachusetts Department of Public Health does not support testing of patients without their knowledge of being tested and the result, and without consent. Patient advocates have historically opposed attempts at mandated testing, including of patients, health care workers, people who are arrested, and prisoners.

Historically, there has been strong opposition from the patient advocacy groups to weakening of Massachusetts laws to mandate testing without consent in the case of occupational exposures.

**Informed Consent in Massachusetts**

Massachusetts law requires informed consent prior to testing for HIV. There is a longstanding common law right in Massachusetts for patients to receive informed consent. A 1982 case in the Supreme Judicial Court in Massachusetts clarified, “A physician owes a duty to his patient to disclose in a reasonable manner all significant medical information that the physician possesses or reasonably should possess that is material to the patient’s informed judgment whether to give or withhold consent to a medical or surgical procedure, and the physician’s failure to make a disclosure constitutes professional misconduct.” Failure to provide informed consent can lead to malpractice liability in certain circumstances.

There are exceptions to this requirement to obtain informed consent, such as rendering emergency care to an incapacitated patient. In addition, there are balancing tests to determine which types of information are material and need to be required in the informed consent process. In fact, in the 1982 case, the Supreme Judicial Court added, “The patient’s right to know must be harmonized with the recognition that an undue burden should not be placed on the physician.”

Broadly speaking, there is no specific legal mandate about how informed consent must be obtained. For many simple procedures, simply having a conversation about the risks, benefits, alternatives, and a confirmation of consent is sufficient.

**Informed Consent for HIV Testing**

In Massachusetts, certain types of medical information require, by statute, specific mechanisms for obtaining informed consent. HIV testing has long been subject to exceptional laws regarding informed consent. For many years, Massachusetts required informed written consent for HIV testing and disclosure. However, in 2012, An Act Increasing Screening for HIV became law, as Chapter 84 of the Acts of 2012. The law now allows for verbal informed consent from the individual being tested.

The law states, “A facility, as defined in section 70E, physician or health care provider shall not (1) test any person for the presence of the HIV antibody or antigen without first obtaining


that person's verbal informed consent; (2) disclose the results of such test to any person other than the subject of the test without first obtaining the subject's written informed consent; or (3) identify the subject of such tests to any person without first obtaining the subject's written informed consent. A written consent form shall state the purpose for which the information is being requested and shall be distinguished from written consent for the release of any other medical information."

Currently, Massachusetts law permits a patient to provide verbal informed consent to be tested for HIV.

However, the confidentiality protections for disclosing the results of a person's HIV test and identifying a person as the subject of an HIV test remain the same, requiring written informed consent. The law clearly mandates written informed consent be obtained prior to disclosing the results of a person’s HIV test, or prior to identifying a person as a subject of an HIV test. Therefore, without written consent, the results of the source's test results could not be revealed to the exposed health care worker.

The same law later notes that a general consent to provide medical treatment that may be obtained upon presentation or admission to a hospital, for example, would not be sufficient to comply with the law. However, if such a form were amended to include a very specific, separate section to address HIV testing consent, this would be considered sufficient to comply with the law.

**Possible Changes to Massachusetts Law**

The first means by which Massachusetts law could be amended would be to strike the requirement that written informed consent be obtained prior to releasing results of HIV laws.

However, following discussions with different legal counsel at Massachusetts hospitals and health systems, if state law were amended to remove the requirement of separate written consent for HIV testing and disclosure, there would not necessarily be a change to the practical approach of hospitals and physicians who wish to perform an HIV test upon occupational exposure. Because of the highly charged history and sensitive nature of an HIV test, counsel indicated that it is likely that hospitals would continue to elect to obtain specific, likely written, informed consent about HIV testing upon occupational exposure. Ideally this language would be included in a form to be reviewed and signed by a patient at admission.

The second means by which Massachusetts could amend its laws would be to allow for the HIV testing of a patient without his or her consent. This approach, taken in various forms by dozens of other states, could allow for hospitals and physicians to avoid the process of obtaining informed consent. This approach raises a host of ethical concerns.

**Ethical issues**

This issue is a balance of the rights of an exposed health care provider, or anyone exposed to potentially infectious bodily fluids, to the information to best develop a post-exposure treatment plan his or her care with the autonomy and rights of the source patient to informed consent or refusal to procedures on his or her body, and to privacy and confidentiality of his or her medical information.

Informed consent is both an ethical and legal principle that is crucial to the physician-patient relationship.

Health care workers are not the only individuals who may be potentially exposed. Patients and visitors may be exposed to potentially infectious fluids from other patients or from their health care workers. The MMS and the AMA oppose the mandatory release of health care
workers HIV status, or other disease status, to patients, though some patient groups have advocated for this information. The concept of recommending a policy for the benefit of one category of people (health care workers) at the expense of another category of people (patients) appears self-serving and hypocritical.

Testing without the source patient’s consent creates further ethical and procedural dilemmas with regard to informing the source patient of test results, particularly in the case of positive test results.

Additionally, testing without informed consent jeopardizes the physician-patient relationship, and the credibility of the profession as an advocate for patients. The MMS’s Code of Ethics, reaffirmed in May 2016, states, in relevant part, “A physician shall, while caring for a patient, regard responsibility to the patient as paramount.”

Removing the requirement of informed consent will not solve all cases of unknown HIV status. The source may be unknown or may have left the premises at the time of the exposure. And individuals, such as janitorial staff, first responders, and the public, may exposed to HIV within and outside of the health care setting.

Conclusion
Exposure to potential blood-borne pathogens can cause anxiety and/or unnecessary treatment and associated side effects and personal consequences. Knowledge of the HIV status of the source of the exposure can help reduce anxiety and inform treatment options. The committees recommend all efforts to support the exposed individual medically and emotionally, without compromising the principles of informed consent or the primacy of the physician’s responsibility to the patient.

Although sharps exposures in health care facilities are fairly common, the risk of contracting HIV from these exposures is low, with no known cases occurring from such an exposure in Massachusetts since 1998. Testing for HIV holds benefit for the source patient as well as the exposed worker. In nearly all cases, patients provide consent to testing; in rare cases patients refuse to provide consent. There are processes for obtaining consent from incapacitated patients, and communication and admissions strategies to increase the likelihood of obtaining consent from autonomous patients. Post-exposure prophylaxis started early is very effective. While PEP has significant side effects, it is generally recommended when the source’s HIV seropositivity is unknown if the source is at high risk.

Testing for and disclosure of HIV status without informed consent is illegal in Massachusetts. In the political climate in Massachusetts, an effort to change the state law is unlikely to succeed. Efforts to advocate for the rights of the health care worker over the rights of the patient may risk the MMS’s credibility among members and the public.

The mandatory testing of a patient in the absence of the patient’s prior informed consent, or contrary to the patient’s expressed wishes, runs counter to legal standards in Massachusetts, and puts physicians and facilities at risk for legal action.

More importantly, informed consent is a critical principle of medical care and of the primacy of the physician-patient relationship, which the MMS holds sacrosanct. Testing without informed consent, particularly for the benefit of someone other than the patient, contrary to the ethical principles medicine. As stated in the MMS’s Code of Ethics, a physician’s responsibility to the patient is the physician’s paramount responsibility.

The committees would encourage that health care providers promote awareness of the benefits of HIV testing and encourage testing for HIV during routine patient visits; that health care facilities and agencies adopt policies and procedures in compliance with
Massachusetts law to facilitate informed consent to HIV testing in the event of an occupational exposure, and to prevent stigma for health care workers and patients related to HIV; that hospitals’ standard admission patient consent forms include a separate written consent to testing for HIV in the event of that of a sharps or other high-risk exposure by a hospital employee, and clearly state that the patient has the right to refuse or revoke permission at any time, and that such refusal or revocation will not jeopardize other aspects of care; that following source testing after an occupational exposure, the physician who ordered the test inform the source patient of the test result, and patients testing positive for HIV will be counseled by a knowledgeable nurse or physician; and that provisions be made for contacting source patients whose test results become available after discharge; that health care facilities make information and support available to health care workers about the risks, procedures, and available support available following occupational exposures to potentially infected bodily fluids; that health care facilities employ primary prevention strategies to prevent exposure from sharps; and that acute care hospitals report sharps injuries to the Massachusetts Sharps Injury Surveillance System.

In discussing these issues and principles internally, and with hospital representatives, patient advocacy groups, and others whom MMS policy might impact, the Committee on Public Health (CPH) recognized the many ethical and legal issues involved, and struggled to make recommendations that are practicable and without unintended negative consequences. The CPH will continue to work on this issue and monitor Massachusetts legislation.

The Organized Medical Staff Section understands and supports the CPH’s investigation and well-crafted report. The CPH and COL will continue to work with appropriate entities related to HIV testing laws and policies for the protection and benefit of Massachusetts health care workers and patients. The OMSS will continue to monitor these initiatives and provide input as needed.

Recommendation:

That the Massachusetts Medical Society not adopt Resolution A-17 A-103 which reads as follows:

1. That the MMS work with appropriate organizations to promote hospital adoption of admission and procedural consent documents that inform the patient that undisclosed HIV testing will be performed in the event of an occupational exposure and results will only be released with further counseling and written consent, with report back of hospital implementation at A-18. (D)

2. That the MMS support HIV testing of a patient while maintaining privacy, but without mandated explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids. (HP)

3. That the MMS work with appropriate organizations, including the AMA, to draft and promote the adoption of legislation and hospital staff guidelines to allow HIV testing of a patient while maintaining privacy, but without mandated explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids with report back at A-18. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
### Reference Committee B — Health Care Delivery

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MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 14
Code: Resolution A-18 B-201
Title: Massachusetts Should Look toward Ending Its Determination of Need (DON) Laws
Sponsors: Raj Devarajan, MD
Massachusetts Gastroenterology Association
Jaya Agrawal, MD, President

Referred to: Reference Committee B
Nicolas Argy, MD, JD, Chair

Whereas, The MMS strategic priorities include improving health care quality, access, and equity for patients, while delivering cost-effective care and promoting a sound public health system; and

Whereas, Current MMS policy on physician-controlled facilities states:

**Physician-Controlled Offices, Ambulatory Surgery Centers, and Free-Standing Imaging Centers**
The MMS will advocate to prevent hospital-based networks from using their market and contracting power to drive patients away from, disadvantage, or otherwise impede, physician-owned in-office and free-standing ancillary services, and the resultant unfair inducement of referrals to hospital-owned outpatient ancillary services. *(D)*

*MMS House of Delegates, 12/5/15*

The MMS will advocate for modification of the DON-related provisions of Massachusetts law and regulation in ways that will remove statutory impediments to the ability of physician-controlled offices, ambulatory surgery centers, and free-standing imaging centers to compete on the basis of cost and quality for the benefit of patients, physicians, and the health system as a whole. *(D)*

*MMS House of Delegates, 12/1/12*

Whereas, Currently the MMS policy to modify DON; it has no policy on repealing the MA Determination of Need (DON) laws; and

Whereas, Many DON laws were initially put into effect as the federal Health Planning Resources Development Act of 1974. This act was aimed at controlling health care price inflation. The federal mandate was repealed in 1987. As of this writing, 34 states currently maintain some form of DON or CON (Certificate of Need) program;¹ and

Whereas, DON laws were enacted in the belief that they would achieve the following goals:

- Ensure an adequate supply of health resources
- Ensure access to care in rural communities
- Ensure an increase in health care quality

Ensure availability of charity care to those unable to pay
Encourage the use of Ambulatory Surgery Centers
Contain the cost of care;¹

Whereas, Forty years of academic research along with studies done at the Mercatus Center at George Mason University suggest that such laws have failed to achieve the set goals and in many cases led to the opposite of what was intended;³ and (Matthew D. Mitchell, 2016)

Whereas, According to studies at the Mercatus Center per capita health care spending patterns in Massachusetts without DON would decrease by $320. Hospitals, ambulatory surgical centers, and rural hospital access would increase if Massachusetts repealed its DON laws. DON programs are associated with lower utilization rates for medical imaging technologies as well as a correlation with more out-of-country travel for imaging services;⁴ and

Whereas, Research finds the quality of hospital care in CON/DON states is not systematically higher than the quality in non–CON/DON states. It cites mortality rates for pneumonia, heart failure, and heart attacks, as well as deaths due to complications following surgery, are statistically higher in hospitals in states with at least one CON/DON regulation;⁵ and

Whereas, Massachusetts is one of 32 states with four or more CON/DON restrictions. Research shows that states with four or more CON/DON laws have systematically lower quality hospitals than non–CON/DON states;⁶ and

Whereas, Matthew Glans, senior policy analyst with the Heartland Institute, said that repealing CON/DON laws would lower the cost of health care services benefiting both patients and smaller health care providers;⁷ and

Whereas, Data from the Kaiser Family Foundation shows health care costs were 11 percent higher in states with CON/DON laws compared to states without CON/DON laws;⁸ and

Whereas, Christopher Koopman, senior research fellow at the Mercatus Center, states that data consistently shows CON/DON laws do not increase quality, or access, or drive the cost control that their proponents claim they do;⁹ and

Whereas, Koopman goes on to state, “There is great momentum towards drastically reforming, if not repealing, state CON laws. In the last legislative session, two dozen states introduced some CON reforms — some more drastic than others. North and

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¹ www.mercatus.org/publication/40-years-certificate-need-laws-across-america
² Ibid.
³ www.mercatus.org/system/files/massachusetts_state_profile.pdf
⁴ www.mercatus.org/conlaws/massachusetts
⁵ Ibid.
⁶ www.hfma.org/content.aspx?id=52833
⁷ www.heartland.org/publications-resources/publications/research-commentary-iowa-looks-to-end-certificate-of-need-laws
⁸ www.mercatus.org/conlaws/massachusetts
South Carolina has pushed to reform or repeal its laws and Tennessee has made efforts in that direction as well\textsuperscript{10} and

Whereas, In January Florida Governor Rick Scott announced he wanted to fight to make the health care system fair for families and ensure health care works for patients and not for the hospital's bottom line. He will put forth legislation that will act to repeal the Florida CON program\textsuperscript{11} and

Whereas, Iowa is also looking to eliminate the CON process in the development of a new or changed institutional health service\textsuperscript{12} and

Whereas, Institute for Healthcare Improvement has put forth the concept of the "triple aim" to guide reform efforts in health care:

\begin{itemize}
  \item Improving the patient experience of care (including quality and satisfaction)
  \item Improving the health of populations
  \item Reducing the per capita cost of health care; therefore, be it
\end{itemize}

1. RESOLVED, That the MMS favors repeal of the Determination of Need (DON) law in Massachusetts in order to further the goals of health care reform; and, be it further \textit{(HP)}

2. RESOLVED, That the MMS work to incorporate repeal of DON into its advocacy agenda with a report to the HOD on its progress at A-19. \textit{(D)}

\textbf{Fiscal Note:} No Significant Impact

\textbf{(Out-of-Pocket Expenses)}

\textbf{FTE:} Existing Staff

\textbf{(Staff Effort to Complete Project)}

\textsuperscript{10} Ibid.
\textsuperscript{11} Ibid.
\textsuperscript{12} www.heartland.org/publications-resources/publications/research--commentary-iowa-looks-to-end-certificate-of-need-laws
Whereas, An MMS strategic priority is to promote transparency while addressing barriers impeding access to quality care; and

Whereas, The MMS currently has policy supporting ongoing efforts to provide patients with objective information on medications, their appropriate use, and their cost; and

Whereas, The MMS currently has policy stating that physicians should be continually educated in clinically appropriate, cost-effective prescribing, and should be encouraged to incorporate the information into their prescribing practices; and

Whereas, The MMS currently has policy advocating for prescription drug price transparency from pharmaceutical companies, pharmacy benefit managers, and health insurance companies; and

Whereas, The MMS has no policy advocating for prescription drug price transparency from retail pharmacies; and

Whereas, The AMA has relevant existing policy (see Appendix); and

Whereas, A large retail pharmacy recently decided they will no longer calculate an individual patient’s medication co-payment without first receiving a prescription, making it difficult to compare drug prices; and

Whereas, Barriers against prescription drug price transparency continue to limit the efficiency and effectiveness with which health care providers can support informed clinical and financial decision making for their patients; therefore, be it

1. RESOLVED, That the MMS include retail pharmacies in advocacy efforts supporting drug price transparency for health care providers and patients; and, be it further (D)

2. RESOLVED, That the MMS work with the AMA and any other relevant organizations to advocate for increased transparency of medication price and out-of-pocket costs for prescription medications at retail pharmacies; and, be it further (D)
3. RESOLVED, That the MMS encourage the AMA, insurance companies, retail pharmacies, and any other relevant organizations to create a national database accessible to health care providers and patients that lists medication price and after-insurance out-of-pocket costs for prescription medications. (D)

Fiscal Note: No Significant Impact

(Out-of-Pocket Expenses)

FTE: Existing Staff

(Staff Effort to Complete Project)
Relevant AMA Policy

Price Transparency D-155.987
1. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.

Price of Medicine H-110.991
1. Our AMA advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; and (3) opposes provisions in pharmacies’ contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient’s co-pay is higher than the drug’s cash price.

Pharmaceutical Costs H-110.987
1. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.

Prescription Drug Price and Cost Transparency D-110.988
1. Our AMA will continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment.

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
1. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
2. Our AMA supports measures that increase price transparency for generic prescription drugs.
EXECUTIVE SUMMARY

The MMS Committee on the Quality of Medical Practice (CQMP) whole heartedly supports the use of Patient Reported Outcome Measures (PROMs) as quality improvement tools that can improve care delivery as well as enhance patient engagement. Patient Reported Outcomes (PRO) are directly reported by the patient without interpretation of the patient’s response by a clinician or anyone else and pertains to the patient’s health, quality of life, or functional status associated with health care or treatment. Patients are provided a validated questionnaire that can turn a symptom into a numerical score. While being a powerful new tool to measure quality, PROMS are still being validated and risk-adjusted for many clinical, social and demographic factors — processes that could take years to complete.

Knowing this, the MMS CQMP does not support the use of Patient-Reported Outcome Measures for quality incentive payments and instead advocates for leaving them in the quality improvement domain until they mature. Payment to providers by health plans and other organizations to implement and perform PROMs will help expedite their implementation, use, and maturation as a quality tool.

The CQMP has drafted this report and 13 working principles for discussion and advocacy purposes.

This report is divided into the following topics:

1) Introduction (Page 86)
2) Current Clinical Performance Measures (Page 86)
3) The Promise of PROMs (Page 87)
4) PROMs and the Triple Aim (Page 87)
5) Payer Perspective on PROMs (Page 88)
6) PROMs Abroad (Page 88)
7) PROMs at Home: BCBS (Page 89)
8) How to Select PROMs (Page 89)
9) Implementation of PROMs (Page 90)
10) Cost of Implementation (Page 91)
11) Barriers to Adopting PROMs (Page 91)
12) Unintended Consequences of Reimbursing PROMs (Page 91)
13) Feasibility of PROMs Implementation (Page 92)
14) Ongoing Challenges (Page 92)
15) Conclusion and Recommendation (Page 93-94)
1) Introduction
Changing market forces have placed a premium on "quality," causing a shift from fee-for-service reimbursement to value-based payment models. Under the 2015 Medicare Access and Children’s Health Insurance Program Reauthorization Act, providers will be evaluated on quality and cost efficiency and receive adjusted reimbursement for their performance. However, there is not much evidence that performance metrics and incentives have resulted in better health outcomes. Patient-reported outcome measures (PROMs) may fill this critical gap in the measure set for global budget contracts. PROMs are validated questionnaires that turn a symptom, or any other patient-reported outcome (PRO), into a numerical score. With PROMs, providers can use numbers to describe, for example, how much a knee replacement helps a patient walk. PROMs can help quantify symptoms, functional status, and mental health. Although current performance reimbursement metrics do not integrate PROMs, numerous clinicians are concerned with whether and how PROMs will play a part in value-based payment reform in the future. Their perspective is that PROMs as a quality improvement tool is supportable but tying reimbursements to the reported outcomes is not.

2) Current Clinical Performance Measures
Clinicians seek to provide better value in health care and want to define what constitutes a good outcome. Currently, there are many clinical performance measures, but they often miss this overarching goal. Most measures capture the process of care, such as drawing labs or starting medication. But, these measures fail to capture the reason that patients are seeking care — to improve their symptoms. Additionally, current outcome measures, such as mortality and hospital readmission, are important but are also multifactorial. These measures are not completely under the control of the provider. Many current outcomes measures vary little across providers and fail to differentiate between bad, good, and exceptional care. These measures focus on diagnoses rather

3 Jha. The Long-Term Effect of Premier Pay for Performance on Patient Outcomes. NEJM. 2012.
than quality across the spectrum of care. Measures that span the spectrum of care
report upon symptoms, patient experience, functional status, pain, well-being, daily
activities, mental health, and quality of life. Lastly, many areas of care, including
specialty, post-acute, and end-of-life, are not covered by these existing outcome
measures.7

3) The Promise of PROMs
The current era of health care is defined by accountability, measurement, control, and
risk bearing. Moving forward, professional pride needs to meet sensible payment so
there can be an increased focus on better quality clinical care.8 This quality can be
achieved by creating metrics most important to patients. PROMs can be used to
demonstrate variation by provider — or modality — to discover value.9 Many medical
conditions have relevant PROs, such as mental health, heart failure, stroke, prostate and
colon cancer, asthma, and inflammatory bowel disease.10 Using validated tools to
measure PROs for these conditions makes the data interpretable and actionable. The
data can then be compared across providers and institutions. This additional data can
save time and enable deeper, more personalized care when PROs are embraced.11

4) PROMs and the Triple Aim
The goals of the Triple Aim are (i) to improve the patient experience, (ii) improve the
health of populations, and (iii) reduce the per capita cost of health care. As mentioned
previously, PROMs provide an opening to improve communication for patients and
clinicians and to enable the delivery of patient-centered and equitable quality care,
consistent with the Triple Aim. PROMs may also cut costs, mainly when used to detect
unmet needs, such as communication of incapacity to pay for medications. The clinician
could counter this problem by prescribing a more cost-effective medication regimen.
Moreover, there has been a suggestion to develop the Triple Aim to the Quadruple Aim,
which would incorporate increasing career satisfaction and decreasing stress
experienced by an allied health care workforce.12 PROMs may bolster this additional
goal by promoting patient-centered care and engaged teams of clinicians.

PROMs were devised to assist patient-centered care, making PROMs a natural solution
to methodically tackle many of the requirements of a patient-centered medical home
(PCMH). From a very concrete standpoint, PROMs can be used to meet the
requirements of the National Committee for Quality Assurance (NCQA) PCMH 2014
standards within Standard 4: Plan and Manage Care, as well as in Standard 6: Measure
and Improve Performance. Regular integration of PROMs may help practices meet
these standards for primary or renewed NCQA PCMH acknowledgement.13 PROMs
permit systematic assessment of patients’ main concerns and can be employed as
instruments to meet the NCQA PCMH 2014 standards.

7 Ibid.
12 Careyva, Setting the Agenda for Patient-Centered Care, J Community Medicine & Health
Education, April 2016.
13 Ibid.
5) **Payer Perspective on PROMs**

Health authorities and payers recognize the importance of patient perspectives and PROMs in health care decision making. However, given the comprehensive diversity of PRO endpoints included in clinical programs and differences in the timing of PROM data collection, the role of PROM data in reimbursement decisions requires further research and characterization.

A 2017 study by Brogan et al. found that PROM data may assist in differentiating treatments, particularly after clinical progression, in oncology. The report also found that payers worldwide identify high-quality PRO data as an important factor of their decision-making process and anticipate the mounting importance of PROMs over the next 5 to 10 years.

Public payers are also approaching PROMs implementation to improve patient outcomes and control costs. For example, under the Comprehensive Care for Joint Replacement program, now a voluntary program by CMS, participating providers will need to monitor for quality and improve value in patient care. CMS will link each hospital’s incentive or penalty to a composite quality score based on three measures, including a PROM linked to functional status and pain management.

Additionally, it is now mandated by CMS that dialysis facilities ask patients to complete the In-Center Hemodialysis Survey Consumer Assessment of Healthcare Providers and Systems semiannually and the Kidney Disease Quality of Life 36 annually. In addition, patients are evaluated for depression and pain once a year.

6) **PROMs Abroad**

Collection of “patient-generated health data” (or PROMs) has been taking place in Europe for quite some time. For instance, in the Netherlands, PROMs are mandated for certain types of patients and conditions, such as behavioral health, orthopedics, and neurology. To address this mandate, electronic tools automatically choose survey instruments from a validated library and administer them at the suitable intervals to patients founded on their ICD diagnosis code.

Recently, the worth of PROMs in Europe has begun to be studied. Preliminary results show that PROMs do support more evidence-based decision making and value-based care delivery. Additionally, PROMs allow providers to better provide care in the right setting (tertiary hospital versus community clinic). Results have shown that obtaining PROMs through traditional, rudimentary approaches, such as paper-based exchanges between providers and their patients during the visit, were less standardized and less useful than online approaches.

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15 Ibid.
19 Ibid.
20 Ibid.
7) PROMs at Home: Blue Cross Blue Shield of Massachusetts

Blue Cross Blue Shield of Massachusetts (BCBSMA) recognized that PROMs fill critical gaps in the measure set for global budget contracts, such as the Alternative Quality Contract. In 2013, BCBSMA provider networks collaboratively chose priority conditions for PROMs implementation. In selecting initial areas of focus, the providers focused on areas of high prevalence, cost, and utilization. Joint degeneration, primarily hip and knee, and depression were identified as areas in need. Additionally, these conditions, which were conducive to measuring and monitoring changes in functional status, have validated PROM instruments already in place that providers can use to initiate participation among their patients.

The results of PROMs implementation among members with joint degeneration or depression were promising. BCBSMA members who reported with a score greater than nine on a baseline PHQ-9, instrument for screening, diagnosing, monitoring, and measuring the severity of depression, were re-administered the PHQ-9 at a 12-month follow-up visit. The PHQ-9 severity category saw substantial improvement among those with mild and moderate depression at baseline. However, among severe and moderately severe patients, more than half see no change after 12 months.

For hip and knee replacement, change scores in pain, symptoms, activities of daily living, sports and recreation, and quality of life were calculated before and after the surgery. All respondents reported decreased pain and symptoms, increased ability to perform daily activities and to participate in sports and recreation, and improved quality of life after the surgery. BCBSMA used these scores to compare provider groups based on these metrics.

8) How to Select PROMs

Consensus on a PROM to measure is challenging but not impossible. There are certain criteria to select a PROM. The PROM should be short, relevant to clinical care, validated, industry-standard, and covered by a PROMIS (Patient-Reported Outcome Measurement Information System) domain.

There is an emerging consensus to use PROMIS. PROMIS is a free, National Institutes of Health-sponsored system. The goal of PROMIS is to develop, validate, and standardize item banks to measure PROs relevant across common medical conditions. PROMIS measures are standardized, allowing for assessment of many PRO domains, including pain, fatigue, emotional distress, physical functioning, and social role participation, based on common metrics that allow for comparisons across domains, across chronic diseases, and with the general population.

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21 Safran. Promoting the Use of PROMs: Early Experiences from BCBSMA Presentation, September 2017.
22 Ibid.
23 Ibid.
25 Ibid.
9) Implementation of PROMs

To implement PROMs successfully, robust collection requires engaging patients, frontline staff, and clinicians on a functioning platform. Ideally, the technology platform would work seamlessly for all three parties, requiring secure, integrating, real-time processing. However, many systems that are collecting PROMs are still doing so manually with paper surveys and follow-up.

Patients

To reach the patient and receive complete results, the survey must get into the hands of the patient. To do this, providers must use a platform that is relatively easy and intuitive to use. Using a tablet, for example, is a convenient way to reach patients regardless of age.²⁶

Most importantly, patients must be assured that the provider to improve clinical care is using the results. The first time, patients must be told in a believable way that the provider will see these results. Subsequent times, patients must see it used by the provider.

Front-Line Staff

PROMs must improve or minimally impact workflow for frontline staff. To avoid making PROMs “one more thing” to be done, there must be no variability or confusion for staff to decide who to give PROMs to. Making all pre-visit activities digital is a possible solution to automate the process as much as possible.

An administrative champion is key to the successful implementation of PROMs. This champion is responsible for creating a PROMs mandate, engineering the workflow, and holding all staff accountable.²⁷

Providers must communicate the imperative to effectively collect PROMs to the frontline staff. In addition to the administrative champion, clinicians must convey the importance of PROMs to clinical care.²⁸

Clinical Providers

Lastly, providers must enthusiastically embrace PROMs rather than just accepting them. By removing administrative burden and using PROMs results for more than just patient care, providers can move from resigned acceptance to enthusiasm. Removing other administrative tasks, such as meaningful use, screening requirements, and symptoms documentation, providers will have more time to analyze and incorporate PROMs into daily clinical care of patients, enabling a deeper connection. Additionally, providers can use PROMs for more than patient care. PROMs can be used to demonstrate value and comparative effectiveness.

²⁶ Ibid.
²⁷ Ibid.
²⁸ Ibid.
10) Cost of Implementation

The implementation of technology to collect PROMs can be costly. For example, a large teaching hospital or medical center that is aiming to create an institutional custom-built program will face many challenges, including a need for IT experts, provider knowledge and interest, and ongoing resources for program maintenance. IT experts, clinician champions, and administrators require salary support. A recent article in NEJM Catalyst details the proposed costs associated with a custom-built PROMs collection platform.

However, there are many benefits to a custom-built collection platform. Data display can be altered and customized for greater analysis. Scoring of PROMs tools and updates can also take place in real time. Sharing data with other groups and practices throughout the institution is easier as well. Controlling data collection means that integration into the workflow is smoother and can be altered more easily.

11) Barriers to Adopting PROMs

There are both technological and operational barriers to adopting and implementing PROMs. The data is best submitted through electronic means to administer surveys, calculate scores, and trend results. This requires an electronic patient platform that works with a patient portal and is also integrated into the EHR. In turn, all these platforms must work seamlessly for patients and physicians to want to use them.

Operationally, instituting PROMs increases demands on all participants in the health care system. Physicians already feel as if they are awash in data and cannot add another step into their schedule. Human connection is what brought many clinicians into medicine and many clinicians feel that adding technology into the relationship is taking away that connection.

12) Unintended Consequences of Reimbursing PROMs

PROMs focus on precisely defined, measurable aspects of a patient’s health and health care. Policies, such as the compulsory use of PROMs and financial or accreditation incentives for achieving PROMs benchmarks, may encourage providers and systems to alter their behaviors and policies. In a practice with severe time and resource constraints, implementing PROMs may mean less time and resources go to other priorities that might be more critical to patient care. For example, a study in the United Kingdom contends that a nationwide initiative linking financial incentive to rapid primary care access, as measured by a single patient-reported experience measure, may have resulted in an extensive decrease in provider-specific continuity in primary care. By incentivizing providers to guarantee swift access to any provider within their organization as a means of ensuring patient satisfaction, organizations may have sacrificed continuity of care, which is crucial for many high-risk patients.

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31 Ibid.
35 Ibid.
Additionally, many clinicians register concern that PROMs may affect or bias provider decision making. For instance, will providers choose not to operate on or treat higher risk patients out of fear of a poor PROM? From the patient side, will athletes choose to forgo a procedure because of unrealistic expectations?

Providers also worry that, if PROMs collection becomes widespread, patients will feel overwhelmed with constant surveys, leading to survey fatigue. If patients feel the surveys are overwhelming or inconvenient, they may begin to complete the survey haphazardly or incompletely, jeopardizing the provider’s reputation or, potentially, reimbursement.

Finally, many providers believe that as virtual survey tools become available and replace verbal, face-to-face contact between provider and patient, the patient-provider relationship will become even more depersonalized.

13) Feasibility of PROMs Implementation
Since PROMs remains in its infancy, many health care providers have numerous concerns surrounding the implementation of PROMs. For instance, what agency will pay for the implementation of PROMs? Will there be recommended standards for administering PROMs and reducing measurement error?

Major EHRs that have integrated patient portals where customizable questionnaires can be formed. However, health care providers need to know if PROMs that are already in place will be copyrighted. If so, will there be a charge for each use or a licensing agreement? Additionally, will certain PROMs measurement tools be available in a public domain?

14) Ongoing Challenges
Despite progress, ongoing challenges remain for the widespread implementation of PROMs and collection platforms.

Lack of PROMs Consensus
There is a lack of consensus for which PROM is best for various conditions. With the development of PROMIS and the International Consortium for Health Outcomes Measurement (ICHOM), there is a push towards the development of a single set of measures for a diagnosis. ICHOM has produced over 10 standard sets of PROs covering approximately 35 percent of the global burden of disease, including cataracts, prostate cancer, lower back pain, coronary artery disease, Parkinson’s disease, stroke, hip and knee osteoarthritis, depression and anxiety, and lung cancer. Currently, ICHOM is establishing systems of hospitals around the globe, to measure, benchmark, and perform PRO comparisons. All this data will translate into further learning about what truly matters to the patient.

Reimbursement
Currently, PROMs are being implemented with a pay-for-participation model. However, with a push for movement towards value-based care, PROMs may eventually be used as a performance measure for reimbursement programs. Researchers and providers

37 Ibid.
must develop a technique to risk-adjust for clinical, social, and demographic patient characteristics.\(^{38}\)

**Survey Fatigue**

If collection of PROMs becomes widespread, there must be strategies to avoid bombarding patients with a multitude of surveys. Reaching patients conveniently, while respecting their privacy and security, is a priority to avoid survey fatigue.\(^{39}\)

**Patient-Facing Reports**

Lastly, visualizing PROM data for patients and generating patient-facing reports on how this data is being used is critical for implementation and continued use of PROMs. After initial surveys, it is essential that patients see the data used by providers in subsequent clinical care.\(^{40}\)

The exercise of public reporting of PROMs will also require careful consideration and input from physicians.

15) **Conclusion**

PROMs are a valid quality improvement and patient engagement tool. However, since PROMs implementation remains in its infancy and many factors, including patient compliance, expectations, social, and demographic aspects, and other risk adjustment can skew the outcomes, PROMs results should not be used to compare providers or outcomes for payment. CQMP has developed principles that can be found below.

**Current MMS Policy**

There is no policy on this topic.

**Relevance to MMS Strategic Priorities**

Quality improvement is an MMS strategic priority.

**Recommendation:**

That the MMS adopt the following:

**MMS Principles on Patient-Reported Outcome Measures (PROMs)**

1. Quality improvement activities are an integral part of health care delivery today.
2. PROMs are expected to play a more prominent role in improving and assessing performance by including the patient’s assessment of the comparative effectiveness of different treatments, in part because of the growing emphasis on patient-centered care and value-based payment designs.
3. In the era of patient-centered care and motivation toward high-quality care, active implementation of patient-reported outcome tools (Internet,


\(^{39}\) Ibid.

\(^{40}\) Ibid.
automated phone systems, phone app, etc.) is a logical next step toward achieving these goals.

4. Implemented correctly, PROMs have the potential to improve patient-physician communication, increase symptom management and control, and increase patient and physician satisfaction.

5. When selecting a PRO to measure, the PROM should be short, relevant to clinical care, validated, industry-standard, and may be covered by PROMIS (Patient-Reported Outcomes Measurement Information System) domain.

6. Routinization of this type of two-way communication between the provider and the patient, through use of the electronic tools mentioned above, may serve to improve care in ways that advance the Triple Aim’s design to (i) improve patient experience, (ii) enhance the health of populations, and (iii) reduce per capita cost of health care.

7. Health plans, payers, and other health care improvement organizations should reimburse for quality improvement implementation activities, especially PROMs, as these measures require technology support, workflow adjustments, and continuous improvement.

8. However, PROMs should not be used to benchmark the performance of providers in different practices, specialties, or geographic locations against one another, potentially influencing payers to link reimbursement to evidence of the effectiveness of their treatment. Instead, these quality improvement tools should be used to advance quality of care within a specific practice or medical center, improve provider-patient communication, and enhance understanding of expectations. Because PROMs are in their infancy, more research needs to be done to understand how to risk-adjust these measures and how to account for realistic and unrealistic patient and provider expectations.

9. In addition to the need for added research on risk adjustment and patient expectations, PROMs performance results should not be linked to reimbursement due to many other factors, including patients’ compliance, demographic, and social factors, which influence outcomes and create bias. Because PROMs results are not completely attributable to the physician’s performance alone, providers find it hard to reconcile reimbursement and the often-imprecise nature of PROMs results. Rather, PROMs should be used to complement quality improvement activities.

10. The need for demographic (age, sex, etc.) risk adjustment to make PROMs more valuable should be emphasized both at the clinical level for providers to be able to use PROMs appropriately but even more so at the health plan level if PROMs are to be used for any type of provider comparison or payment.

11. Although the goal of medicine is to improve health outcomes for patients, using PROMs results for physician accountability and reimbursement requires additional research and validation of measures and outcomes.

12. The MMS strongly advocates for monitoring national dialogue surrounding PROMs.
13. The MMS will keep the membership informed of identified issues with relevant implemented patient-reported outcome measures and advocate strongly, by whatever means appropriate, for the growth and maturation of PROMs as a quality improvement tool and against implementation of inappropriate or inadequate PROMs, and against the use of PROMs results for quality incentive payments.

(Fiscal Note: One-Time Expense of $5,000)

(Out-of-Pocket Expenses)

(Existing Staff)

(Staff Effort to Complete Project)
EXECUTIVE SUMMARY

The CQMP recognizes that encouraging patients to read and potentially add notes to their personal visit notes in their medical records — a task that is typically handled only by the provider — may help patients feel more engaged with their own care and improve relationships with their providers. Due to the growing popularity of this philosophy, the CQMP, led by Barbara Spivak, MD, chair, and Richard Lopez, MD, vice chair, initiated a status report on the topic of OpenNotes. OpenNotes is not a software package or product. Rather, it is a simple philosophy in how a practice uses its patient portal platform to promote engagement, increase transparency, and enhance patient-provider relationships.

This report details the evolution of medical record transparency that has led to the OpenNotes movement, as well as the benefits and challenges of implementing OpenNotes. The report details implementation strategies for providers that are considering this philosophy. Finally, the report describes the challenges ahead and where this movement is going as OpenNotes continue to spread and strategies and safeguards evolve.

Upon review of this report and with discussions at several meetings of the CQMP, the committee proposes the following:

That the MMS support the OpenNotes philosophy whereby patients have access to their visit notes from their medical records via patient portals or other cost-effective means. (HP)

That, The MMS shall monitor the use of OpenNotes and educate its members on the benefits and challenges of its usage. (D)

Fiscal Note: One-Time Expense of $5,000 (Out-of-Pocket Expenses)

FTE: Existing Staff (Staff Effort to Complete Project)
The Evolution to OpenNotes

The Committee on the Quality of Medical Practice, led by Barbara Spivak, MD, chair, and Richard Lopez, MD, vice chair, chose to review the growing trend toward open notes in the medical record. The medical record began as a way for providers and patients to remember what transpired at their visits as well as what care plan was prescribed. Today, electronic medical records contain a range of data, including demographics, medical history, medications and allergies, immunizations, test results, images, vital signs, personal statistics, and billing information. Electronic systems allow providers and payers to store and track this type of data across time.

The movement toward medical record transparency began in 1973 when the American Hospital Association adopted the Patient's Bill of Rights, fueling the patients' rights movement and outlining steps for patients to become more active in their care. In 1996, President Clinton signed into law the Health Insurance Portability and Accountability Act (HIPAA), which mandated that patients have the right to inspect, review, and receive copies of their medical records. A few years after HIPAA, health systems and technology companies began to develop patient portals. However, notes written after a visit are not seen by patients.

The OpenNotes movement began in 2010 to engage patients in care delivery. A study, led by providers at Beth Israel Deaconess Medical Center, sought to examine the effects of sharing notes between providers and patients. The study results showed that a simple intervention could have an enormously positive impact on patients and providers. In response, several health systems chose to open provider notes to patients.

Currently, patient portals — secure websites that give people access to medical information — let patients easily access medical information and some include access to provider notes. More and more providers are beginning to offer patient portals. The Office of the National Coordinator for Health Information Technology reports that 64% of hospitals had some type of online patient portal in 2014. Another Healthcare Information and Management Systems Society survey found that in 2016, 58% of health care providers were offering portals. These portals have made it easier and easier for providers to offer patients access to their medical notes. To meet the 2014 requirements of the CMS Electronic Health Record Incentive Program, often referred to as "Meaningful Use," providers must have a patient portal installed.
Background

The OpenNotes movement began in 2010, funded by the Robert Wood Johnson Foundation, as a year-long demonstration project, with 105 primary care physicians at three varied United States health care centers inviting 20,000 patients to read visit notes online through patient portals. Today, more than 11 million patients in the United States have easy access to their notes through what has become a standard-of-care initiative. OpenNotes are written by physicians, nurses, therapists, or other health providers to describe interactions with a patient as part of the medical record and the patients are invited to read these notes.

OpenNotes is not a software package or product. Rather, it is a simple philosophy in how a practice uses its patient portal platform to promote engagement, increase transparency, and enhance patient-provider relationships. The American Medical Association supports the OpenNotes movement as a practice management and improvement tool that increases transparency. The AMA has issued a STEPS Forward module (www.stepsforward.org/modules/adopting-opennotes) where providers can learn more about adopting OpenNotes.

In Massachusetts, six health care delivery systems employ OpenNotes as a simple tool to empower patients and providers with organizational transparency and inclusivity: Beth Israel Deaconess Medical Center (BIDMC), Cambridge Health Alliance (CHA), the Veterans Affairs Healthcare System, Iora Health, and Boston Children’s Hospital and Partners. As evidenced by local and national health care systems that utilize OpenNotes, there are many benefits as well as some potential risks. Additionally, this fundamental paradigm shift in practice has occurred with many challenges and surprises throughout implementation. The benefits and risk of OpenNotes as well as lessons learned for implementation will be discussed below.

Pros

The potential benefits of OpenNotes include enhanced communication and engagement between the health care provider and patient, better medication adherence, improved quality of care, and heightened caregiver support.

Evidence has shown that transparent medical records can increase patient engagement — patients who read the clinical notes written by their health care professional report feeling more in control of their care and being better able to adhere to the treatment plan. OpenNotes investigators at BIDMC found that allowing patients to provide feedback about their notes further enhances engagement and can improve patient safety because patients can help identify mistakes. The investigators also found that most patients provided positive feedback that encourages the providers and delivers an “anti-burnout” experience. Providers perceived that their patients were more satisfied and trusting, leading to greater satisfaction for the providers that they are being the best providers they can be.

Studies have shown that sharing providers’ notes through an electronic portal is associated with improved medication adherence. Specifically, a study from BIDMC and

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1 Bell, SK, et al., BMJ Quality and Safety, 2016
2 Ibid.
Geisinger Health System found that the availability of notes following primary care visits was associated with improved adherence by patients who were prescribed antihypertensive medications. As the use of fully transparent records spreads, patients invited to read their providers’ notes may modify their behaviors in clinically valuable ways. With access to notes, chronically ill patients can help themselves avert potentially complex and costly problems, including poor medical adherence, inaccurate medication lists, and preventable readmissions. Evidence suggests that patients who read notes and are familiar with how the provider thinks about their care can help keep diagnostic processes on track between visits.

Also, OpenNotes supports caregivers. Research shows that many patients are already sharing their notes with care partners and that OpenNotes is becoming an increasingly important tool to help empower patients and caregivers alike. In fact, a study found that 1 in 5 OpenNotes patients shared a visit note with someone, and those sharing Web access to their visit notes reported better adherence to self-care and medications, proving that facilitating access to caregivers may improve perceived health behaviors and outcomes.

Cons

The potential risks of OpenNotes include more time needed out of hectic schedules to answer phone calls, questions and potentially increased documentation time for providers, as well as apprehension to write candidly about sensitive topics (such as mental health or substance use) misinterpretation of results by patients, and privacy risks for patients if medical records are accessed by outside parties, family, or acquaintances without consent.

Provider-centric

A study led by providers at BIDMC found that a maximum of 5% of providers reported longer visits with patients, and 8% said they spend extra time addressing patients’ questions outside of visits. Additionally, 21% reported taking more time to write notes. Between 3% and 36% reported changing documentation content. Of note, however, is that no provider elected to stop providing access to notes after the experimental period ended.

Patient-centric

On the patient side, 1–8% of patients reported worry, confusion, or offense while reading the notes. Furthermore, 3 out of 5 patients felt they should be able to comment on the

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3 Wright, E, et al., Journal of Medicine Internet Research, October 2015
4 Weissman, JS, et al., Annals of Internal Medicine, July 2008
5 Jackson, S, et al., Journal of Medical Internet Research, November 2014
6 Walker, J, et al., Annals of Internal Medicine, October 2012
7 Ibid.
8 Ibid.
9 Ibid.
10 Ibid.
notes. Astoundingly, 86% of patients agreed that the availability of notes would influence their choice of provider in the future.

Behavioral Health Considerations

Concerns have been raised about access to mental health care notes — for example, that access to mental health care notes could harm the patient-provider relationship or could upset or worry some patients. Psychiatrists and some social workers are sharing access with their patients at BIDMC. Since 2013, the VA has offered patients access to all clinical notes, including mental health notes.

A study explored patient perspectives of how online access to notes within the VA may affect patients’ relationships with their mental health providers. The researchers found that reading notes can either strengthen or strain the patient-provider relationship depending on how the patients perceived that the notes showed the providers’ respect and transparency. Patients felt more respected and more trusting when the notes were thorough and accurate, and the assessments were forthcoming. However, when patients noticed discrepancies between what happened and what the notes said (missing info or mistakes), trust was strained. Some patients were worried the inaccuracies could affect their treatment.

Regarding behavioral health notes, ensuring what appears in notes accurately reflects what occurs during appointment will ensure patient respect and trust. Highlighting patient strengths and individuality also promotes trust. Providers should always initiate a conversation about the contents of notes and the documentation process.

Implementation

OpenNotes validates how a simple intervention can have a large impact, even absent of cutting-edge technology. The business practice decision to begin an OpenNotes philosophy starts with a choice for record transparency. The ensuing implementation costs of support, training, education, and patient marketing needed for success could reach well into the six figures for a large institutional hospital. These costs hinge primarily on the capability of the electronic health record that is being used. For example, the Epic EHR already has the functionality to release notes to patients through the portal. It is as simple as flipping a switch in the health record.

For systems that do not have this functionality, though, reconfiguration could be costly. Numerous grants for the expansion of OpenNotes or a shared notes system are available. Since providing clinical notes on a patient portal may require a costly reconfiguring of the electronic medical record, the OpenNotes movement suggests starting with a low-tech solution, such as emailing clinical notes to the patient or printing notes to hand to the patient. However, it is understood this type of initial implementation will impact the workflow of the practice and can be time intensive.

As evidence of the benefits of OpenNotes grows and consumers increasingly weigh their

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11 Ibid.
12 Ibid.
13 Cromer, R, et al., Psychiatric Services, May 2017
14 Baumhauer, JF, et al., NEJM Catalyst, January 2018
health care options, more organizations may want to increase medical record transparency. Should this be of interest, there are many things providers can do right now to begin

**Steps to Implementation**

First, providers should feel confident that patients want to read their notes. As mentioned, a very small percentage of patients feel worried or confused by OpenNotes. Second, providers can start with low technology ways to help patients access their notes. For example, if an organization does not already provide OpenNotes on a patient portal, providers can print or email patient notes. If the organization has a patient portal or not, providers can start the momentum by sharing evidence and knowledge of OpenNotes with their colleagues and leadership.

Third, providers can start to advertise OpenNotes and encourage patients to register for a patient portal. Past implementation has shown that when patients know about OpenNotes, they are more likely to register for the patient portal, manage their care, and stay with the provider and practice. After encouraging patients to use the patient portal, providers must partner with patients and ensure them that their medical record is accurate and up-to-date.

Fourth, providers must make it easy for patients to access notes on their patient portal or medical record by creating a button on the portal that allows patients to access notes with one click. For providers that are just starting to encourage OpenNotes, reminding new and returning patients often is key to improving usage.

Fifth, providers must modify the way they write notes. Providers should aim to be clear and succinct. Avoiding jargon and acronyms enables a patient to better understand the notes. Directly and respectfully addressing patients’ concerns will ally their apprehensions about discussing potentially embarrassing topics. Similarly, providers should support their patients by underscoring the patients’ accomplishments and positive changes.

Including patients in the note-writing process is yet another way to ensure patients comprehend the notes while making the provider and patient reflect on the goals of the visit. Including patients may allow providers to make sure a patient understands a diagnosis and treatment plan. Additionally, the comprehensive nature of notes could help patients feel that their providers know and care about them, strengthening their relationship through shared values and goals.

However, including patients in the note-writing process to make sure the patient thoroughly understands the provider’s thoughts and process could add time to the visit. Also, providers may have to do more education than is necessary if questions come up during the note-writing process.

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15 Weissman, JS, et al., Annals of Internal Medicine, July 2008
16 Kahn, MW, et al., JAMA, 2014
17 Delbanco, T, et al., Annals of Internal Medicine, 2012
18 Macda, G, et al., Journal of Medical Internet Research, July 2017
Last, providers must ask and utilize feedback from their patients after visits. Encouraging patients to read their notes after the visit could help identify missed or incorrect information. Though patients rarely request changes, providers must be familiar with the amendment process. This allows providers to help patients distinguish between factual inaccuracies and clinical judgment.

While this is a cursory outline to OpenNotes implementation, the team at OpenNotes.org has made a toolkit that guides the provider through all phases of OpenNotes implementation. Visit [www.opennotes.org/wp-content/uploads/2017/04/OpenNotes_For-Professionals_Implementation-1.pdf](http://www.opennotes.org/wp-content/uploads/2017/04/OpenNotes_For-Professionals_Implementation-1.pdf) to see the toolkit.

Looking Ahead — Opportunities and Challenges

Patient access to open notes may become the standard of care. In December 2015, the Robert Wood Johnson Foundation, the original investor for the OpenNotes pilot, joined forces with the Cambia Health Foundation, the Gordon and Betty Moore Foundation, and the Peterson Center on Healthcare to expand access to OpenNotes for 50 million patients nationwide. Over three years, the $10 million in new funding is aimed to spread the initiative, discover new ways to engage patients and families through OpenNotes, and measure and evaluate the value and effectiveness of OpenNotes. The data coming in show that 70% of patients feel more in control of their care thanks to OpenNotes and 97% wanted to continue the program.

Going forward, there are many upcoming issues pertaining to the OpenNotes movement. First, notes should be written in a way that preserves a patient’s unique social, familial, cultural, and medical determinants. However, structure or templates are very helpful for research and quality improvement processes. Reconciling these two ideas will necessitate provider and patient feedback, documentation requirements, and larger-scale EHR policy attention.

Additionally, some providers, who lament laborious documentation requirements already, propose that patients might document their own visit, leaving the provider to edit, amplify, and interpret. Others contend that providers and patients sign the note, acknowledging the visit and subsequent care plans, if any.

Second, some providers argue that OpenNotes should have measurable metrics to assure the quality of the notes as well as the care. If the patient and provider agree upon what is in the note, then quality of care can be measured by whether the provider or patient lived up to what was written in the note. However, measurable metrics could lead to payers being privy to these intimate discussions between providers and patients.

Finally, should notes be peer-reviewed for quality by both other providers and the patients? If review by other providers does take place, privacy is trumped by transparency, even though some patients may want to maintain confidentiality.

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19 Ibid.
21 Ibid.
22 Delbanco, T, et al., Health Expect., 2001
23 Delbanco, T, et al., Annals of Internal Medicine, 2012
Despite these challenges, the researchers that initiated the OpenNotes movement have questioned if simply reading providers notes is enough. The researchers have recently taken the logical next step for engaging patients even more actively: inviting them to co-produce notes with their providers. The idea of OurNotes is now being explored and the first study into this concept found that a range of different providers widely agree that OurNotes could bring patient engagement to the next level as well as enhance patient-provider communication, shared decision making, and patient-centered care.24 The growing OpenNotes philosophy coupled with this novel OurNotes idea could combine to allow patients to actively read and interact with their provider notes.

Current MMS Policy
There is no MMS policy on this topic.

Relevance to MMS Strategic Priorities
Patient advocacy and quality improvement are MMS strategic priorities.

Conclusion
Upon review of this report and with discussions at several meetings of the CQMP, the committee proposes the following.

Recommendations:
1. That the MMS support the OpenNotes philosophy whereby patients have access to their visit notes from their medical records via patient portals or other cost-effective means. (HP)

2. That the MMS shall monitor the use of OpenNotes and educate its members on the benefits and challenges of its usage (D).

Fiscal Note: One-Time Expense of $5,000
(Out-of-Pocket Expenses)

FTE: Existing Staff (Staff Effort to Complete Project)

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24 Mafi, JN, et al., Annals of Internal Medicine, November 2017
Item #: 5
Code: OMSS Report A-18 B-3
Title: Impact of the High Capital Cost of Hospital EMRs on the Medical Staff
Sponsor: Organized Medical Staff Section
Frank Carbone Jr, MD, Chair
Referred to: Reference Committee B
Nicolas Argy, MD, JD, Chair

Background
Health care institutions, especially hospitals, are facing huge costs in the installation of electronic medical records (EMRs) and related health information technology. Although somewhat expected, the ballooning costs are decimating the assets of large hospital systems and community locations. The need for smaller entities and private practices to purchase this expensive software in order to align with hospital systems has, along with other financial stressors, resulted in further consolidation of independent practices. Increased costs have also led to belt-tightening in other areas, such as reductions in staff, which decrease access and quality of care. All of which elicits the question of whether implementation of EMRs truly leads to better care for patients.

Current MMS Policy
There is MMS policy regarding EMRs and their adoption, but none on the impact of hospitals investing massive amounts of money on EMRs, and its effect on medical staffs, especially when considering physician recruitment and retention.

Relevance to MMS Strategic Priorities
An MMS strategic priority is Physician and Patient Advocacy:
- Ensure that the Society is a productive and credible voice for physicians and patients at the state and federal level, as well as local and national health care organizations.
- Provide a leadership voice through its advocacy, collaboration, and public health efforts, and will continue to carefully monitor the impact of the rapidly transforming health care landscape on Massachusetts physicians and patients.
- Advocate to improve the physician practice environment and work toward improved patient care and outcomes.
- Ensure that the voices of physicians and their patients are heard during the ongoing debate on health care reform, while promoting transparency and addressing barriers that impede access to quality care, such as administrative burdens and excessive regulations.

Discussion
The MMS advocates for its members particularly in improving the environment in which they practice and thus ensuring a stable physician workforce for the citizens of Massachusetts.
In theory, installing an EMR that is interoperable with the hospital EMR will lead to improved quality and safety for patients, such that the high installation and conversion costs will be recovered over time. However, this theory may not play out in reality.

The need for physician practices to be aligned with hospital systems to share data and communications (interoperability) has driven consolidation because the systems are expensive, and the hospital can underwrite 85 percent of the cost of a new EMR for a practice only if the practice is “clinically integrated” with the hospital. Practices that are owned by the hospital easily pass the clinical integration standards for alignment.

For example, the high cost of Epic’s software makes installing it in community practices impractical from a financial point of view even if the practice(s) have been acquired by the hospital. The high costs for EHRs are inappropriate for certain institutions. For example, Partners has chosen Epic and as such a large organization, it can afford it, however Epic can be twice the price of other EHRs that are much more suitable and can be easily integrated. But, Epic is the choice exactly because many large institutions are using it and the downstream organizations and practices follow. This results in sizeable and often unaffordable costs for both smaller hospitals and physician’s practices.

Therefore, the level of support and “interoperability” is dependent on finances for both the practice and hospital and the degree of alignment. Hospital systems that are “all in” on interoperability (one enterprise-wide EMR system) have huge capital outlays and larger budget deficits as result. This results in a lack of interoperability for independent physician practices (particularly specialists) that are not owned by the hospital, so that they can, at best, only view patient data in the hospital system.

There have been instances where hospital staff physicians have been “laid off” or dismissed at an alarming rate because of the enormous investments in hospital Electronic Medical Records (EMRs). These expenditures have resulted in the destabilization of hospital finances with many institutions ending up in the “red,” leading to a downgrade of the hospital bond ratings and the pressure to “balance the books”.¹

These investments are now rivaling the capital costs of entire budgets for new facilities and equipment at many institutions.²,³

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These capital investments have been driven by legislation regarding “population health” (such as ACOs, etc.) and the need for improved analytics. It is not clear that the investment of hundreds of millions of dollars will result in more of an improvement in the health status of a given community than a direct investment in the delivery of health care through improving the physician and nursing workforce, which is the exact opposite of the current movement. The highly competitive health care market in Massachusetts requires hospital and health care systems to aggressively advertise further increasing financial deficits.

Conclusion
The absolute magnitude of the expense has increased to an extent that a return on investment may not be feasible.\textsuperscript{4,5,6,7} It is well known that an EMR have a finite useful life and requires expensive upgrades. This will likely increase financial deficits and result in more physician layoffs and personnel downsizing.

Recommendations:
1. That MMS work with relevant stakeholders, including medical staffs, to monitor the current and projected fiscal impact of electronic medical record (EMR) implementation on the Massachusetts health care system including the potential impact on recruitment and retention of the Massachusetts physician and health care workforce, population health, cost and quality of patient care, and access to patient care and report back on this study at A-19. (D)

2. That the MMS work to distribute to medical staffs information on the current and projected fiscal impact of EMR implementation on the Massachusetts health care system to educate and encourage their participation in medical staff issues, and work closely with hospital administration on the downstream financial impact of large capital expenditures such as EMRs. (D)

Fiscal Note: One-Time Expense of $20,000
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)


MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item: 6
Code: EGPS Report A-18 B-4
Title: Billing and Collections Practice Policy
Sponsor: Committee on Ethics, Grievances, and Professional Standards
Ronald Arky, MD, Chair

Referred to: Reference Committee B
Nicolas Argy, MD, JD, Chair

Background
At I-99, the House of Delegates adopted the following policy, which was most recently reaffirmed at A-13:

Billing and Collection Practices

1. Physician Participation in Development of Billing and Collection Policies. Every physician should have input into the development of their own, their group’s or their employer’s billing and collections policies because those policies affect the physician’s ethical obligation to his or her patients and they impact on the physician/patient relationship.

2. Periodic Review of Billing and Collection Policies. Billing and collection policies should be reviewed periodically in order to assess the impact on patient care and avoid physician/patient conflict over reimbursement for professional services.

3. Physician Review of Accounts Designated for Collection. The decision to send a patient account to collection may have ethical ramifications due to the potentially serious consequences for the patient and the physician/patient relationship. Physicians are encouraged to review their accounting/collection policies to ensure that no patient’s account is sent to collection without the physician’s knowledge. (AMA Council on Ethical and Judicial Affairs Opinion 6.08 “Interest Charges and Finance Charges,” (1998-99 ed.). Employers should accord employed physicians the opportunity to review their patients’ accounts prior to such accounts being sent to collection. If physician review of all accounts is impractical, it may be appropriate for physicians to review only those accounts where the patient or patient’s representative has communicated with the physician’s office about the delinquent bill.

4. Content of Billing and Collection Policies. Billing and collection policies should be reasonable and should not conflict with applicable state and federal law and the physician’s ethical duties to his or her patient.

5. Departure from Established Policies. It is ethical for a physician to depart from established billing and collection policies in order to accommodate the particular needs of a patient.
6. Professional Courtesy. Professional courtesy refers to the provision of medical care to physician colleagues or their families free of charge or at a reduced rate. While professional courtesy is a long-standing tradition in the medical profession, it is not an ethical requirement. Physicians should use their own judgment in deciding whether to waive or reduce their fees when treating fellow physicians or their families. Physicians should be aware that accepting insurance payments while waiving patient co-payments may violate CEJA Ethical Opinion 6.12. (AMA CEJA Opinion 6.13, “Professional Courtesy.”)

7. Forgiveness or Waiver of Insurance Co-payments. Under the terms of many health insurance policies or programs, patients are made more conscious of the cost of their medical care through co-payments. By imposing co-payments for office visits and other medical services, insurers hope to discourage unnecessary health care. In some cases, financial hardship may deter patients from seeking necessary care if they would be responsible for a co-payment for the care. Physicians commonly forgive or waive co-payments to facilitate patient access to needed medical care. When a co-payment is a barrier to needed care because of financial hardship, physicians should forgive or waive the co-payment.

A number of clinics have advertised their willingness to provide detailed medical evaluations and accept the insurer’s payment but waive the co-payment for all patients. Cases have been reported in which some of these clinics have conducted excessive and unnecessary medical testing while certifying to insurers that the testing is medically necessary. Such fraudulent activity exacerbates the high cost of health care, violates [CEJA] Opinion 2.19, and is unethical.

Physicians should be aware that forgiveness or waiver of co-payments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver. Routine forgiveness or waiver of co-payments may constitute fraud under state and federal law. Physicians should ensure that their policies on co-payments are consistent with applicable law and with the requirements of their agreements with insurers. (AMA CEJA Opinion 6.12, “Forgiveness or Waiver of Insurance Co-payments.”)

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Relevance to MMS Strategic Priorities
The policy on Billing and Collection Practices pertains to the MMS’s strategic priority on Physician and Patient Advocacy. Ensuring fair and carefully designed billing and collection practices can promote improved patient care and outcomes.

Discussion
At A-14, the House of Delegates adopted OMSS Report A-14 A-103, Review of Positions on Medical Ethics, which requires the MMS to monitor the statements related to medical ethics adopted by the American Medical Association and other sources periodically, as events and circumstances demand.

As directed by OMSS Report A-14 A-103, Review of Positions on Medical Ethics, the Committee on Ethics, Grievances, and Professional Standards (EGPS) monitors
statements related to medical ethics adopted by the American Medical Association (AMA) and other sources. One June 13, 2016, the AMA completed its first comprehensive update to the AMA Code of Medical Ethics in more than 50 years. According to the AMA, this update was undertaken to improve the code’s (1) relevance (by ensuring that the language applies to contemporary medical practice), (2) clarity (by improving structure and formatting to ensure that foundational ethical principles and specific physician responsibilities are easy to find, read and apply), and (3) consistency (by consolidating related issues into a single, comprehensive statement).

The MMS policy on Billing and Collection Practices is based in part on the CEJA Opinion 6.08 Interest Charges and Finance Charges, CEJA Opinion 6.12 Forgiveness or Waiver of Insurance Copayment, and CEJA Opinion 6.13 ProfessionalCourtesy. The updated version of the AMA’s Code of Medical Ethics has amended, renamed, or moved these opinions. Changes made to the AMA opinions, such as the deletion of a section describing a scenario whereby a clinic waived co-pays and fraudulently billed insurers, were made to remove dated or purely descriptive language.

Conclusion

EGPS voted at its October 11, 2017, meeting to recommend amending the MMS’s policy on Billing and Collection Practices to update the references to reflect the new numbering in the AMA’s updated Code of Medical Ethics, and to amend certain language to remain consistent with the related AMA guidance as follows (added text is shown as “text” and deleted text is shown as “text”):

3. Physician Review of Accounts Designated for Collection. The decision to send a patient account to collection may have ethical ramifications due to the potentially serious consequences for the patient and the physician/patient relationship. Physicians are encouraged to review their accounting/collection policies to ensure that no patient’s account is sent to collection without the physician’s knowledge. (AMA Council on Ethical and Judicial Affairs Opinion 6.08 “Interest Charges and Finance Charges,” (1998–99 ed.). Employers should accord employed physicians the opportunity to review their patients’ accounts prior to such accounts being sent to collection. If physician review of all accounts is impractical, it may be appropriate for physicians to review only those accounts where the patient or patient’s representative has communicated with the physician’s office about the delinquent bill.

6. ProfessionalCourtesy. Professional courtesy refers to the provision of medical care to physician colleagues or their families free of charge or at a reduced rate. While professional courtesy is a long-standing tradition in the medical profession, it is not an ethical requirement and is prohibited in many jurisdictions. Physicians should use their own judgment in deciding whether to waive or reduce their fees when treating fellow physicians or their families. Physicians should be aware that accepting insurance payments while waiving patient co-payments may violate CEJA Ethical Opinion 6.12. (AMA CEJA Opinion 11.3.1 “Fees for Medical Services.” 6.13, “Professional Courtesy.”)
7. Forgiveness or Waiver of Insurance Co-payments. Under the terms of many health insurance policies or programs, patients are made more conscious of the cost of their medical care through co-payments. By imposing co-payments for office visits and other medical services, insurers hope to discourage unnecessary health care. In some cases, financial hardship may deter patients from seeking necessary care if they would be responsible for a co-payment for the care. Physicians commonly forgive or waive co-payments to facilitate patient access to needed medical care. When a co-payment is a barrier to needed care because of financial hardship, physicians should forgive or waive the co-payment.

A number of clinics have advertised their willingness to provide detailed medical evaluations and accept the insurer’s payment but waive the co-payment for all patients. Cases have been reported in which some of these clinics have conducted excessive and unnecessary medical testing while certifying to insurers that the testing is medically necessary. Such fraudulent activity exacerbates the high cost of health care, violates [CEJA] Opinion 2.19, and is unethical.

Physicians should be aware that forgiveness or waiver of co-payments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver. Routine forgiveness or waiver of co-payments may constitute fraud under state and federal law. Physicians should ensure that their policies on co-payments are consistent with applicable law and with the requirements of their agreements with insurers. (AMA CEJA Opinion 11.1.4 “Financial Barriers to Health Care Access,” 6.12, “Forgiveness or Waiver of Insurance Co-payments.”)

Recommendation:
That the Massachusetts Medical Society adopt as amended and reaffirm the Billing and Collection Practices policy reaffirmed at A-13 to read as follows:

**Billing and Collection Practices**

**Principles Related to Billing and Collection Practices for the Reimbursement of Professional Services.**

1. **Physician Participation in Development of Billing and Collection Policies.** Every physician should have input into the development of their own, their group’s or their employer’s billing and collections policies because those policies affect the physician’s ethical obligation to his or her patients and they impact on the physician/patient relationship.

2. **Periodic Review of Billing and Collection Policies.** Billing and collection policies should be reviewed periodically in order to assess the impact on patient care and avoid physician/patient conflict over reimbursement for professional services.

3. **Physician Review of Accounts Designated for Collection.** The decision to send a patient account to collection may have ethical ramifications due to the potentially serious consequences for the patient and the physician/patient relationship. Physicians are encouraged to review their accounting/collection policies to ensure that no patient’s account is sent to collection without the physician’s knowledge. (AMA Council on Ethical and
Judicial Affairs Opinion 1.3.3 “Interest and Finance Charges”). Employers should accord employed physicians the opportunity to review their patients’ accounts prior to such accounts being sent to collection. If physician review of all accounts is impractical, it may be appropriate for physicians to review only those accounts where the patient or patient’s representative has communicated with the physician’s office about the delinquent bill.

4. Content of Billing and Collection Policies. Billing and collection policies should be reasonable and should not conflict with applicable state and federal law and the physician’s ethical duties to his or her patient.

5. Departure from Established Policies. It is ethical for a physician to depart from established billing and collection policies in order to accommodate the particular needs of a patient.

6. Professional Courtesy. Professional courtesy refers to the provision of medical care to physician colleagues or their families free of charge or at a reduced rate. While professional courtesy is a long-standing tradition in the medical profession, it is not an ethical requirement and is prohibited in many jurisdictions. (AMA CEJA Opinion 11.3.1 “Fees for Medical Services”).

7. Forgiveness or Waiver of Insurance Co-payments. Under the terms of many health insurance policies or programs, patients are made more conscious of the cost of their medical care through co-payments. By imposing co-payments for office visits and other medical services, insurers hope to discourage unnecessary health care. In some cases, financial hardship may deter patients from seeking necessary care if they would be responsible for a co-payment for the care. Physicians commonly forgive or waive co-payments to facilitate patient access to needed medical care. When a co-payment is a barrier to needed care because of financial hardship, physicians should forgive or waive the co-payment.

Physicians should be aware that forgiveness or waiver of co-payments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver. Routine forgiveness or waiver of co-payments may constitute fraud under state and federal law. Physicians should ensure that their policies on co-payments are consistent with applicable law and with the requirements of their agreements with insurers. (AMA CEJA Opinion 11.1.4 “Financial Barriers to Health Care Access”).

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)
FTE: Existing Staff
(Staff Effort to Complete Project)
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 7
Code: Resolution A-18 B-203
Title: No-Cost Volunteer License to Practice Medicine
Sponsor: Berkshire District Medical Society

Basil Michaels, MD, President

Referred to: Reference Committee B
Nicolas Argy, MD, JD, Chair

Whereas, An MMS strategic priority is practice viability and sustainable health care delivery, the MMS should participate in promoting and fostering volunteerism in the practice of medicine by advocating with the Massachusetts Board of Registration in Medicine (BORIM) for a no-cost volunteer medical license; and

Whereas, The MMS has no policy on this topic; and

Whereas, A full, active medical license in Massachusetts has a fee of $600 for the initial licensure period and a fee of $600 for each two-year renewal;¹ and

Whereas, The BORIM has a volunteer medical license category for which the fee is $600 for the initial licensure period and a fee of $600 for each two-year renewal;² and

Whereas, The BORIM limits practice for physicians with a volunteer license to “work sites approved by the Board”³

Whereas, There are no advantages granted to a volunteer medical licensee in Massachusetts such as decreased malpractice coverage requirements or lower continuing medical education requirements; and

Whereas, As of February 2018, there are no holders of volunteer licenses to practice medicine in Massachusetts;⁴ and

Whereas, There are a limited number of physicians in the Commonwealth who work exclusively pro bono to care for financially disadvantaged patients; and

Whereas, At least 16 states offer volunteer licenses with no fee; and five others offer volunteer licenses at reduced fees;⁵ and

⁴ Correspondence with Carol Purmort, BORIM Director of Licensing by Brendan Abel, Esq., MMS Legislative and Regulatory Affairs Counsel, January 19, 2018.
Whereas, A no-cost license to practice medicine may encourage more volunteerism — particularly with the retired physician population; therefore, be it

RESOLVED, That the MMS advocate for the Massachusetts Board of Registration in Medicine (BORIM) to eliminate the fee for a volunteer license to practice medicine; and, be it further (D)

RESOLVED, That the MMS advocate for the removal of the requirement that the BORIM approve work sites for physicians with volunteer licenses. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Whereas, An MMS strategic priority is physician and patient advocacy; and

Whereas, Third-party payers may question the medical necessity for certain medical procedures, encounters, care, medicines, or medical devices in the course of a provider rendering treatment for a covered patient; and

Whereas, Third-party payers may withhold payment for such treatment, medicines, or medical devices; and

Whereas, The provider should have timely access to a medical director at said third-party payer to discuss disputed care and explain the medical necessity thereof; and

Whereas, The MMS has the following policy on this topic:

… b. Any denials should be issued by a licensed, board certified, actively practicing physician who regularly treats patients in a clinical setting and who would typically manage the medical condition under review. Such a physician should be available whenever a preauthorization is required.

5. Prior authorization process should support patient point-of-contact submissions with approval or denial of said submissions available at patient point-of-contact. (HP)

MMS House of Delegates, 12/3/05
Amended and Reaffirmed MMS House of Delegates, 5/18/07
Amended and Reaffirmed MMS House of Delegates, 12/6/14

The Massachusetts Medical Society (MMS) opposes pre-certification programs of third-party payers that interfere with the physician-patient relationship, delay medically necessary care, or impose an undue administrative burden on physicians. (HP)

The MMS will work with third-party payers to develop meaningful hassle-free utilization review programs that are educational in design and enhance quality of patient care. (D)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

; therefore, be it
RESOLVED, That the MMS advocate that third-party payers must provide medical
director access to the provider to discuss disputed care and the care management
within 48 hours of the provider requesting such access. The request for such
access to the medical director may be made by phone or in writing, whichever is
most convenient for the provider who is administering care of said patient. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Whereas, MMS strategic priorities include access to care and physician and patient advocacy; and

Whereas, The MMS monitors in an ongoing dynamic manner health care systems and the health care environment, including all methods of health care delivery in the Commonwealth such as accountable care organizations (ACOs), health care system reform, and health care costs; and

Whereas, It has become apparent using data from CHIA, the Statewide Quality and Cost Transparency website, that provider reimbursement fee schedules are about 25 percent higher in the eastern compared to western parts of the Commonwealth for state-sponsored health plans, an amount greater than simple cost of living differences;¹ and

Whereas, In the opinion of many, access to care is likely to decrease when reimbursements are inequitable due to multifactorial issues including but not limited to lack of providers accepting Medicaid and difficulty recruiting qualified physicians; and

Whereas, The new state proposed Medicaid ACOs should be mandated to reimburse providers, regardless of physical address, identical transparent reimbursement fee schedules to support equal access to care regardless of patient and/or ACO location; therefore, be it

RESOLVED, That the MMS actively advocate at the state level for one reimbursement fee schedule for all Medicaid accountable care organizations rendering care to Medicaid health care recipients in the Commonwealth. (D)

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 10
Code: Resolution A-18 B-206
Title: Equality in Reimbursement for Patient-Related Care
Sponsors: Kevin Moriarty, MD
Hampden District Medical Society
Nikhil Thakkar, MD, President

Referred to: Reference Committee B
Nicolas Argy, MD, JD, Chair

Whereas, An MMS strategic priority is access to care and physician and patient advocacy; and

Whereas, The MMS monitors in an ongoing dynamic manner health care systems and the health care environment, including all methods of health care delivery in the Commonwealth such as accountable care organizations, health care system reform, and health care costs; and

Whereas, The Massachusetts Medical Society has existing policy that states:

The MMS will advocate that the equation that third-party payers use to calculate the fee schedule include the most recent economic data and the cost of delivering care at the time of contracting in the geographic area where the physician is practicing. 

(D)

(Approved MMS Board of Trustees, 10/11/17)
Accepted MMS House of Delegates, 12/2/17

; and

Whereas, It has become quite apparent using data from CHIA, the Statewide Quality and Cost Transparency website, that provider reimbursement fee schedules are substantially different in the eastern compared to western parts of the Commonwealth. The reported data reveals reimbursements by private health plans in Eastern Massachusetts are about 350 percent of those in Western Massachusetts, which cannot be attributed to simple cost of living differences;¹ and

Whereas, Access to care decreases when reimbursements are inequitable due to multifactorial issues including but not limited to lack of providers accepting Medicaid and decreased recruitment of qualified physicians; and

Whereas, To attempt to bend the cost curve and improve patient access across the Commonwealth, the fees schedule and multiplier used to reimburse providers, regardless of physical address, should be readably transparent to patients; therefore, be it:

RESOLVED, That the MMS actively advocate that insurance companies publish
the fees schedules and multipliers used to reimburse providers in the
Commonwealth. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Background
This report is based on and in part excerpted from a recent American Medical Association Organized Medical Staff (AMA-OMSS) Governing Council resolution (Res. 3 I-17) entitled Hospital Disaster Plans and Medical Staffs.

Current MMS Policy
This report focuses on the ability and initiative of hospitals and similar health care facilities to plan a coordinated response. Although comprehensive, there is no direct policy that relates specifically to hospital responsibility for the coordination. See MMS policy in Appendix.

Relevance to MMS Strategic Priorities
This report supports the MMS Strategic Priority addressing Physician and Patient Advocacy that states: Provide a leadership voice through its advocacy, collaboration, and public health efforts, and will continue to carefully monitor the impact of the rapidly transforming health care landscape on Massachusetts physicians and patients.

Discussion
Hospitals are required by laws, regulations, and accreditation requirements to plan for natural and other disasters. These plans require extensive involvement from medical staff physicians, who have an individual and collective obligation to provide urgent medical care during such disasters.

However, research has shown that medical staffs are often confronted with numerous barriers that impact their ability and willingness to report to work during and following natural and other disasters.

Factors shown to influence staff decisions to report to work include
1. perceived emergency preparedness of the organization;
2. perceived importance of one’s role during a disaster; and
3. the strength of an individual’s sense of professional duty.

2 Ibid.
Even prior experience with disasters has been shown to influence hospital evacuation and disaster response decisions.

Conclusion
The ability to address these barriers in advance allows hospitals to better plan and prepare for predictable problems and increase the likelihood of being able to ensure adequate staffing to provide timely access to care following a natural or other disaster.

Recommendation:
That the Massachusetts Medical Society adopt the following adapted from American Medical Association policy:
That the MMS:
1. Encourage appropriate stakeholders to examine the barriers and facilitators that medical staffs encounter following a natural or other disaster
2. Encourage hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts that reduce barriers to staff response during a natural or other disaster
3. Update the MMS Model Medical Staff Bylaws to include such policy recommendations

Fiscal Note: One-Time Expense of $5,000
(Out-of-Pocket Expenses)
FTE: Existing Staff
(Staff Effort to Complete Project)
Appendix

MMS Policy

Hospital Disaster Plans and Medical Staffs

Emergency Preparedness
The Massachusetts Medical Society recognizes that emergency preparedness
awareness and disaster response training are an essential part of public health and will
work to engage physicians in preparedness efforts because of the critical role they play
in limiting the medical, including psychological, impact of disasters on individuals and the
community. (HP)

The Massachusetts Medical Society supports the development of emergency
preparedness and disaster response resources for physicians in order to increase
awareness and knowledge of emergency preparedness structure, response, agencies,
and trainings. (D)

MMS House of Delegates, 12/7/13

The Massachusetts Medical Society (MMS) will continue to work in collaboration with
appropriate local, state, and federal public health agencies and others responsible for
disaster management to develop and implement a comprehensive and integrated
education, communications, and strategic response plan for the physician community to
protect the health and safety of our patients and our communities in the event of a
disaster. (D)

The MMS will emphasize and advocate for the importance of routine child and adult
immunizations, such as tetanus and influenza, as a first step in preparedness. (D)

Other basic public health functions, such as statewide trauma care and hospital
capacity, and post trauma care and rehabilitation will be included in the preparedness
planning process and final plans. (D)

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

The Massachusetts Medical Society (MMS) recognizes the reality that an infectious
disease outbreak, terrorist attack, or other catastrophic event can occur at any moment
with the potential to cause severe morbidity and mortality. The MMS is dedicated to
enhancing and continually improving the planning, mitigation, response and recovery
activities needed to protect the health of the Commonwealth. (HP)

The MMS Committee on Preparedness will work in collaboration with local, state, and
federal public health agencies, hospitals, and others responsible for emergency
preparedness and disaster management, on the development, coordination, and
facilitation of educational initiatives, communications systems, and integrated response
plans for the medical community to minimize the consequences of natural or man-made
disasters and other public health emergencies. The Committee on Preparedness will
incorporate into its work advocacy for adequate resources, for populations with special
medical needs during disasters, and for community engagement in all phases of
preparedness planning. (D)

The Committee on Preparedness will endeavor to assist physicians and other health
care professionals in their preparedness efforts with planning and response tools and
other resources, and will encourage them to volunteer with MA Responds, the
Massachusetts centralized volunteer management system, in order to enhance the
state’s capacity to respond to health emergencies. (D)

MMS House of Delegates, 11/17/01
Amended and Reaffirmed MMS House of Delegates, 5/9/08
Amended and Reaffirmed MMS House of Delegates, 5/2/15
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item: 12
Code: CPL Report A-18 B-6
Title: Transforming the Medical Liability Environment
Sponsor: Committee on Professional Liability
   Stephen Metz, MD, Chair

Referred to: Reference Committee B
   Nicolas Argy, MD, JD, Chair

Executive Summary
In 2012, the Massachusetts Medical Society House of Delegates voted to join other entities in providing the Massachusetts Alliance for Communication and Resolution following Medical Injury (“MACRMI”) with funding (Report 201 A-12) to transform the medical liability environment within Massachusetts. This vote was based on the state of the medical liability environment in Massachusetts at the time, and the good work the House believed MACRMI could do to improve the system. In 2016, the MMS again provided support ($50,000 annually for two years) for the MACRMI project. Since then, MACRMI has made great progress, and continues to lay the groundwork for future improvements. The Massachusetts Medical Society is being asked to continue its support for this work.

Background
The traditional tort-based medical liability system has several fundamental flaws that negatively impact patients, physicians, and the health care system as a whole. The system is slow, inefficient, often inequitable, fails to distinguish between individual and system errors, breeds mistrust, takes a severe toll on both patients and physicians, encourages the practice of defensive medicine, thwarts patient safety improvement efforts, drives up overall health care costs, and compromises access to care.

In 2006, the Medical Society, unsuccessful in multiple efforts to enact Medical Injury Compensation Reform Act (MICRA)-style tort reform, appointed a task force to investigate alternative approaches. The task force investigated multiple alternative dispute resolution programs developing across the country and determined that Disclosure, Apology, and Offer (DAO) as implemented at the University of Michigan provided the best alternative to pursue a fundamental transformation of our liability system.

Disclosure, Apology, and Offer is a model in which clinicians and hospitals respond to an adverse event with full disclosure, an appropriate apology, and timely and fair financial compensation, if warranted. This had been shown to be a viable alternative to litigation at the University of Michigan since 2001, reducing liability premiums, the practice of defensive medicine, and improving patient safety.

In 2010, the Massachusetts Medical Society, in collaboration with Beth Israel Deaconess Medical Center, received a planning grant from the Agency for Health Care Research and Quality (AHRQ) to develop a roadmap for transforming the medical liability system in Massachusetts. That planning grant had four aims:

- To identify barriers to implementation of a DAO model in Massachusetts
To develop strategies for overcoming these barriers
To design a roadmap for DAO program implementation in Massachusetts
To assess applicability of the DAO model in other states

The roadmap that resulted from that planning grant contained several key findings, including:

- That stakeholders interviewed felt that the DAO model holds great potential and is the best liability reform alternative for Massachusetts
- That ethical considerations trump cost-saving implications as the most appealing aspects of adopting the model
- That the stakeholders viewed the DAO model as a patient-safety priority

The roadmap also contained several near-term and longer-term recommendations, including:

- Creation of a centralized education resource center for education and training of the public, physicians, hospital/health care organization leadership, attorneys, and insurers.
- Identification of champions among leadership in each stakeholder group to engage them in promoting the DAO model
- Development of implementation guidelines that offer practical strategies for addressing operational issues
- Uniting groups to work collaboratively to resolve key impediments identified in the roadmap
- Pursuit of enabling legislation

*In fall 2011, the MMS initiated an effort to negotiate consensus-enabling legislation with the MA Bar Association and MA Academy of Trial Attorneys. This legislation, introduced in spring 2012, was signed by Governor Patrick and took effect in November 2012. It provided for a six-month pre-litigation resolution period, sharing of all pertinent medical records, strong apology protection for physicians, and guidelines for full disclosure of any significant adverse event.

In summer 2012 an alliance to support the implementation of the roadmap was formed, which goes by the acronym "MACRMI," (Massachusetts Alliance for Communication and Resolution following Medical Injury). The alliance included some of the most notable health care and advocacy groups in the Commonwealth (the MMS, the MHA, the MA Coalition for Prevention of Medical Errors, the MA Board of Registration of Medicine, the Medically Induced Trauma Support Service (MITSS), the MA Bar Association, and two premiere medical systems as pilot sites—the BIDMC in Boston and its affiliated hospitals, and the Baystate Health System in Springfield and affiliated hospitals).

To fund the implementation of the roadmap, MACRMI applied for a three-year, 3 million dollar AHRQ demonstration grant. However, Congress failed to appropriate funding for this initiative. Therefore, MACRMI sought local funding to conduct the work of the collaborative and received pledges from the Massachusetts Medical Society (via House of Delegates adoption of Report 201 A-12 providing $200,000), Blue Cross/Blue Shield of Massachusetts, Reliant, Harvard Pilgrim Health Care, COVERYS, CRICO, and the Baystate Health Insurance Company, Ltd.
Thus far, MACRMI has:

- Designed and implemented a DAO program, the CARE (Communication, Apology, and Resolution) program at eight pilot sites, including large and small hospitals, large physician practices, sites covered by both captive and non-captive insurers, and sites where the physician and the entity didn’t necessarily have the same insurer.
- Developed multiple best practices, algorithms for managing cases, a readiness checklist, a detailed implementation guide and an award-winning website (www.macrmi.info) with resources for patient providers and attorneys, including an extensive list of resources and links.
- Worked with the MA Bar Association to develop best practices for attorneys representing patients and providers through the CARE process.
- Worked with the MA Bar Association to develop a list of attorneys committed to representing patients and working collaboratively through the CARE process, which is posted on the MACRMI website.
- Completed data collection on over 1,000 cases at the original pilot sites and a number of others. MACRMI has also been working with the National Patient Safety Foundation and the national collaborative to disseminate this model across the country, the Collaborative for Accountability and Improvement.
- Hosted its five annual symposia at the MMS, at which it presented the initial data analysis from the pilot sites, and its sixth symposium is scheduled for May 15, 2018. Each of these symposia included, or will include, a discussion of the most comprehensive data set on this issue available nationwide.
- Engaged Partners Healthcare which has now committed to implementing CARE; Newton Wellesley Hospital launched their program in July 2017, and Brigham and Women’s Hospital began implementation in January 2018.
- Has published the first part of the three-pronged study on the CARE program in Health Affairs summarizing the impressive results, touting provider satisfaction with the experience, and arguing for more widespread implementation of this approach.\(^1\) As a result of these publications, as well as the evidence from the University of Michigan’s program,\(^2\) and several others in the United States\(^3\) the American Medical Society now supports CRPs as a viable option to settle disputes.

The MACRMI Board and leadership strongly believe that MACRMI should continue to play a critical role in the dissemination, implementation and analysis of additional programs across the Commonwealth over the next several years. Going forward, MACRMI’s anticipated annual budget will be $75,000 for support of the program manager (.25 FTE), some continued data collection and analysis, implementation efforts at additional Massachusetts institutions, and funding of the annual forums. Meeting this budget will require additional outside financial support. However, MACRMI anticipates that after two years it will be self-supporting through grants, membership dues, and/or fees.

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Relevance to MMS Strategic Priorities

Professional liability reform has been a long-standing concern and is a current strategic priority of the Massachusetts Medical Society.

Recommendation:

That the Massachusetts Medical Society contribute $25,000 annually for two years ($50,000 in total) to ensure the ongoing viability of the Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI) as an essential alliance working to transform the medical liability system in the Commonwealth through its Communication, Apology, and Resolution (CARe) program. (D)

Fiscal Note: Annual Expense of $25,000 for Two Years (Out-of-Pocket Expenses) Total Expense: $50,000

FTE: Existing Staff (Staff Effort to Complete Project)
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 13
Title: Health Care Is a Basic Human Right
Sponsors: MMS Presidential Officers: Henry Dorkin, MD, FAAP
Alain Chaoui, MD, FFAFP
Maryanne Bombaugh, MD, MSc, MBA, FACOG

Report History: Resolution A-17 B-202
Original Sponsors: Michael Kaplan, MD, and Berkshire District Medical Society

Referred to: Reference Committee B
Nicolas Argy, MD, JD, Chair

Background
At A-17, the House of Delegates (HOD) referred Resolution A-17 B-202, Health Care Is a Basic Human Right, to the Board of Trustees (BOT) for report back with recommendations at A-18. The BOT referred this resolution to the MMS Presidential Officers. The resolution states:

That the Massachusetts Medical Society recognizes that health care is a basic human right for every person and not a privilege. (HP)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

Reference Committee and HOD Testimony
At A-17, the reference committee recommended that this resolution be referred for report back at I-17. The HOD voted to refer for report back at A-18. The following is the reference committee’s rationale:

Your reference committee heard significant testimony on this resolution in person and online which highlighted the importance of the concept of health care for all. There were numerous concerns voiced about the specific language and wording of the resolution. In some cases, those testifying indicated that defining some of the words that were selected would be important. For example, the question arose regarding what exactly a “human right” is, and whether it is within the MMS’s purview to define human rights. One delegate noted that this resolution might belong within the ambit of MMS’s Committee on Ethics, Grievances, and Professional Standards, while another testified that they were concerned about implications of the language on services that would fall into this right and the potential cost to the health care system. Additionally, there was some concern that stating that health care is a human right would lead to compelling physicians to provide care for little or no compensation, whether or not they wanted to do so.
An amendment was proposed with the intent of clarifying the language by including the word “basic” to further define health care, so that the right would only extend to “basic health care, and not necessarily to all health care. Your reference committee discussed both the testimony and the proposed amendment and determined that sentiment was largely in favor of the intent of the resolution but the underlying complexities of the issues requires study and report back from the Board of Trustees. As such, your reference committee recommends referral to the Board for report back at I-17.

The resolution was extracted at the HOD second session. An amendment was made to divide the resolve into two statements: The MMS recognizes that health care is a basic human right; and, health care is not a privilege. Comments heard during the hearing were repeated which included a comments discussion of the meaning of the language and implications on the health care system.

Current MMS Policy
The MMS has the following policy:

The Massachusetts Medical Society strongly asserts that the fundamental goal of any change to the American health care system should be to provide universal access to medical care for all Americans.

Any proposed change to the American health care system which will decrease the likelihood of movement towards universal access to health care for all Americans will be strongly opposed by the Massachusetts Medical Society.

Reaffirmed MMS House of Delegates, 5/14/10
(Item 3 of 3, Sunset)

Relevance to MMS Strategic Priorities
The resolution as submitted relates to the current general MMS strategic priority of physician and patient advocacy

Discussion
The presidential officers reviewed the testimony heard at the HOD and recognizes, by the current MMS policies, that the fundamental goal of any change to the American health care system should be to provide universal access to medical care for all Americans, and further, that the MMS will oppose any changes which will decrease the likelihood of movement towards this goal.

The officers also recognize the underlying complexities of the issues raised during discussions at the HOD meeting and implications of the statement in the resolution.

Agreeing that this deserves further study and discussion in the context of current discussions about the US Health Care System and its challenges and future direction, the officers recommend that a discussion on health care as a basic human right for every person and not a privilege be recommended to the Committee on Medical Education for inclusion in the educational conference on Universal Health Care, planned for the fall 2018.
Conclusion

To further study and consider the statement that health care is a basic human right for every person and not a privilege in the context of current discussions about the US Health Care System and its challenges and future direction, the presidential officers recommend the following.

Recommendation:

That the Massachusetts Medical Society adopt in lieu of Resolution A-17 B-202 the following:

That the educational conference on Universal Health Care, planned for fall 2018, include a discussion on health care as a basic human right for every person and not a privilege. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses) (Absorbed in the conference budget)
FTE: Existing Staff
(Staff Effort to Complete Project)
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 14

Title: Maximizing Function and Minimizing Disability

Sponsors: Committee on Public Health
Steven Ringer, MD, Chair
Committee on Medical Education
Kevin Hinchey, MD, Chair

Report History: Resolution A-17 A-111
Original Sponsors: Janet Limke, MD, and
Norfolk South District Medical Society

Referred to: Reference Committee B
Nicolas Argy, MD, JD, Chair

Background
At A-17, the House of Delegates (HOD) referred Resolution A-17 A-111, Maximizing Function and Minimizing Disability, to the Board of Trustees (BOT) for report back with recommendations at A-18. The BOT referred item 1 to the Committee on Public Health and items 2 and 3 to the Committee on Medical Education (in consultation with) Committee on Public Health. The resolution states:

1. That the MMS recognizes the important role it can play in mitigating the adverse health effects of chronic disability. (HP)

2. That the MMS encourage and support CME faculty to include functional-related outcomes and disability assessment into courses that address chronic health conditions. (D)

3. That the MMS investigate and pursue options for enhancing physician knowledge, skills, and resources in disability assessment and management through unique CME interdisciplinary course offerings, and/or online tools, as well as work to enhance collaboration with available rehabilitation services in the Commonwealth. (D)

Fiscal Note: One-Time Expense of $5,000
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

Reference Committee and HOD Testimony
At A-17, the reference committee recommended that this resolution be not adopted. The following is the reference committee’s rationale:

Your reference committee heard significant testimony highlighting the challenges of issues pertaining to patient disability in clinical practice. This testimony supported the concept of additional education or training, but substantial uncertainty arose about the specific issue at hand. Questions were raised about whether the education and training
were to be focused on occupational medicine and disability, on determinations for
government disability programs, or on other issues related to care for persons with
disabilities. These ambiguities raised concerns about how the directives would be
executed. Ultimately, your reference committee recommends to not adopt this resolution,
and would encourage a future resolution with a clearer definition of the problem, and a
more structured outline of the suggested CME. A detailed fiscal note could then also be
revisited.

The resolution was extracted at the HOD second session. Given significant interest in
the care and management of patients with chronic disability and the need for education,
delegates preferred that the resolution be referred for report back to allow time to clarify
the goal of the proposed resolution and answer the questions raised about
implementation.

Current MMS Policy
The MMS has current policy, which states:
The Massachusetts Medical Society (MMS) accepts the Institute of Medicine’s (IOM)
thirteen recommendations in their report, “Crossing the Quality Chasm:” …
Recommendation 1: All health care organizations, professional groups, and
private and public purchasers should adopt as their explicit purpose to continually
reduce the burden of illness, injury, and disability, and to improve the health and
functioning of the people of the United States.
…
MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15

Relevance to MMS Strategic Priorities
The resolution as submitted relates to the MMS strategic priority of:
Support members in developing the skills and knowledge they need to continue to be
successful practitioners, leaders, and patient advocates in a changing health care
environment.

Discussion
In its 2017 Position Statement entitled, “The Personal Physician’s Role in Helping
Patients With Medical Conditions Stay at Work or Return to Work,” the American College
of Occupational and Environmental Medicine (ACOEM) states that the personal
physician has a role in assisting his or her patients minimize life and work disruption
resulting from new injury or illness, changes in chronic health conditions and existing
disabilities, or the advance of age. The report further indicates that studies show that a
lack of work increases morbidity and mortality and results in decreases in mental, family,
social, and economic well-being.¹ It concludes that the patient, his or her family,
community, employer, and society all benefit from the patient’s employment.

¹ Maja Jurisic, MD, CPE, Melissa Bean, DO, MPH, MBA, John Harbaugh, MD, Marianne Cloeren,
MD, MPH, Scott Hardy, MD, Hanlin Liu, MD, Cameron Nelson, MD, and Jennifer Christian, MD,
MPH. The Personal Physician’s Role in Helping Patients With Medical Conditions Stay at Work or
The Committee on Medical Education and the Committee on Public Health (CPH) discussed the proposed resolution and the questions raised and the ambiguities about whether the education and training were to be focused on occupational medicine and disability, on determinations for government disability programs, or on other issues related to care for persons with disabilities. Representatives of the committees spoke with the sponsor of the resolution to obtain a clearer understanding of the intent of the resolution and clarification of goals and to address the issues raised by CPH members.

The sponsor advised that the goal of the resolution is to advocate for care delivery strategies that aim to minimize work disability while enhancing function and well-being for patients and to provide education for physicians. The intent was not to make a general comment on chronic health conditions. Physicians can have a great deal of influence on whether patients choose to apply for disability through Social Security and the escalation in reliance on Social Security Disability Insurance is rising significantly.2

Physicians are often not trained to complete a disability assessment and do not realize the detriment to health, wellness, and financial well-being that work disability status can cause. This is corroborated in the ACOEM guidelines: “Medical training does not prepare physicians to address the intersection between work and health, and they often lack familiarity with workplace environments.” The Committee on Public Health and the Committee on Medical Education support the development of an online educational activity to help physicians develop strategies for patients to return to work. Online learning fosters greater control for learners over their learning environment by allowing them to participate in an educational activity when they choose and to complete that activity at their own pace. This format for accredited education continues to grow with more than 40,000 educational activities offered to physicians and other learners in 2016.

Conclusion
The Committee on Medical Education and the Committee on Public Health recommend policy in support of advocacy and education. The fiscal note has been adjusted to $10,000 for content development and production costs for an online educational activity.

Recommendation:
The Massachusetts Medical Society adopt-in-lieu of Resolution A-17 A-111 the following:

1. That the MMS is an advocate for the need for effective care-delivery strategies that aim to enhance function and well-being for patients challenged by chronic health conditions while minimizing work disability. (HP)

2. That the MMS will develop an online activity to educate physicians on coaching strategies to maximize vocational success for patients with temporary work disabilities. (D)

Fiscal Note: One-Time Expense of 10,000
(Out-of-Pocket Expenses)
FTE: Existing Staff
(Staff Effort to Complete Project)

2 www.ssa.gov/policy/docs/chartbooks/disability_trends/sect01.html
Background

At A-17, the House of Delegates (HOD) referred Resolution A-17 B-207, Recognition of Out-of-State DNR/Physician Orders for Life Sustaining Treatment (POLST) Forms in Massachusetts, to the Board of Trustees (BOT) for report back with recommendations at A-18. The BOT referred this resolution to the Committee on Geriatric Medicine (CGM). The resolution states:

That the MMS advocate to the Massachusetts state legislature for recognition of an out-of-state Physician Orders for Life Sustaining Treatment form as valid and enforceable in Massachusetts. (D)

Fiscal Note: No Significant Impact (Out-of-Pocket Expenses)

FTE: Existing Staff (Staff Effort to Complete Project)

Reference Committee and HOD Testimony

At A-17, the reference committee recommended that this resolution/report be adopted. The following is the reference committee’s rationale:

Your reference committee heard overwhelming testimony in support of this resolution. Many spoke in favor of having Massachusetts paramedics and EMTs accept out of state Physician Orders for Life Sustaining Treatment (POLST) forms in addition to the already accepted Massachusetts Medical Orders for Life Sustaining Treatment forms in order to heed the wishes of the out of state patients. There was also strong support for MMS to work with the legislature to make these necessary changes. Your reference committee heard enthusiastic support for this concept and one person even suggested that reciprocity between states would be an added benefit, which could be explored in the future. Based on the overwhelming testimony, your reference committee recommends adopting this resolution.
Current MMS Policy
The following MMS policy is related to this recommendation:

End-of-Life Care
The Massachusetts Medical Society endorses and encourages statewide
dissemination and adoption of the Massachusetts Medical Orders for Life Sustaining
Treatment (MOLST) Program, which assists individuals in communicating their
preferences for life-sustaining treatments near the end of life. (HP)

The Massachusetts Medical Society will roll out continuing medical education
appropriate for risk management credit that includes information to assure that
clinicians can work with appropriate patients to communicate their preference for life-
sustaining treatment across health care settings, document these preferences on a
Massachusetts Medical Orders for Life Sustaining Treatment (MOLST) form, and
respond appropriately when they encounter a patient with a MOLST form. (D)

MMS House of Delegates, 5/21/11

Relevance to MMS Strategic Priorities
The resolution as submitted relates to the MMS strategic priority of patient care
advocacy.

Discussion
The Committee on Geriatric Medicine discussed this resolution at several meetings and
at its January 2018 meeting met with Amy Vandenbroucke, JD, executive director,
National POLST Paradigm (NPP), by conference call. Ms. Vandenbroucke discussed the
POLST Paradigm, how the current MOLST form does not meet the POLST Paradigm
requirements, and the ongoing work regarding a national online registry.

The POLST Paradigm is working toward nationwide honoring of each patient's POLST
form. Each state conforming to the POLST Paradigm is reviewed every three years to
ensure continued endorsement. POLST forms are intended for patients who are
seriously ill or frail; suffer from advanced, progressive chronic illness; or are at the
greatest risk of having a medical emergency, and who may or may not want all life-
saving measures. It is important to note that completing POLST forms for healthy people
— even those entering a skilled nursing facility — devalues the intent of POLST and is a
detriment to the entire concept.

The POLST Paradigm includes the POLST form, which is a brightly colored portable
medical order sheet, typically in some shade of pink. The form documents treatment
decisions made after conversations between a patient and his or her clinician about the
patient's diagnosis, prognosis, treatment options (including risks and benefits), and the
patient’s decisions regarding an acceptable quality of life. The health care proxy may
participate in these conversations or discuss them with the patient later to make
decisions about desired treatment.

After both the patient and the physician complete and sign a POLST form, the original is
given to the patient and the provider enters a copy into the patient's medical record.
Note, too, that the POLST form is intended to be a dynamic document and may be
changed or even voided by the patient over time. It reflects the patient’s current wishes
about medical treatments. This can also alleviate surrogate burden or any confusion
among family members or clinicians about what the patient wants.
The POLST form then supports patients who transition between facilities or who live outside of a facility by communicating those patient treatment wishes. In a medical emergency, the POLST form is an immediately available and recognizable order set in a standardized format to aid emergency personnel in implementing patient treatment wishes as communicated to and documented by the appropriate patient provider. The National POLST Paradigm sets the standards and guidelines for the POLST form elements so that there is reciprocity among the states; that is, a patient's POLST form filled out in one state will be recognized and honored in another state. This is important for patients who have travelled out of state.

Members of the CGM were pleased to learn that on January 12, 2017, the Palliative Care and Quality of Life Interdisciplinary Advisory Council urged the Massachusetts Department of Public Health (MDPH) to join the National POLST Paradigm (www.polst.org) to ensure that Massachusetts conforms to the national paradigm. The current Massachusetts MOLST form does not include the "limited intervention" section that is the heart of the POLST Paradigm but instead lists a variety of questions. This lack of structure in the form causes confusion, lacks clarity, likely reduces effectiveness in honoring patient wishes, and creates potential reciprocity issues. Reciprocity concerns are especially problematic since the POLST Paradigm promotes portable medical orders that help ensure patient treatment wishes are followed, regardless of where they are during a medical crisis.¹

The recommendation to join the NPP advances the MDPH's goals to improve palliative care initiatives in the Commonwealth, and its understanding of the importance of the NPP in improving the quality of care for seriously ill or frail patients by creating a voluntary system that honors patient medical treatment wishes. The MOLST name/acronym may be retained even after meeting criteria for the NPP.

The CGM recognizes that the MOLST, as well as the POLST, is a work in progress. There may be special circumstances involved in a patient's health status, prognosis, or pain threshold. While members of the CGM acknowledge the complexity of this population appropriate for MOLST/POLST, recognition of the need for universality is sought to ensure the best and most appropriate care honoring the patient's wishes.

Ongoing education in the use of the MOLST form in its current state is necessary. Health care organizations, physicians, nurses, administrators, and other health professionals are encouraged to honor a patient's properly executed and signed MOLST form, regardless of its location of origination. Health care providers completing a MOLST should provide supporting documentation, such as a progress note written at the time of the MOLST signing. A MOLST form should not be ignored pending reconfirmation at another facility when a patient has been admitted or transferred.

It is also important to know that some states have developed or are in the process of developing registries for POLST and, in some instances, advance directives. Most are also working to connect with health information exchanges.

¹ www.polst.org
Most such registries have state funding, have received a grant, or collaborate with a neighboring state. Registry success is predicated on POLST forms which have enough form matches across states for emergency medical services to access a patient's current orders.

Conclusion

As the Commonwealth is actively working toward changing the parameters of the MOLST form to comply with the National POLST Paradigm, it would be counter-productive to advocate to the state legislature for an out-of-state POLST form to be recognized as valid and enforceable in Massachusetts.

Members of the CGM consider it a standard of care that when treating a potentially life-threatening illness, the clinician elicits the patient's health care wishes, which includes a reasonable effort to gather and review documents already in existence, such as the completed health care proxy document, living will, MOLST/POLST, and medical records, no matter the state or institution of origin of the documents.

Completion of a MOLST is voluntary and should be offered by the clinician as an option for suitable patients of any age with a serious advancing illness, including life-threatening illness or injury; chronic progressive disease; medical frailty; or any patient with whom DNR orders would be discussed.

Recommendation:

That the Massachusetts Medical Society adopt-in-lieu of Resolution A-17 B-207 the following:

That the MMS support the use of Medical Orders for Life Sustaining Treatment (MOLST) in Massachusetts. (D)

That the MMS encourage the ongoing work of the Massachusetts Department of Public Health and other stakeholders to meet the National Physician Orders for Life Sustaining Treatment (POLST) Paradigm, which includes a section on limited medical intervention for the seriously ill and frail patient. (D)

That the MMS encourage the Massachusetts Department of Public Health, the Massachusetts Department of Emergency Medical Services, and other appropriate stakeholders to honor medical orders from other states that may or may not meet the National POLST Paradigm. (D)

That the MMS be active in the stewarding of MOLST and its appropriate use across the state in health care settings and among physicians. (D)

That the MMS encourage the state to fund education in the suitable and proper use of MOLST for appropriate health care providers and administrators. (D)

That the MMS encourage the state to fund an online registry to conform with the national registry for secure, private, and safe storage and accessibility of MOLST forms, including up-to-date changes. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
# Reference Committee C — MMS Administration

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* *(Placed on Speakers’ Consent Calendar)*
Item #: 1
Code: CSP Report A-18 C-1
Title: MMS Annual Strategic Plan
Sponsor: Committee on Strategic Planning
        Alain Chaoui, MD, FAAFP, Chair

Referred to: Reference Committee C
        Mangadharma Rao Madineedi, MD, Chair

Background
The MMS Committee on Strategic Planning (CSP), a committee of the Board of Trustees (BOT), with broad-based input from MMS leadership, MMS membership, MMS staff, external experts, and informed by comprehensive primary and secondary research, determines the strategic priorities for the Society. These are presented to the House of Delegates (HOD) annually for endorsement, with a comprehensive report about the health care environment. The following report contains the recommendations for A-18.

The one- and three-year strategic plans (see Appendix A for previous plans) continue to provide guidance to leadership, committees, and staff when assessing the resources and initiatives needed to address day-to-day issues and for planning for the future needs of the Society. While MMS officers and senior management use these strategic priorities to develop tactics that guide the Society’s internal and external actions, changes in the environment may require different tactics, scheduling, or focus. Therefore, to be most effective, the strategic planning process must continue to evolve.

Process
As part of the annual strategic planning process, the CSP provides a comprehensive review of the local and national health care environment (see Appendix B), paying specific attention to issues and concerns facing Massachusetts physicians and their patients. As part of this process, in the fall of 2017, the chair and vice chair arranged for a facilitated discussion among members of the CSP about the key issues facing physicians in today’s health care landscape. In addition, the CSP held a retreat in November 2017 to participate in an overview of the health care environment and to continue the discussion about challenges experienced by today’s physicians. Finally, the issues raised during those discussions, coupled with the overview of the health care environment, were synthesized into a recommendation for the key strategic priorities for 2018–2019.

Conclusion
Both physicians and patients are being forced to continue to manage increasing demands from the government, payers, and the marketplace, while balancing costs, quality, and risk. The attached report (Appendix B) covers a wide range of issues detailing the current pressures on the health care environment. The Massachusetts Medical Society is well-positioned to serve as a strong advocate for physicians and patients, providing the leadership needed to navigate rapid, complex change. By focusing on its strategic priorities (sustainable health care delivery, practice viability, and preservation of professionalism) through its commitment to physician and patient
advocacy, membership value and engagement, and professional knowledge and satisfaction, the Society is working toward fulfilling its mission as an organization:

“The purposes of the Massachusetts Medical Society shall be to do all things as may be necessary and appropriate to advance medical knowledge, to develop and maintain the highest professional and ethical standards of medical practice and health care, and to promote medical institutions formed on liberal principles for the health, benefit and welfare of the citizens of the Commonwealth.”

Commonwealth of Massachusetts Act of Incorporation, Chapter 15, Section 2 of the Acts of 1781

Recommendation: One Year Strategic Priorities for Fiscal Year 2018–2019

The Society’s strategic priorities for Fiscal Year 2018–2019 include a focus on physician and patient advocacy, membership value and engagement, and professional knowledge and satisfaction. In order to advance the Society’s mission and serve the needs of the physician community and their patients, the goals of our one-year strategic plan will be the following:

• **Physician and Patient Advocacy:** As a trusted and respected leadership voice in health care, ensure that the perspectives of physicians and patients are represented at the state and national level on the most important issues impacting physicians, the health care environment, and patient care and outcomes.

• **Membership Value and Engagement:** Ensure that the Society is positioned to meet the changing needs of physicians across all demographic segments and practice settings. Align member benefits, services, and communication channels with the needs of the physicians we serve, creating a clear membership value proposition. Ensure that the Society’s governance structure maximizes membership growth, diversity, and engagement and expands access to leadership opportunities. Ensure that communication engages physicians and promotes the Society’s efforts and achievements.

• **Professional Knowledge and Satisfaction:** Advance medical knowledge to develop and maintain the highest standards of medical practice and health care. Support members in developing the skills and knowledge they need to further learning, transform the practice of health care, and achieve lifelong professional growth. Build and promote a sense of community, professional satisfaction, and meaning in practice through support, networking, mentoring, education, and physician wellness programs. Support physicians in building strong patient-physician relationships.
Recommendation:

1. That the Massachusetts Medical Society’s strategic priorities for Fiscal Year 2018–2019 are the following: a focus on physician and patient advocacy, membership value and engagement, and professional knowledge and satisfaction. In order to advance the Society’s mission and serve the needs of the physician community and their patients, the goals of our one-year strategic plan will be the following:

- **Physician and Patient Advocacy:**
  - As a trusted and respected leadership voice in health care, ensure that the perspectives of physicians and patients are represented at the state and national level on the most important issues impacting physicians, the health care environment, and patient care and outcomes.

- **Membership Value and Engagement:**
  - Ensure that the Society is positioned to meet the changing needs of physicians across all demographic segments and practice settings.
  - Align member benefits, services, and communication channels with the needs of the physicians we serve, creating a clear membership value proposition.
  - Ensure that the Society’s governance structure maximizes membership growth, diversity, and engagement and expands access to leadership opportunities.
  - Ensure that communication engages physicians and promotes the Society’s efforts and achievements.

- **Professional Knowledge and Satisfaction:**
  - Advance medical knowledge to develop and maintain the highest standards of medical practice and health care.
  - Support members in developing the skills and knowledge they need to further learning, transform the practice of health care, and achieve lifelong professional growth.
  - Build and promote a sense of community, professional satisfaction, and meaning in practice through support, networking, mentoring, education, and physician wellness programs.
  - Support physicians in building strong patient-physician relationships.

(HP)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
APPENDIX A
Massachusetts Medical Society One-Year (2017–2018) and Three-Year (2017–2020) Strategic Plans

The one-year strategic plan, adopted at A-17, is as follows:

- **Physician and Patient Advocacy**: Ensure that the Society is a productive and credible leadership voice for physicians and patients. The Society will continue to monitor the impact of the rapidly transforming health care landscape, advocate to improve the practice environment, and work toward improved patient care and outcomes. Ensure that the voices of physicians and patients are heard during the health care reform debate, while promoting transparency and addressing barriers that impede access to quality care, such as excessive regulations and administrative burdens.

- **Membership Value and Engagement**: Ensure that the Society is positioned to meet the changing needs of its members. Support members in developing the skills and knowledge they need to continue to be successful practitioners, leaders, and patient advocates. Create opportunities to grow, diversify, and engage membership across all demographic segments and practice settings. Enhance member participation through innovative education, support, mentoring, and networking opportunities.

- **Governance**: Ensure that the Society stays relevant and is structured to maximize membership growth, diversity, and engagement. Look for ways to create meaningful local and remote participation and promote physician engagement and leadership opportunities.

- **Communication**: Ensure two-way communication that fulfills the needs of our physician members, promotes the Society’s efforts and achievements, and positions the Society as a leadership voice in health care, working on behalf of all physicians and patients. Enhance engagement through social media, online channels, marketing, collaboration, support, mentoring, and networking.

The three-year strategic plan, adopted at A-17, is as follows:

The Massachusetts Medical Society’s strategic priorities for Fiscal Years 2017–2020 are rooted in the long-term objective of quality improvement and the effective control of health care costs, with a focus on sustainable health care delivery, practice viability, and preservation of professionalism. In order to advance the mission of the Society and prepare for the future needs of the physician community and their patients, the three-year strategic priorities are as follows:

- **Sustainable Health Care Delivery**: Play a leadership role in developing a sustainable model of health care delivery by promoting the integration of public health, behavioral health, and the social determinants of health across physician practices; engage physicians and patients in end-of-life and aging patient care issues; develop resources and tools on marijuana and opioid use, misuse, dependence, and abuse; and promote physician-led care teams in support of improved patient care and outcomes.

- **Practice Viability**: Advocate for practice viability and physician professionalism, including the fair practice of clinical and economic integration, appropriately funded
mandates, professional liability reform, a sustainable physician workforce, and an
optimal practice environment, which, among other things, combats physician
burnout.

- **Preservation of Professionalism:** Advocate for health care settings that foster a
culture of professionalism to ensure patient-centered, physician-led care teams;
promote a sense of community, professional satisfaction, and meaning through
physician wellness, education, training, support, mentoring, and networking
opportunities.

MMS House of Delegates, 4/29/2017
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APPENDIX B
The Massachusetts Medical Society and the
National and Local Health Care Environment

INTRODUCTION AND SUMMARY

As part of the annual strategic planning process, the Committee on Strategic Planning (CSP) provides the following comprehensive review of the local and national health care environment. The Affordable Care Act (ACA) has significantly improved health insurance coverage rates across the nation, and Massachusetts continues to lead the nation with the highest insurance coverage rate. Overall, access to care is strong in Massachusetts. However, some access issues persist, particularly with respect to timely access to care.

Given the improvements in coverage and the resulting demand for physicians to care for the newly insured, it is not surprising that the Association of American Medical Colleges (AAMC) projects a significant national physician workforce shortage. Beyond workforce and access issues, health care will likely experience uncertainty in the years ahead, given the many changes occurring under health reform and emerging innovations. Health industry experts are optimistic that the health care system will remain resilient if it can manage to collaborate across sectors, make new strategic investments and create efficiencies.

Among the topics addressed in this report:

- **Health care spending.** Slowing the growth in health care spending remains a key concern of policymakers at the local and national level. In Massachusetts, physicians play a leadership role in containing costs as the industry moves toward alternative payment methodologies that emphasize high-quality, efficient care. Insurance coverage in Massachusetts and around the nation continues to improve; however, the trend toward rising insurance premiums and increased cost-sharing continues to create financial pressure and impact patients’ access to care.

- **Complexity, change, and uncertainty.** Physicians and their patients face a health care system undergoing rapid change, resulting in increased uncertainty. To understand and address the complexity of today’s health care environment, the MMS collaborates with a variety of stakeholders, including payers, policy experts, physician-leaders, and practicing physicians in the community, to gather and analyze information to strategically inform and target its efforts.

- **MMS activities and services.** This report also highlights MMS activities, collaborations, and partnerships undertaken to advocate for and address the shared interests of physicians and their patients within the current landscape. The MMS directly supports physicians and patients in several ways, including:
  
  - Conducts research to examine physician practice challenges and sustainability issues, and conducts surveys on focused topics such as physicians’ opinions on medical aid-in-dying;
  - Builds an active membership base through enrollment and outreach efforts, resulting in an all-time high of 25,277 members;
As a leadership voice in health care, the Massachusetts Medical Society is dedicated to educating and advocating for the physicians of Massachusetts and patients locally and nationally. This report reflects the challenges present in today’s health care environment and summarizes the ways in which the MMS is responding to those challenges, by influencing health-related legislation at the state and federal levels, working in support of public health, providing expert advice on physician practice management, and addressing issues of physician well-being.

**NATIONAL OVERVIEW**

Since the passage of the Affordable Care Act (ACA) in 2010, the percentage of people of all ages who are uninsured has declined and currently stands at 9%. The rate of adults aged 18–64 who are uninsured has decreased to 12.5%. The percentage of adults with public coverage has increased to 19.2%, while those covered by private insurance stands at 69.6% (see trends in coverage for adults in Figure 1 next page).  

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2 Ibid.
Post-ACA, the percentage of adults who were uninsured has declined most dramatically for young adults aged 18-24, which is not surprising given the ACA provision that extended dependent child coverage up to age 26. Figure 2 (next page) outlines the long-term declines in uninsurance rates for each adult age group showing that age is inversely related to percentage declines in uninsurance.

Five percent of children aged 0-17 are currently uninsured, which is an all-time low for this population. Experts credit the ACA with an increase in insurance rates led by expansions in children’s coverage under Medicaid, CHIP, the ACA marketplaces, and subsidies. The ACA has also resulted in more streamlined insurance enrollment and renewal processes, and more focused outreach and enrollment efforts for low-income children and their families. Nine million U.S. children are covered by the Children’s Health Insurance Program (CHIP), low-cost health coverage to children in families that earn too much money to qualify for Medicaid. Congress has passed a ten-year extension of CHIP funding, providing stable funding for the program, which had expired in September 2017.

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3 Ibid.
4 Ibid.
5 Ibid.
Health Care Industry Trends in 2018

According to health industry experts from the Price Waterhouse Coopers Health Research Institute, an organization that advises executive decision-makers about health care, 2018 will be “a year of resilience amid uncertainty,” in which the challenges of the uncertainties inherent in the current health care market have the potential to drive innovation and improvement for the overall system, as well as the health and well-being of patients across the country. However, these positive outcomes will likely be predicated on health organizations collaborating across sectors, making new strategic investments, and creating efficiencies (see Figure 3 next page).

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9 Ibid.
These experts maintain that collaborations across sectors include efforts to address the opioid crisis and social determinants of health, natural disasters, and the rising cost of prescription drugs via state legislation. Strategic investments will likely be needed in Medicare Advantage, Medicare benefits provided through private health plans, as enrollment rates continue to climb. On average, one-third of U.S. Medicare beneficiaries are enrolled in these private Medicare Advantage plans. Figure 4 (next page) provides an overview of enrollment in Medicare Advantage plans by state, with Massachusetts enrollment at 21%, falling well below the national average of 33%.

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10 Ibid.
These experts believe that health reform efforts could grow more uncertain – and, therefore, more complicated – while threats to cybersecurity associated with health care data breaches multiply. Meanwhile, strategic investments will need to also focus on patient engagement to ensure that patients are motivated to get healthy and maintain wellness. For example, physician and other provider reimbursements under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will be tied to, among other measures, patient engagement measures that include promotion of self-management and coaching patients, measures not traditionally used by the health care industry, which has been more focused on other quality measures such as patient satisfaction scores.\(^{11}\) Creating more efficiency in health care will likely be focused on the integration of artificial intelligence into the health care workforce while health care industry middlemen, such as pharmacy benefit managers and wholesalers, will have to prove their value or be eliminated. Real-world data will likely take center stage as changes in the FDA approval process under the 21\(^{st}\) Century Cures Act extend beyond the submission of random control trial data to secure approval. Further, tax reform will likely impact business strategies for health care organizations in the new year.\(^{12}\)

Health Care Spending

In 2016, U.S. health care spending increased 4.3%, similar to the average annual growth rate of 4.2% during the 2008-2015 period, but down from 5.1% in 2014 and 5.8% in 2015. Current spending has reached $3.3 trillion, or $10,348 per person, which is $354 higher than per-capita spending in 2015 and accounts for 17.9% of the health care-

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\(^{11}\) Ibid.

\(^{12}\) Ibid.
related portion of the gross domestic product (GDP). This was a deceleration of health spending growth, down from the faster spending growth of 5.1% in 2014 and 5.8% in 2015, attributed to ACA expansions and prescription drug growth spending. The slowdown in spending for 2016 was broadly based with decelerating spending growth across all major payers as enrollment growth from the Affordable Care Act slowed. Retail prescription drug spending declined as a result of a decline in Hepatitis C drug spending, the introduction of fewer drugs compared to last year, and slower growth in drug prices. Hospital care and physician and clinical services also contributed to the deceleration in health spending growth due to slower growth in use and intensity of services. Figure 5 provides an overview of the growth in spending over time for total health expenditures as well as for hospital, prescription drug, and physician and clinical expenditures since the passage of the ACA in 2010.

Figure 5

Source: MMS staff analysis of CMS NHE data published in Health Affairs, January 2018.
Total spending for physician and clinical services increased more rapidly than any of the other health care goods and services categories in 2016, reaching $665 billion and accounting for 20% of total health spending as outlined in Figure 6.\textsuperscript{19}

\textbf{Figure 6}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{nation-health-dollar.png}
\caption{The Nation's Health Dollar ($3.3 Trillion), Calendar Year 2016, Where It Went}
\end{figure}

Note: Physician and Clinical Services covers services provided in establishments operated by Doctors of Medicine (M.D.) and Doctors of Osteopathic Medicine (D.O.), and outpatient care centers, plus the portion of medical laboratories services that are billed independently by the laboratories. This category also includes services rendered by a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) in hospitals, if the physician bills independently for those services. Clinical services provided in freestanding outpatient clinics operated by the U.S. Department of Veterans' Affairs, the U.S. Coast Guard Academy, the U.S. Department of Defense, and the U.S. Indian Health Service are also included. The establishments included in Physician and Clinical Services are classified in NAICS 6211-Offices of Physicians, NAICS 6214-Outpatient Care Centers, and a portion of NAICS 6215-Medical and Diagnostic Laboratories.\textsuperscript{20}

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.


\textsuperscript{20} Ibid.
For the twelfth year in a row, total spending growth for clinical services has outpaced total spending growth for physician services. Clinical services accounts for about 20% of the total spending in the physician and clinical services category and increased by 8.2% in 2016. This growth was driven by spending for freestanding ambulatory surgical and emergency centers, compared to a growth in spending for physician services of 4.6% in 2016. Medicare and Medicaid experienced slower growth in physician and clinical services spending in 2016 compared to 2015, driven by the slowdown in physician spending under Medicare Advantage and slower growth in spending for physician and clinical services in Medicaid due to a slowdown in enrollment. Figure 7 shows the change in Medicare payments by type of service over the last decade. The portion of payments to physicians has declined by 6% between 2006 and 2016, while the percentage of payments for outpatient prescription drugs and Medicare Advantage plans has grown over time.21

Figure 7

Medicare Benefit Payments by Type of Service, 2006 and 2016

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>2006 Percentage</th>
<th>2016 Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital inpatient services</td>
<td>32%</td>
<td>21%</td>
</tr>
<tr>
<td>Physician payments</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>Outpatient prescription drugs</td>
<td>16%</td>
<td>14%</td>
</tr>
<tr>
<td>Hospital outpatient services</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Skilled nursing facilities</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Home health services</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Other services*</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>15%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Note: *Consists of Medicare benefit spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services.

Source: Congressional Budget Office, June 2017 Medicare Baseline.

Despite slower growth for physician and clinical services under Medicare and Medicaid, a national survey indicates that more than two-thirds of responding physicians are continuing to take new and current Medicare/Medicaid patients (see Figure 8 next page).

With major ACA expansions in health insurance enrollment complete and 91% of U.S. residents now covered by health insurance, spending growth for health care at the national level will continue to decelerate and will likely return to being influenced primarily by fluctuations in the economy and demographics as it has in the past.22

**Physician Workforce**

The Association of American Medical Colleges (AAMC) projects a shortage of between 40,800 and 104,900 physicians by 2030.23 Nationally, primary care shortfalls are expected to range between 7,300 and 43,100 physicians by 2030, while demand for non-primary care physicians will exceed supply by approximately 33,500 to 61,800 physicians.24 Population growth and aging are the main demand drivers in the projected shortfalls, with the population aged 65 and older projected to grow by 55%; physician retirements are the main driver impacting supply. The ratio of physicians to APRNs and PAs will fall, while a focus on population health will result in a reduction in the short-term demand for physicians – giving way to an increase in long-term demand for more physicians as these improvements cause Americans to live longer.25

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24 Ibid.

25 Ibid.
The Cost of Insurance Coverage

In 2017, the average cost of annual premiums for single coverage increased by 4% to $6,690; the cost increased by 3% to $18,764 for family coverage (Figure 9).²⁶

**Figure 9**

*Average Annual Premiums for Single and Family Coverage, 1999-2017*

High-deductible health plan premiums were lower for single and family coverage – $6,024 for single coverage and $17,581 for family coverage.²⁷

Over the past ten years, average family premiums have increased by 55%, while worker contributions toward premiums have increased by 74% (see Figure 10 next page).


²⁷ Ibid.
The number of workers enrolled in employer-sponsored, high-deductible health plans continues to grow, increasing by eight percentage points since 2014. Cost-sharing continues to be an issue of concern under both public and private plans and policymakers are concerned that the American public will not have enough savings to meet these out-of-pocket charges. A 2016 national study found that about 40% of all households with private insurance coverage and incomes between 150% and 400% of the federal poverty line do not have enough liquid assets to cover the average employer-provided deductible of $1,500 for single people and $3,000 for families. The White House Administration’s recent decision to stop ACA cost-sharing subsidies to low-income people will likely further negatively impact the affordability of health insurance for patients across the nation. Health insurers warn that the decision to stop these subsidies will likely result in an increase in health insurance costs, less consumer choice for insurance products, and a negative impact on the stability of the insurance marketplace.

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28 Ibid.
Given that cost concerns continue to grow among the public, it is encouraging to note that three out of four physicians indicate that they are talking with their patients about health care costs. As outlined in Figure 11, more than one-third of physicians responding to a national survey indicated that they regularly speak to their patients about costs, while an additional 40% speak to their patients about cost occasionally.31

**Figure 11**

Source: Medscape Physician Compensation Report 2017

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**MACRA**

The transition to the new Medicare payment system for physicians under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP) was ongoing in 2017, with “Pick your Pace” decisions made by physicians this past year impacting their payments in 2019. The "Pick your Pace" program was designed to allow physicians to participate in the QPP while minimizing penalties for those who were new to reporting quality and other metrics. As we enter the second year of MACRA implementation, the MMS continues to work closely with other medical societies to refine the QPP requirements and implementation process. The recently finalized CMS regulations to the QPP program include a number of provisions recommended by physicians, such as raising the threshold level for non-participation in the QPP for small practices and an expanded definition of who qualifies as a small practice.

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Accountable Care Organizations (ACOs)

Findings from the 2017 Medscape Physician Compensation Survey indicate that participation by physicians in ACOs is on the rise nationally, with more than one-third of physicians participating in ACOs, up from less than 3% five years ago (see Figure 12).

Figure 12

Physician Participation in Various Payment Models

- Accountable care organization (ACO) participation
- Cash-only practice
- Concierge practice

Source: Medscape Physician Compensation Report 2017

Physician Compensation

Nationally, physician salaries are on the rise, according to the Medscape Physician Compensation Survey (see Figure 13 next page). According to researchers, the increase in salaries is due to competition among health systems that employ physicians, including hospitals and health care systems, urgent care centers, and community health centers, that are driving up demand for physician services.32

National survey data indicate that average annual full-time compensation is higher for specialist physicians compared to primary care physicians (see Figure 14 next page).\textsuperscript{33}

Burnout and administrative burdens continue to plague physicians. The Medscape Lifestyle Report 2017 found that burnout is increasing among U.S. physicians. The report authors defined burnout as “a loss of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment.” In 2017, more than half (51%) of U.S. physicians surveyed Medscape reported burnout, up from 40% in 2013. Specialties experiencing the highest rates of burnout nationally were emergency medicine (59%) and OB/GYN (56%), followed by family physicians, internists, and infectious disease physicians (all at 55%) (see Figure 15 next page).

Source: Medscape Physician Compensation Report 2017

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35 Ibid.
Physicians ranked “too many bureaucratic tasks,” “spending too many hours at work,” “feeling like a cog in a wheel,” EHRs, and low income as the main causes of burnout.

Contributing to burnout are the number of hours spent on paperwork and administration. As indicated by the results from the Medscape Physician Compensation Report (see Figure 16 next page), nearly one in five physicians say they are spending 20 or more hours per week on paperwork and administrative tasks.
Figure 16: Physician Hours Spent on Paperwork and Administration per Week

Source: Medscape Physician Compensation Report 2017
MASSACHUSETTS OVERVIEW

Access to Health Care

Massachusetts continues to lead the nation in health insurance coverage, with an uninsurance rate of 4%, compared to the national uninsurance rate of 9%. Uninsured Massachusetts residents are more likely to be male, single, without children, Hispanic, and low-income. The majority (53%) of Massachusetts residents with coverage have employer-sponsored coverage. Access to care is strong in Massachusetts, with 89% reporting a usual source of care and 82% indicating they had visited a doctor during the previous year. However, 18% of patients reported difficulty getting an appointment as soon as needed.

Figure 17 provides trend data for specific difficulties patients have had in accessing care over the past 12 months.

**Figure 17**

**Difficulties Accessing Care Over the Past 12 Months, 2008-2017**

Source: Center for Health Information and Analysis (CHIA), 2017 Massachusetts Health Insurance Survey

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37 Findings from the 2017 Massachusetts Health Insurance Survey. Center for Health Information and Analysis Website. CHIA, December 2017. Findings from the 2017 Massachusetts Health Insurance Survey.

38 Ibid.

39 Ibid.
A portion of non-emergency care issues may be tied to access difficulties. For example, more than one in three emergency department visits in the Commonwealth are for non-emergency conditions. Of those Massachusetts residents reporting a non-emergent emergency department visit, 58% said the reason for the visit was because they were unable to get an appointment at a doctor’s office or clinic as soon as needed. More than two-thirds (68%) indicated that they needed care after normal operating hours at a doctor’s office or clinic. However, cost is also an important access barrier. Specifically, about one in four (26%) of Massachusetts residents had unmet medical or dental care needs due to cost, while 78% of families with medical debt incurred that debt while insured.

Cost Trends in Massachusetts

Total health expenditures (THE) grew by 2.8% from 2015-2016, below the 3.6% set benchmark (the statewide target for the rate of growth of THE for the year) and below the 3.6% average annual rate of growth for THE from 2012-2016 (see Figure 18).

Figure 18

Total health care expenditures (THCE) per capita grew 2.8% in 2016, below the benchmark rate

Annual per-capita total health care expenditure growth in Massachusetts, 2012-2016

Notes: 2015-2016 growth is preliminary. All other years represent final data. Sources: Center for Health Information and Analysis, Total Health Care Expenditures Source: Health Policy Commission Board Meeting. December 12, 2017.

40 Ibid.
41 Ibid.
As the trend data in Figure 19 demonstrates, the growth has been decreasing since 2014.

**Figure 19: Per Capita Total Health Care Expenditures Growth, 2015-2016**

![Graph showing per capita total health care expenditures growth from 2012 to 2016. The graph indicates a decrease in growth rates from 2014 to 2016.]

The initial assessment of total health care expenditures per capita growth is 2.8% for 2016, below the health care cost growth benchmark.

Source: Center for Health Information and Analysis, Performance of the Massachusetts Health Care System Annual Report, September 2017.  

Health care spending in Massachusetts continued a trend begun in 2010, where annual growth in per capita health spending remains below the U.S. growth rate as outlined in Figure 20 (next page).
Nationally, Massachusetts’ efforts to control costs have resulted in a health care spending growth rate lower than all but three states (see Figure 21 next page).
Physicians in Massachusetts play a central role in the state’s efforts to contain costs and are demonstrating an ability to successfully manage and contain total medical costs. Specifically, physician costs in Massachusetts are rising very slowly over time: 1.7% in 2016, according to data from the Center for Health Information and Analysis (CHIA). Physician costs are lower than any of the other claims categories, including pharmacy, hospital, and other professional service category expenditures, as illustrated in Figure 22 and Figure 23, next page.

---

Figure 22: Health Care Expenditures by Service Category, 2015-2016

Health care spending increased in all claims-based service categories, ranging from 1.7% to 6.4%.


Figure 23: Health Care Expenditures by Service Category, 2015-2016

Source: Extraction from Figure 22

1 Spending growth on physician and other professionals from 2015-2016 was lower at 3.1%, compared to the 2014-2015 spending growth of 4.1%. Meanwhile, pharmacy drugs and hospital outpatient spending grew faster than physician services from 2015-2016. Despite slower growth in spending, physician and professional services continue to have the largest share of spending at 27% (see Figure 24 next page).
Commercial Insurance Cost Growth

Private health insurance spending growth rates have declined in recent years and are consistently below national rates (see Figure 25 next page).

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Figure 25

In recent years, growth in spending on private health insurance in Massachusetts has been consistently lower than national rates

Annual growth in commercial health insurance spending from previous year, per enrollee, MA and the U.S.

Source: Health Policy Commission Board Meeting. December 12, 2017.48

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1 Also, the differences between Massachusetts and U.S. premiums has narrowed over the past five years for both family and individual coverage (see Figure 26 next page).

While employer annual premiums in Massachusetts remain higher than those in the U.S., benchmark premiums for the Massachusetts Health Connector (the Massachusetts marketplace for health and dental insurance) are lower than all but one state in the U.S. (see Figure 27 next page).

Source: Health Policy Commission Board Meeting. December 12, 2017.49

49 Ibid.
Prescription drug spending continues to grow in Massachusetts, with mid-single-digit growth anticipated through 2021. Current spending growth for prescription drugs is 6.1% in 2016, down from 7.2% in 2015.

Hospital outpatient spending has increased by 5.5% in 2016; surgery and administered drugs are the highest growth areas for spending (see Figure 28 next page).
Figure 28

Surgery and administered drugs were high growth areas for commercial hospital outpatient spending from 2013 - 2015

Per member per year spending by hospital outpatient service category, 2015 and contribution to growth 2013-2015

Source: Health Policy Commission Board Meeting December 12, 2017 Presentation, Massachusetts Health Policy Commission

Medicare prices are higher at the state and national level for hospital-based rates compared to professional service office (community) rates (see Figure 29 next page).

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Figure 29

In both MA and U.S., Medicare prices are substantially higher in the hospital outpatient setting than in community settings

Comparison of Medicare prices for Evaluation & Management visits and other services in hospital outpatient and community settings, 2015

<table>
<thead>
<tr>
<th></th>
<th>Community setting</th>
<th>Hospital outpatient setting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare program payment</strong></td>
<td><strong>Office rate</strong></td>
<td><strong>Facility rate</strong></td>
</tr>
<tr>
<td>$64.53</td>
<td>$44.87</td>
<td>$92.38</td>
</tr>
<tr>
<td><strong>Beneficiary cost sharing</strong></td>
<td>$16.13</td>
<td>$11.22</td>
</tr>
<tr>
<td><strong>Total payment</strong></td>
<td>$80.66</td>
<td>$56.09</td>
</tr>
</tbody>
</table>

Source: Health Policy Commission Board Meeting December 12, 2017 Presentation, Massachusetts Health Policy Commission

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Routine office visits covered by Medicare are twice as likely to take place in a hospital outpatient setting than in a community setting in Massachusetts compared to the U.S. (see Figure 30 next page).

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Ibid.
And the cost for these routine visits is substantially higher in Massachusetts than in the U.S. The HPC estimates this excess spending to be $56 million per year (see Figure 31 next page).

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53 Ibid.


**Figure 31**

Hospital outpatient

Cost per Medicare beneficiary for routine visits is 25% higher in MA compared to the US average

<table>
<thead>
<tr>
<th>Evaluation and Management Visits (99211 - 99215)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average visit cost:</strong>&lt;br&gt;Weighted average of visit prices using the Medicare facility use rate</td>
</tr>
<tr>
<td>$99.76</td>
</tr>
<tr>
<td><strong>Visit rate:</strong>&lt;br&gt;Mean number of visits per beneficiary</td>
</tr>
<tr>
<td><strong>Cost per Medicare beneficiary</strong></td>
</tr>
</tbody>
</table>

*Excess spending in Massachusetts due to higher use of hospital outpatient departments for Medicare E&M visits totals an estimated $56 million annually*

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Source: *Health Policy Commission Board Meeting December 12, 2017 Presentation*, Massachusetts Health Policy Commission

*Health Care Utilization in Massachusetts*

Behavioral health emergency department visits are up by 40% for alcohol-related disorders and 54% for substance use-related disorders in Massachusetts (see *Figure 32* next page).
Thirty-day readmission rates, once declining in both Massachusetts and the U.S., have started to increase in Massachusetts, while U.S. rates continue to trend downward (see Figure 33 next page).

Source: Health Policy Commission Board Meeting, December 12, 2017 Presentation, Massachusetts Health Policy Commission

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55 Ibid.
Alternative Payment Methodologies (APMs)

An uptake in alternative payment methodologies continues to grow in 2016, mainly due to growth in commercial PPO products (see Figure 34 next page).

Source: Health Policy Commission Board Meeting December 12, 2017 Presentation, Massachusetts Health Policy Commission\textsuperscript{56}

\textsuperscript{56} Ibid.
Figure 34

Uptake of alternative payment methods (APMs) increased in 2016, driven by growth in commercial PPO products

Proportion of member months under APM by insurance category, 2014-2016

Source: Health Policy Commission Board Meeting, December 12, 2017. 57

Figure 35 (next page) shows the uptake in APMs is more limited for smaller Massachusetts insurers and national insurers.

Figure 35

Smaller MA insurers and national insurers have limited growth in APMs

Proportion of commercial member months under APMs by carrier type

Source: Health Policy Commission Board Meeting, December 12, 2017.58

Figure 36 (next page) provides an overview of the adoption of APMs by commercial payers. Most commercial payers demonstrated an increase in the adoption of APMs over time, with Unicare, Harvard Pilgrim Health Care, and Blue Cross Blue Shield of Massachusetts leading the way.

58 Ibid.
Tiered and limited-network insurance products also continue to grow in 2016, mainly due to Group Insurance Commission (GIC) plans for state employees (see Figure 37 next page).

---

Cost and Utilization Comparisons for Physician-Led Systems vs. Other Systems

The Massachusetts Health Policy Commission (HPC) conducted an analysis of physician-led system cost and utilization compared to cost and utilization for systems anchored by academic or other hospital-based systems. Findings demonstrated that physician-led systems demonstrate lower spending than non-physician-led systems. As Figure 38 (next page) outlines, physician-led systems demonstrated 17% lower spending than academic medical center (AMC) anchored systems, and 7% lower spending than other hospital-anchored systems.

---

Physician-led provider organizations had 66% lower spending on per-member, per-year (PMPY) outpatient costs and 9% lower spending on inpatient costs compared to AMC-anchored systems. Physician-led costs were also lower than hospital-anchored system costs for both inpatient and outpatient PMPY spending in 2015 (see Figure 39 next page).

---

Notes: PMPY=per member per year, PCP=primary care provider, AMC=academic medical center. Other hospital-anchored includes systems anchored by either a teaching or community hospital. Spending adjusted using ACG risk-adjuster applied to claims data. Data include only privately insured adults (age 18+) covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan. Only members with a PCP affiliated with one of the 14 largest PCP groups, as identified by number of patients attributed in the All-Payers Claims Database, are included here.

Sources: HPC analysis of Massachusetts All-Payers Claims Database, 2014; Registration of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December, 2015

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Physician-led systems also had the lowest laboratory and pharmacy spending see (see Figure 40).

**Figure 40**

**AMC-anchored groups also had the highest laboratory and pharmacy spending**

*Average commercial PMPY spending on labs and prescription drugs, by system composition, 2014*

Source: Massachusetts Health Policy Commission, Joint Meeting of the Cost Trends and Market Performance and Community Health Care Investment and Consumer Involvement Committees, December 6, 2017.63

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Overall, spending in the highest-cost systems was 32% higher than spending in the lowest cost systems as outlined in Figure 41.

**Figure 41**

Member spending in the highest-cost organization was 32% higher than in the lowest-cost organization

Average commercial PMPY spending, by provider organization, 2015

![PMPY spending chart]

Notes: PMPY=per member per year, PCP=primary care provider, AMC=academic medical center. Spending adjusted using ACG risk-adjuster applied to claims data. Data includes only adults over the age of 18. Commercial payers include Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan. MassHealth includes only MCO enrollees who had coverage through BMC HealthNet, Neighborhood Health Plan, or Network Health/Tufts. Members in the MassHealth Medical Security Program (MSP) were excluded. Shown here are the 14 largest PCP groups as identified by number of patients attributed in the All-Payers Claims Database. Average calculated using all attributed adult members in the sample, not just those with a PCP associated with one of the 14 largest provider groups.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2014; Registry of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December 2015

For the most part, physician-led systems also demonstrated fewer avoidable emergency department visits and lower rates of non-recommended imaging than AMC-anchored and other hospital-anchored systems, while two of the three physician-led organizations had low rates of avoidable hospital visits as well (see Figure 42, Figure 43, and Figure 44 next pages.

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Notes: ED=emergency department; AMC=academic medical center. Adjusted avoidable ED visits by provider group were defined according to the NYU Billings Algorithm and calculated after adjusting for the following patient characteristics: risk score, median community income, area deprivation index, fully insured (commercial patients only), age, gender, and payer. Data include only privately insured adults (age 18+) covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan. Shown here are the 14 largest PCP groups as identified by number of patients attributed in the All-Payers Claims Database. The avoidable hospital measure is based on criteria developed by the Agency for Healthcare Research and Quality’s Prevention Quality Indicators to identify ambulatory care sensitive conditions – adapted for use in the APCD.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2014; Registration of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December 2015.65

65 Ibid.
Figure 43

Rates of non-recommended imaging were lowest for members in physician-led organizations

*Rate of non-recommended imaging among commercial members per 100 eligible encounters, by system composition, 2014*

Source: Massachusetts Health Policy Commission, Joint Meeting of the Cost Trends and Market Performance and Community Health Care Investment and Consumer Involvement Committees, December 6, 2017.66

Notes: POP = primary care provider; AMC = academic medical center. An encounter is defined as an insurance claim for the same patient, on the same day, for the same service. Other hospital-anchored includes systems anchored by either a teaching or community hospital. Rate of non-recommended imaging encounter is a composite measure of four low-value care imaging measures, including: back imaging for non-specific back pain, head imaging for uncomplicated headache, imaging for plantar fasciitis, and head imaging in the evaluation of syncope. These measures are from the Choosing Wisely campaign, for which researchers have developed algorithms for claims data. Data include only privately insured adults (ages 18+) covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan. Only members with a PCP affiliated with one of the 14 largest PCP groups, as identified by number of patients attributed in the All-Payers Claims Database, are included here.

However, physician and other professional spending was slightly higher in physician-led groups – 12% higher than other hospital-anchored systems and 6% higher than AMC-anchored systems for average commercial PMPY spending as indicated in Figure 44.

**Figure 44**

**Physician and other professional spending was slightly higher in physician-led groups**

Average commercial PMPY professional spending, by system composition, 2014

<table>
<thead>
<tr>
<th></th>
<th>Risk adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$2,433</td>
</tr>
<tr>
<td>$500</td>
<td>$2,130</td>
</tr>
<tr>
<td>$1,000</td>
<td>$2,287</td>
</tr>
<tr>
<td>$1,500</td>
<td></td>
</tr>
<tr>
<td>$2,000</td>
<td></td>
</tr>
<tr>
<td>$2,500</td>
<td></td>
</tr>
<tr>
<td>$3,000</td>
<td></td>
</tr>
</tbody>
</table>

Notes: PMPY = per member per year; PCP = primary care provider; AMC = academic medical center. Other hospital-anchored includes systems anchored by either a teaching or community hospital. Spending adjusted using AGG risk-adjuster applied to claims data. Data include only privately insured adults (ages 18+) covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan. Only members with a PCP affiliated with one of the 14 largest PCP groups, as identified by number of patients attributed in the All-Payers Claims Database, are included here.

Source: Massachusetts Health Policy Commission, Joint Meeting of the Cost Trends and Market Performance and Community Health Care Investment and Consumer Involvement Committees, December 6, 2017.67

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**Health Reform Implementation**

The evaluation of the 2012 Health Care Cost Containment Law in Massachusetts, conducted by the Massachusetts State Auditor’s office in 2017, found the following overall key findings:

- Massachusetts maintained access to care, but continued to grapple with high levels of hospital readmissions and avoidable ED visits.

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67 Ibid.
• There were mixed results on quality measures for population groups and a lack of data on outcomes for people with disabilities.

• Care coordination, more visits to non-physician PCPs, and integration of behavioral health are outcomes that have not yet been achieved according to the evaluation. The report noted that more treatment for mental health and substance abuse is needed. A policy implication of the evaluation findings is that Massachusetts needs to increase the capacity of PCPs to treat behavioral health needs.

• There was growth in both the Massachusetts health care workforce and demand, yet wages remain stagnant. Skill acquisition and enhancement will be critical for these workers in the future, according to the evaluation, with a focus on lower-wage workers such as home health aides and personal care assistants. The report also noted that a recent ban on immigration at the federal level is further exacerbating problems with workforce supply.

• The evaluation found mixed results on prevention and not enough data to assess wellness programs. While racial/ethnic disparities persist, the report noted that social determinants of health were powerful predictors of disparities.

• Survey data from the Massachusetts Health Reform Survey shows that shifting visits to non-physician PCPs, a goal of the law, has not occurred. The data are from 2010, 2012, and 2013. However, separate report findings demonstrate that health care providers are redesigning delivery systems to allow workers to work at the top of their licenses and to increase efficiencies and quality. Both of these findings will likely impact scope of practice discussions in the coming year.

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**Health Insurance Enrollment Trends**

Trends in enrollment and spending varied by market segment in Massachusetts as detailed in Figure 45 (next page). Enrollment in commercial plans increased slightly, by 0.3%, while Medicare enrollment was up by 3% in Advantage plans and 2% in FFS plans. Enrollment in MassHealth declined slightly by 0.8%, despite an increase in spending of 5%. Spending increased in the commercial market by 3.4%, while Medicare spending decreased (-2% in the Advantage market) or remained nearly flat (+0.3% in FFS).
Figure 45

Trends in spending and enrollment differed by market segment

Spending growth per enrollee and enrollment growth by market, 2015-2016

<table>
<thead>
<tr>
<th></th>
<th>Commercial</th>
<th>MassHealth (PCC and MCO)</th>
<th>Medicare Advantage</th>
<th>Medicare FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spending</td>
<td>3.4%</td>
<td>5.0%</td>
<td>3.0%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Enrollment</td>
<td>0.3%</td>
<td>-0.8%</td>
<td>-2.0%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Source: Health Policy Commission Board Meeting, December 12, 2017. 68

Figure 46 demonstrates commercial enrollment by payer. Blue Cross Blue Shield of Massachusetts has the largest market share, covering over 1.6 million of Massachusetts residents. Tufts and Harvard Pilgrim Health Plans round out the top three insurers with the largest share of enrollees in the Commonwealth.\textsuperscript{69}

\textbf{Figure 46}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{commercial_enrollment}
\caption{Commercial (Private & Public) Enrollment by Payer}
\end{figure}

Source: CHIA, Enrollment Trends, August 2017.\textsuperscript{70}

\textsuperscript{69} Findings from the 2017 Massachusetts Health Insurance Survey, Center for Health Information and Analysis Website. CHIA, December 2017. Findings from the 2017 Massachusetts Health Insurance Survey.

Under ongoing health reform efforts in the Commonwealth, the Governor’s office announced that 17 health care organizations have executed agreements to participate in a major restructuring of the state’s Medicaid program, MassHealth. As of March 2018, 850,000 MassHealth members will be covered by Accountable Care Organizations (ACOs) established by the following “networks of physicians, hospitals and other community-based health care providers, and will be financially accountable for cost, quality, and member experience”:

- Atrius Health with Tufts Health Public Plans
- Baystate Health Care Alliance with Health New England
- Beth Israel Deaconess Care Organization with Tufts Health Public Plans
- Boston Accountable Care Organization with Boston Medical Center HealthNet Plan
- Cambridge Health Alliance with Tufts Health Public Plans
- Children’s Hospital Integrated Care Organization with Tufts Health Public Plans
- Community Care Cooperative, an organization of 13 federally qualified health centers.
- Health Collaborative of the Berkshires with Fallon Community Health Plan
- Lahey Health
- Mercy Health Accountable Care Organization with Boston Medical Center HealthNet Plan
- Merrimack Valley ACO with Neighborhood Health Plan
- Partners HealthCare ACO
- Reliant Medical Group with Fallon Community Health Plan
- Signature Healthcare Corporation with Boston Medical Center HealthNet Plan
- Southcoast Health Network with Boston Medical Center HealthNet Plan
- Steward Medicaid Care Network
- Wellforce with Fallon Community Health Plan

High-Deductible Health Plans

The IRS defines high-deductible plans as those with a minimum deductible of $1,300 for an individual plan and $2,600 for a family policy. About one million Massachusetts residents with private coverage are enrolled in high-deductible health plans. This is an increase of seven percentage points since 2012, impacting an additional 350,000 people.

Findings from the MMS report, Assessment of the Impact of High-Deductible Health Plans on Patient Health and the Financial Impact on Medical Practices, indicate that the numbers of Massachusetts residents covered by high-deductible health plans (HDHPs) will continue to grow in the future. The report recommends that the MMS continue to use its voice and influence at both the state and federal levels to raise concerns about the potentially adverse impact HDHPs can have on patient health and financial security, as well as the impact of the increase in cost-sharing in general on patients in the Commonwealth.

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73 Ibid.
Despite a high cost of living in the Northeast region, physician compensation continues to lag behind many of the other geographic areas of the U.S., as outlined in Figure 47.

Figure 47

![Physician Compensation by Geographic Area]


According to data from the Bureau of Labor Statistics (BLS), Massachusetts annual mean wages for “Physicians and Surgeons, All Other” (i.e., all physicians and surgeons not listed separately) are the lowest in New England and are among the lowest in the nation. Figure 48 below provides an overview of mean wages by state for all physicians in the U.S.

Figure 48

![Annual mean wage of physicians and surgeons, all other, by state, May 2016]

MMS ACTIVITIES, SERVICES, AND MEMBER SURVEYS

The MMS continues to address the key issues of quality, cost-effective care, access to care, price transparency, equity in health care, as well as health reform nationally and locally. As a foundation for understanding these topics, the MMS conducted surveys, interviews, and secondary research, as well as participated in a large number of local and national meetings with the administration, payers, policy experts, physician-leaders of large medical groups and ACOs, and practicing physicians in the community to gather critical input. Understanding key topics such as health reform, payment reform (including MACRA), the rising cost of health care, tiering, limited networks, high-deductible health plans, access to care, new physician practice structures, use of retail and urgent care clinics and telemedicine, the opioid crisis, consolidation (e.g., ACOs), physician employment status, licensure requirements, and new laws and regulations – and how they affect how physicians deliver care – is critical.

Annual Membership Survey – 2017

The MMS continues to monitor general and targeted issues in the physician community through surveys, focus groups, interviews, and daily physician interactions with staff. The following are the results of the 2017 Annual Membership Survey.

Member Satisfaction

• The overall level of satisfaction with MMS membership continues to be very high, with 94% of members surveyed responding that they were either "very satisfied" or "satisfied" with their membership.
• 98% of respondents reported that they were likely to renew their membership in the coming year. This high likelihood of renewal was consistent across all age groups and practice types.

MMS Priorities

• Members consistently rate advocacy on behalf of physicians as the principal responsibility of the MMS. Advocating with the state government was cited as "very important" by 87% of physicians responding to the survey while 79% said advocating for administrative relief with health plans was "very important." More than two-thirds of respondents indicated that advocating for physicians with the federal government (68%) and advocating for patients (69%) was "very important."
• Members also indicated that it is “very important” for the MMS to help Massachusetts physicians by keeping them informed, specifically in the areas of payment reform (67%) and issues facing the profession (78%).
• Education is also an important priority for respondents, with 68% indicating that providing continuing medical education (CME) opportunities is “very important.”
• About half of respondents (51%) indicated that providing public health resources is “very important,” while 41% indicated that assisting physicians with practice management issues is “very important.”

Key Performance Ratings

• Advocacy: The MMS’s advocacy efforts received solid ratings. Respondents rated advocacy with state government (87%), federal government (85%), and patients (92%) as either “good,” “very good,” or “excellent.” Respondents also gave the MMS high marks on advocacy related to physician practice challenges.
Specifically, 77% of those responding said the MMS’s advocacy efforts for health plan administrative relief was “good,” “very good,” or “excellent.”

- **Education and Resources:** 98% of members surveyed rated the MMS as “good,” “very good,” or “excellent” at providing CME opportunities, while 94% of physicians responding indicated that the MMS is “good,” “very good,” or “excellent” at providing them with public health resources. 85% percent of respondents said that the MMS is “good,” “very good,” or “excellent” at assisting physicians with practice management issues.

- **Communication:** The MMS’s communication efforts received high marks. 94% of members surveyed rated the MMS as “good,” “very good,” or “excellent” at keeping physicians informed about issues facing the profession and payment reform, and 98% of respondents said that communicating information in a timely way about MMS activities and initiatives was “good,” “very good,” or “excellent.”

**Membership Value**

- Members were asked to rank the aspects of membership that were most valuable to them. The following list demonstrates that respondents ranked advocacy, NEJM products and services, and leadership opportunities as the three most valuable aspects of their MMS membership:

1. Advocacy
2. NEJM Group Products and Services
3. Continuing Medical Education
4. Leadership Opportunities
5. Networking
6. Practice Management Support
7. Public Health Resources
8. Boston Medical Library

**Feedback Related to Practice Issues and Challenges Faced by Physicians**

- Physicians were also asked: “Please tell us how challenging you find the following practice issues.” The following list ranks the practice issues by the proportion of physicians indicating an issue is “Very Challenging” or “Somewhat Challenging”:

<table>
<thead>
<tr>
<th>Practice Issue</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handling health plan administration</td>
<td>71%</td>
</tr>
<tr>
<td>Amount of reimbursement for your services</td>
<td>67%</td>
</tr>
<tr>
<td>Electronic health records (EHR)/Health information technology (HIT)</td>
<td>64%</td>
</tr>
<tr>
<td>Sustainable level of practice income</td>
<td>64%</td>
</tr>
<tr>
<td>High-deductible health plans</td>
<td>62%</td>
</tr>
<tr>
<td>MACRA (Medicare Access and CHIP Reauthorization Act of 2015) / Medicare Quality Payment Program</td>
<td>61%</td>
</tr>
<tr>
<td>Meeting targets for quality measures used by payers, the state, and others</td>
<td>61%</td>
</tr>
<tr>
<td>Meeting targets for cost measures used by payers, the state, and others</td>
<td>59%</td>
</tr>
</tbody>
</table>
Feedback Related to Clinical Issues and Challenges Faced by Physicians

Physicians were also asked: “Please tell us how challenging you find the following clinical issues.” The following list ranks the clinical issues by the proportion of physicians indicating an issue is “Very Challenging” or “Somewhat Challenging”:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintaining autonomy in clinical decision-making</td>
<td>64%</td>
</tr>
<tr>
<td>Preservation of medical professionalism</td>
<td>62%</td>
</tr>
<tr>
<td>Opioid prescribing</td>
<td>50%</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>43%</td>
</tr>
<tr>
<td>Patient engagement</td>
<td>41%</td>
</tr>
<tr>
<td>Prescribing medication-assisted treatment (MAT) to treat patients with dependence/addiction to opioids (narcotics)</td>
<td>41%</td>
</tr>
<tr>
<td>Access to medical library services</td>
<td>26%</td>
</tr>
</tbody>
</table>

Feedback Related to Professional Issues and Challenges Faced by Physicians

Physicians were also asked: “Please tell us how challenging you find the following professional issues.” The following list ranks the practice issues by the proportion of physicians indicating an issue is “Very Challenging” or “Somewhat Challenging”:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work/life balance</td>
<td>81%</td>
</tr>
<tr>
<td>Burnout</td>
<td>69%</td>
</tr>
<tr>
<td>Lack of physician “community”</td>
<td>68%</td>
</tr>
<tr>
<td>Hospital-physician relationship</td>
<td>57%</td>
</tr>
<tr>
<td>Determining which group practice/organization to join</td>
<td>33%</td>
</tr>
<tr>
<td>Determining whether to be self-employed/employed</td>
<td>30%</td>
</tr>
</tbody>
</table>

MMS Physician Practice Survey – 2017

The MMS Physician Practice Survey was developed at the request of the Committee on the Sustainability of Private Practice. The results of the survey enabled the MMS to compare private practice physician members’ issues with employed physician members to better understand the difference and similarities of their practice concerns. However, caution should be used in generalizing the findings to the full population of MMS physician members, due to the potential for non-response bias given the small sample size. The survey was sent to a sample of approximately 7,500 practicing physician members between January and February 2017. The survey yielded a response rate of 7%, with 524 physicians responding to the survey. The following provides an overview of the findings from the survey:

More than one-half of respondents were employed physicians, while approximately one-third were owners.
Nearly half of respondents (46%) worked for a practice that was wholly owned by one or more physicians in the practice, while slightly more than one in four (29%) worked in a practice that was wholly owned by a hospital or hospital system.

Both employed and owner physicians ranked the following issues as their top five most challenging: administrative simplification, work/life balance, EHR/IT, sustainable level of practice income, and coding/HIPAA compliance (see Figure 49). These issues are similar to those cited by U.S. physicians in the Medscape Survey findings outlined in the national overview section of this report. Some of the top causes of burnout were bureaucracy, EHRs, and low income, as well as the causes reflected in the MMS Membership Satisfaction Survey outlined above.

Figure 49

**Ranking of issues by most challenging for all physicians**

<table>
<thead>
<tr>
<th>All Physicians</th>
<th>Owners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administrative Simplification</td>
<td>1. Administrative Simplification</td>
</tr>
<tr>
<td>2. Work/Life Balance</td>
<td>2. EHR/IT</td>
</tr>
<tr>
<td>3. EHR/IT</td>
<td>3. Work/Life Balance</td>
</tr>
<tr>
<td>4. Sustainable Level of Practice Income</td>
<td>4. Sustainable Level of Practice Income</td>
</tr>
<tr>
<td>5. Coding/HIPAA Compliance</td>
<td>5. Coding/HIPAA Compliance</td>
</tr>
</tbody>
</table>


Medical Aid-in-Dying/Physician-Assisted Suicide Survey – 2017

A policy adopted at I-16 called for a survey of MMS membership on medical aid-in-dying, also known as physician-assisted suicide (MAID/PAS). In September 2017, the MMS conducted a statewide survey of current members to measure the attitudes of physicians and physicians-in-training in Massachusetts. MMS officers, with the Committee on Public Health (CPH) and the Committee on Geriatric Medicine (CGM), developed a work plan and timeline for implementation of the directive. The MMS contracted with Robert H. Aseltine, Jr., PhD, Professor and Chair in the Division of Behavioral Sciences and Community Health at UConn Health, to consult on the survey.

The MMS hosted five focus groups with MMS physician members across Massachusetts to better understand physicians’ perspectives and guide survey development. The officers and members of CPH and CGM reviewed and approved the final focus group questions. The finalized survey instrument was tested by leadership and members of CPH and CGM. Those completing the survey received a code to waive the fee for an MMS end-of-life focused online CME program.
The initial sample contained all 22,597 members drawn from the membership lists maintained by the MMS as of August 2017. Members without a valid email address on file received a print copy of the survey via postal mail to be completed and returned in a postage-paid envelope (N=5,021). Members who had valid email addresses on file were initially invited to complete the survey online, using a secure link sent through email (N=17,576). Fifty-two percent of those who received the email opened it. Members of the sample not responding to the email invitation within the allotted time received three follow-up email invitations throughout September 2017. A total of 2,294 members completed the survey online and 355 members of the sample completed the survey by mail, for a total of 2,649 and a response rate of 12%. The MMS also attempted to contact a random sample of 219 non-respondents by telephone to determine eligibility; this information was then used to adjust the sample denominator for response rate calculations, resulting in an adjusted response rate of 13%. The response rate for physicians was 16%; the response rate for physicians-in-training (medical students, residents, and fellows) was 5%.

Physician respondents’ opinions on three key questions regarding MAID/PAS are indicated below:

- 60% of physicians responding either supported or strongly supported the practice of physicians giving terminally ill adults prescriptions for lethal doses of medications, to be self-administered at such time as the patient sees fit.
- 62% of respondents either supported or strongly supported the proposed “aid-in-dying” legislation in Massachusetts, An Act Relative to End of Life Options (House Bill 1194/Senate Bill 1225).
- 41% of physicians completing the survey favored changing the MMS’ policy position to support MAID/PAS.
- 30% of respondents favored maintaining the MMS’ current policy opposing MAID/PAS.
- 19% favored changing the policy so that the MMS neither formally supports nor opposes MAID/PAS, with 6.5% choosing “Not Sure” and 3.5% choosing “None of These/Other.”
- 66% of physicians who rarely or never treated patients at the end of life either supported or strongly supported the practice of MAID/PAS, compared to 53% of physicians who often or sometimes treated such patients.
- 68% of physicians who rarely or never treated patients at the end of life either supported or strongly supported the proposed “aid-in-dying” legislation in Massachusetts, compared to 56% of physicians who often or sometimes treated such patients.
- 45% of physicians who rarely or never treated patients at the end of life favored changing the MMS policy position to support MAID/PAS; 24% of such physicians favored maintaining the current MMS policy. In contrast, roughly equal proportions of physicians who more frequently treated patients at the end of life favored changing the policy to support MAID/PAS (38%) and maintaining the current MMS policy opposed to MAID/PAS (37%).

The survey results were taken into account in considering the MMS’ position on end-of-life care moving forward at I-17 by the HOD. At I-17, HOD voted:

1. That the Massachusetts Medical Society rescind the following policy: The Massachusetts Medical Society is opposed to physician-assisted suicide. (HP)
1a. That the MMS defines medical aid-in-dying as the act of providing care — palliative, hospice, compassionate — to patients at the end of life. The act of a physician writing a prescription for a lethal dose of medication to be used by an adult with a terminal illness at such time as the patient sees fit will, if legalized, be recognized as an additional option in the care of the terminally ill. (HP)

2. That the MMS adopt the position of neutral engagement, serving as a medical and scientific resource to inform legislative efforts that will support patient and physician shared decision-making regarding medical aid-in-dying, provided that physicians shall not be required to provide medical aid-in-dying that involves prescribing lethal doses of medication if it violates personally held ethical principles. (HP)

3. That the MMS asserts that medical aid-in-dying that involves prescribing lethal doses of medication should be practiced only by a duly licensed physician in conformance with standards of good medical practice and statutory authority. (HP)

4. That the MMS will support its members regarding clinical, ethical, and legal considerations of medical aid-in-dying, through education, advocacy, and/or the provision of other resources, whether or not members choose to practice it. (HP)

5. That the MMS notify the AMA and its Council on Ethical and Judicial Affairs of the MMS position on medical aid-in-dying. (D)

6. That the MMS supports effective palliative care, especially at the end of life. (HP)

Membership Activities

Membership in the MMS reached another all-time high of 25,277 members at the close of FY’17.

In April 2017, the MMS extended complimentary membership to physicians practicing in a federally qualified community health center setting. As of November 2017, the MMS has welcomed 440 new members through this program (total of 645 members working in a CHC). Group membership also continues to grow, with 4,900 physicians and 5,367 resident members as of January 1, 2018.

The MMS continues to develop new tactics and channels for general member recruitment, including:

1. Digital advertising campaign in Q1 & Q2 2018 – sponsored posts on Facebook and LinkedIn, and retargeting ads via GoogleAds.

2. Targeted marketing and audience-specific messaging, including:
   • Former MMS members
   • Physicians scheduled for license renewal in 2018 – reminding physicians that MMS members save on required CME.

3. Calculating an ROI for membership; the MMS has begun to promote the value and economic return on membership ($400+ annually).

The MMS also continues to pursue opportunities to enhance the value of membership and, at I-17, announced the addition of a complimentary subscription to *NEJM Journal Watch Online* as a new benefit of membership.
The engagement of diverse demographic groups within the medical profession remains a priority, and the MMS continues to develop initiatives to engage young physicians, women physicians, and physicians from minority communities, including:

- A planning committee working on the formation of the new Minority Affairs Section (MAS) has been formed and is making progress on the development of the section’s operating guidelines. Once formally established, the MAS will provide a pathway for members interested in minority affairs issues to advance policies and increase participation in the MMS and MMS leadership among physicians from underrepresented communities.
- The Task Force on Academic Physicians has convened to determine whether or not to revive the Academic Physician Section. The Task Force is working on assessing and strengthening the ways in which the MMS brings value to academic physician members.
- The Committee on Women in Medicine continues to develop programs that address women’s health and foster women’s networking. The Committee is currently planning a combined Women’s Health and Leadership Forum event for Fall 2018.
- The Committee on LGBTQ Matters recently awarded five grants to medical students and residents/fellows, which will be used for curriculum development or to produce research that addresses lesbian, gay, bisexual, and transgender health disparities.
- Medical Student/Residents/Young Physician legislative briefing and training workshop.
- Young Physician Section Community Service Day(s); students are planning spring community service events.
- Young Physicians have one MMS-funded representative and Residents have two funded representatives attending the AMA National Advocacy Conference with the Massachusetts Delegation. Students have four funded representatives (one from each school) attending the AMA Student Advocacy Conference.
- Financial Focus Series for Young Physicians, Residents/Fellows, and Medical Students – combination of live, webinar, and online educational programs (Financial Literacy 101: Basics, Emerging Payment Models, Understanding Employment, Employment Contract & Benefits Negotiation, and Reading Financial Forms) in collaboration with the HFMA.
- The MMS will introduce regional social/networking events, inviting members and non-members to convene with colleagues from across specialties, disciplines, and organizations.

The MMS’ Committees and Task Forces continue to focus on the MMS key strategic priorities. For example, the Committee on the Quality of Medical Practice continues to work on quality issues such as patient-reported outcome measures, open notes medical records, and physician burnout, as well as state initiatives on price transparency. Beginning January 2018, the MMS will begin a MMS-MHA Joint Task Force on Physician Burnout to raise awareness on the issue and to develop strategic recommendations to reduce burnout. The MMS Committee on Legislation continues to review and assess relevant bills and legislation that impact physicians’ practices and care delivery.
Continuing Education and Certification

The MMS provided or jointly provided learning opportunities to physicians and other health professionals in a variety of formats, including in-person (live), webinar, online, journal-based and performance improvement. Most of these activities were developed to address gaps in practice or performance, and to help physicians meet medical licensure requirements and state-mandated continuing professional development in subject areas such as end-of-life care, pain management/opioid prescribing education, electronic health records, and risk management.

In May 2015, the MMS determined that price should not be a barrier for physicians to access quality education in pain management and opioid prescribing, and began to offer its online CME on this topic free of charge. Since that time, more than 40,000 online courses have been completed by over 6,700 unique users. Data indicates that 77% of participants are physicians and 52% are in Massachusetts.

Collaboration in education has continued in FY‘17, with more than 60% of the MMS’ CME activities were developed and delivered in concert with national and statewide organizations, including the Department of Public Health, state chapters of national specialty societies, other state medical societies, and organizations considered to be clinical content experts.

Advancement of physician knowledge has been addressed through partnerships with Harvard Medical School Center for Bioethics, the Alzheimer’s Association’s regional chapter, and the Heller School at Brandeis University (Executive MBA for Physicians), to name a few examples. The MMS’ Annual State of the State of Health Care event, Public Health Leadership Forum, Women’s Leadership Forum (Managing Workplace Conflict: Improving Leadership & Personal Effectiveness), and related online courses continue to address the complexities of the evolving health care environment.

The MMS continues to respond to the educational needs of physicians at the grassroots level through its Recognized Accréditor Program. This long-standing MMS service enables 49 community hospitals, state specialty societies, and other health-related organizations to provide accredited CME for their medical staff, members, and clinicians focusing on the health care of the community they serve. During the past year, 11 institutions were surveyed for CME compliance to national education standards and 16 other recognized providers submitted progress reports outlining their improvement strategies.

As the health care environment continues to change, the MMS will adapt its CME curriculum to help physicians improve their knowledge and skills, with the goal of improving the overall health and care of patients. The MMS will continue to collaborate and jointly provide CME activities to bring relevant content to learners. As new technologies develop, the MMS will work to improve content delivery formats and platforms to meet the educational needs of physicians and other health professionals within Massachusetts and beyond.
Examples of CME Activities include:

**Patient Experience/Satisfaction — Live**
- Clinical Observation and Coaching Program Performance Improvement CME (PICME) — Ongoing through CY’18, jointly provided with LogixHealth
- Amplifying Empathy Forum: Relationship Centered Communication – June 1, 2016

**Health Care Quality/Access/Clinical — Live**
- 14th Annual Symposium on Men’s Health – June 16, 2016
- Evolutionary Biology in Clinical Medicine Webinar – September 19, 2016
- Medication Assisted Treatment Summit: Improving Access to Evidence-Based Care – October 31, 2016
- 2016 Annual Oration: Zika Virus - Consequences for Massachusetts – December 2, 2016
- MACRA: What Physicians Need to Know - offered in several locations in FY’17
- 5th Annual Communication, Apology, and Resolution Following Medical Injury Conference – April 13, 2017, jointly provided with the Massachusetts Alliance for Communication and Resolution Following Medical Injury (MACRMI)
- “Stop the Bleed” Training – April 28, 2017
- Engaging Physicians and Care Teams to Prevent Diabetes Webinar – May 2, 2017, jointly provided with the Massachusetts Department of Public Health

**Health Care Quality Access/Clinical Medicine — Online**
- Firearm Violence: Prevention & Public Health - Reducing Firearm Injury (Modules 1-6)
- Efficacy of FIT-FOBT for Colorectal Cancer Screening
- Starting the Conversation about End-of-Life Care with Patients
- MassPAT: Incorporating the New PMP into Your Practice
- Helping Patients with COPD Breathe Easier
- Avoiding Medical Mistakes and Errors
- Running on Empty? Physicians’ Path to Enjoying Life and Medicine More
- Telehealth: A Primer
- Legal Advisor: Dealing with Difficult Patients and Managing the Risk of Board Complaints

**Practice Research and Resources**
The MMS works closely with Massachusetts Health Quality Partners and the Coalition for the Prevention of Medical Errors to research issues and educate physicians and the public about key health care topics.

The MMS has continued its efforts in providing relevant and timely tools, resources, educational programs, and access to knowledgeable experts with the goal of providing the most up-to-date information necessary to help physicians navigate the rapidly changing practice environment. The MMS has developed resources and support in four key areas, which include:
2. Licensing Requirements for Practicing Medicine in the Commonwealth of Massachusetts
3. Holding the Line: How Massachusetts Physicians Are Containing Costs
4. Stark Series

Practice Education Series – 2017 Education Program Examples:

- Running on Empty? Physicians’ Path to Enjoying Life and Medicine More, January 25, 2017
- Discussion on Concussions: Clinical Headlines, May 10, 2017
- MACRA MIPs Trainings with Healthcentric Advisors, Summer and Winter 2017
- Summer 2017: Independent Claims Consultation Days (Total of 3)
- Restoring Well-Being to the Medical Profession: What Can Individuals, Teams, and Organizations Do?, October 2017
- 4th Annual PPRC Talks: Crucial Conversations in an Era of Transitions – Patient Physician Engagement and Compensation Arrangements
- Current and Future Models of Physician Compensation (Finance Series Component), December 2017

Physician Practice Help Center (PPHC): 2017 Review

The MMS continues to promote awareness of resources and access to assistance for practice management questions. The PPHC responded to approximately 550 calls and emails from physicians, practice managers, and other office staff from across the state from January to December 2017. Work time associated with the calls was approximately 20 minutes per call. Most frequently asked questions received include:

- Physician Retirement Issues
- Payer Issues/Coding
- Human Resources Questions
- BRM Requirements for Re-licensure
- Legal Referrals
- General Practice Management Questions
  - HIPAA/Security
  - Staffing Resources

Practice Management Consulting

The MMS continues to develop innovative programming and service offerings that can be customized and delivered onsite in physician practices. A few examples of 2017 projects include:

- Super Group (multiple practices) – Design, Planning and Implementation
- Patient Experience Trainings for Providers/Practice Staff
- Compliance Review/Assessment
- Organizational and Financial Assessments
- Medical Practice Start-Up (e.g. Cash-Flow Analysis, Demographic Study, Website Design and Online Marketing)
- Physician Recruitment Strategies
- Succession Planning Educational Sessions
- PCMH Transformation
Massachusetts Collaborative

The MMS participates in the Massachusetts Collaborative, a voluntary group of payers and providers working on administrative simplification initiatives. The MMS, MHA, BCBSMA and MAHP are the primary members of the strategy and operations group, and there is representation across the industry in workgroups and on monthly stakeholder calls. A core focus has been reducing the time necessary to credential new physicians in Massachusetts. The Collaborative hired AMS consulting to assess the pain points in the end-to-end credentialing processes. The Collaborative met with key stakeholders (Board of Registration in Medicine or BORIM, Massachusetts Controlled Substance Registration or MCSR, and the health plan credentialing service Healthcare Administrative Solutions or HCAS), presented the consultant’s report and spurred action to address points identified. BORIM is working toward online application processes for late 2018 and has since hired three staff members to support incoming calls and work on backlog information. MCSR should have their processes online by spring/summer 2018, and HCAS has reduced their backlog by working closely with their contacted vendors. The MMS continues to monitor this situation closely, as well as prior authorization form development and the provider directory issue.

Practice Advocacy

The MMS advocated with the state regarding the state’s price transparency website. After attending committee meetings, the MMS ensured that specialty societies had input into patient materials created for the site and secured four weeks’ time for practices to review cost data prior to public dissemination. Further, there was considerable input and conversation on cost methodology. The state’s efforts to go live with cost and quality data is expected in February 2018.

The Division of Insurance reached out to the MMS to communicate their plans to put Minuteman Health into receivership, thus prompting notification to physicians via Vital Signs This Week. Providers were informed that there were sufficient funds to pay claims for services rendered to the small number of enrollees, so physicians should continue providing care. Within a few months, the DOI notified the MMS that Minuteman would close in 2017. Again, notification was placed in Vital Signs This Week.

Federal and State Government Relations and Advocacy

This year, the strength of the MMS’ federal advocacy efforts were challenged by a relentless assault on many of the legislative and regulatory health care reforms essential to health and supported by the MMS. The MMS joined with our colleagues from the national and state arena, including other physician, patient, and health care provider organizations, to successfully defeat every legislative proposal to repeal the Patient Protection and Affordable Care Act (ACA). To this end, the MMS worked closely with the Massachusetts Congressional delegation, participating in roundtables, press events, and other forums and venues focusing on the importance of ACA from the physician/patient perspective. The MMS engaged the MMS’ membership in a grassroots campaign to reach out to colleagues in other key states to fight proposals to undermine the ACA. The MMS was a participant on the AMA task force on the ACA and participated in several state-based coalitions.

The MMS worked closely with the delegation, the Governor and state partners in calling for the reauthorization of the CHIP program and Community Health Center Legislation – two additional federal programs critical to our health care delivery system. As with our efforts on the ACA, the MMS participated in press conferences with members of the
Mass. Congressional delegation, co-signed letters with our state partners, and was active in other advocacy efforts designed to support the delegation’s efforts to secure funding for these programs.

The MMS’ advocacy at the federal level to combat the opioid addiction crisis also continued unabated. Following successful passage of the partial-fill bill into law, the MMS worked with the Mass. Congressional delegation to encourage the DEA to upgrade its regulations to enable implementation of the new law. The MMS is also working with members of the delegation to update DEA regulations governing e-prescribing of Schedule II drugs to make implementation more accessible and feasible. Among a number of legislative initiatives, the MMS is continuing to work with Representative Clark, who introduced legislation based on the McPAP model. This model would grant funds to states for experts in pain and substance abuse counseling. The MMS continues to serve on the AMA Task Force on Opioids, which develops education programs and resources at the national level. The MMS is working with the delegation on a Congressional briefing to educate staff about Supervised Injection Facilities (SIFs), informed by the landmark MMS report.

This past year, the MMS was a vocal supporter of the DREAM Act and efforts to restore protections for children protected under Deferred Action for Childhood Arrivals (DACA). The MMS was active in several other arenas at the federal level, including: support for efforts to address the pricing of prescription drugs, support for increased funds for the Substance Abuse and Mental Health Block Grant, support for parity laws for mental and behavioral health, support for legislation that would lift the federal ban on research into preventing gun violence, and support for legislation to address several corrections necessary for MACRA.

At the federal regulatory level, the MMS continued its work to support MACRA implementation and the changes to the Medicare physician fee schedule, such as payment for telemedicine services. The MMS also continued its advocacy seeking regulatory reform, including streamlining of regulations.

This year, the MMS increased its work with Community Servings, a statewide program which provided medically tailored meals at no expense to low income people with illnesses in several communities in the Commonwealth. The MMS serves on the statewide planning committees assessing food insecurity across the state and is developing a plan to expand services.

Recognizing that the MMS’ advocacy program is only as strong as its members, the MMS devoted a significant amount of time to training members on legislative issues and grassroots advocacy. Several programs were hosted for students, residents, and young physicians, as well as for pediatric residents, the Mass. Chapter of the American College of Physicians, district medical societies, and other health care organizations. The MMS is frequently called upon to speak to both MMS staff and other health care organizations about legislation in the state and nationally. Presentations to such organizations as the Medical Group Management Association, the Health Care Financing Organization Home and Health Care organization, the Boston Bar Association, and numerous hospital and physician organizations continue to promote both the reputation and advocacy agenda of Massachusetts physicians and the patients they serve.

This year brought another active advocacy initiative to Beacon Hill. The MMS was engaged with many high-profile issues, including the state budget and dozens of bills affecting the priorities of the MMS.
The FY’17 state budget, as proposed by the Governor and the houses of the state legislature, saw continued threats to the physician practice sustainability. Various versions of the budget included provisions that would cap physician reimbursement in GIC plans to 160% of Medicare, and that would place growth caps on physicians depending on their relative rate of reimbursement. The MMS successfully opposed those provisions, offering alternative policies for consideration aimed at constraining health care costs and addressing the rising cost of prescription drugs.

The MMS spent considerable time on out-of-network billing, or “surprise billing.” As this is a relatively new issue, the MMS educated legislators and regulators and developed its own legislative strategy. Several poorly conceived legislative solutions were successfully opposed by the MMS in 2017.

The MMS continues to advocate in favor of the twenty bills it filed in the legislature this session, and dozens more bills deemed to be consistent with MMS policy. Broadly speaking, the end of 2017 saw two important issues emerge in the legislature: health care cost containment and the opioid epidemic. MMS leadership and staff worked diligently to ensure that cost containment proposals are steered towards policies that promote high-value, high-quality care for patients and physicians. In addition, Governor Baker filed a second bill aimed at addressing the opioid crisis in Massachusetts. The CARE bill includes many provisions relevant to the MMS’ priorities, including a proposed mandate for electronic prescribing of controlled substances, a return to the concept of involuntary civil commitments for persons with substance use disorder, and a “prescribing oversight board” that would oversee compliance with various opioid prescribing laws and regulations. The MMS provided strong oral testimony at the hearing, provided extensive written testimony on the bill, and has been meeting with key legislators to educate them on MMS priorities and positions.

In addition, the MMS has advocated for several other opioid-related bills and budget amendments, including partial-fill legislation, funding for youth education, and expansions in treatment funding. The MMS strongly supported provisions of the MassHealth 1115 waiver that improved substance use disorder treatment in the Commonwealth. Lastly, the MMS continues to balance opioid prescribing policy with an urge to remain cognizant of the importance of maintaining balance with the ability for physicians to adequately treat patients with pain. The MMS has been engaged in extensive dialogue and education on Supervised Injection Facilities (SIFs). A budget amendment offered by the Senate which would have established a SIF task force was supported by the MMS, but ultimately not included in the final budget. Further avenues for advocacy of the MMS’ SIF policy are being explored.

The MMS continues to actively advocate with various regulatory agencies, including the Board of Registration in Medicine, the Department of Public Health, and the Health Policy Commission. This year, BORIM proposed substantial amendments to regulations that the MMS successfully opposed. The MMS also worked with the DPH on several issues, including the reconstitution of the Drug Formulary Commission, and improvements to the Prescription Monitoring Program and the Massachusetts Controlled Substances Registration.

The MMS reviewed thousands of bills filed at the state house, closely tracked hundreds of bills related to MMS priorities, and testified on dozens of bills with both extensive written testimony and at hearings. In addition, MMS leadership and staff met with key figures such as Governor Baker, Secretary Sudders, Commissioner Bharel, and other legislators, regulators, and staff to advance MMS priorities and oppose legislation and policies deemed by the MMS to not be in the interest of patients and physicians.
Communications

The MMS' voice in the media remains frequent and strong, with MMS officers and physician members demonstrating leadership on many health care issues. Our website and other digital communications channels achieve their goals of positioning the MMS as a thought leader, engaging new and current members, and promoting education programs. Highlights include:

- In 2017, the MMS received and facilitated more than 140 media requests; most popular topics included the ongoing opioid crisis and our support for SIFs, gun violence, MAID/PAS, health care cost containment, and ongoing health care reform efforts.
- The MMS engaged in robust, proactive media outreach, distributing nearly 60 media statements or press releases on a wide range of topics, including health care access, contraceptive coverage, drug costs, and the opioid crisis.
- With the influence of video as a growing communication tool, the MMS developed internal filming and editing capabilities. Videos are used to promote educational programs, share perspectives of MMS leadership and members, and reflect on MMS-hosted events. A total of 35 videos were published in 2017.
- The MMS' enhanced social media presence continues to expand the organization’s ability to educate the public online. The MMS’ Facebook page has more than 9,600 followers and Twitter has more than 7,700 followers. Both are steadily growing; the MMS' Twitter profile (@MassMedical) was recently confirmed as “verified.”

Public Health Activities

Public Health areas of focus for FY’18 include end-of-life care (addressed earlier in this report in the section on MAID/PAS), firearm safety, opioid abuse, and population health/social determinants of health.

Firearms

The MMS' policy, adopted in 2013, states that the MMS is “guided by the principles of reducing the number of deaths, disabilities, and injuries attributable to guns; making gun ownership safer; promoting education relative to guns, ammunition, and violence prevention, for physicians and other health professionals as well as for the public; encouraging research to understand the risk factors related to gun violence and deaths.”

The American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), led by Christopher Barsotti MD, FACEP, FAAEM, Chair of the Trauma and Injury Prevention Section at the American College of Emergency Physicians, and an emergency physician with Berkshire Medical Center, is an independent, physician-led 501(c)(3) organization whose mission is to raise monies from the private sector in order to fund firearm injury prevention research, and to support professional guideline groups in the development of evidence-based, best practice recommendations for health care providers to reduce the incidence and health consequences of firearm-related violence.

Firearm-related victimization, injury and death are among the most urgent public health problems facing our country. A public health approach to gun violence prevention has been inhibited by a lack of funding available for research. Between 2004-2015, U.S. federal agencies invested only $22 million in gun violence research, whereas other medical concerns with similar or lower mortality rates received substantially higher
funding (> $1 billion)\textsuperscript{74}. Although $10 million in appropriations for gun violence prevention research were requested in the CDC FY'14-16 budgets, these were unfunded by Congress, and the CDC budget for firearm injury prevention research remains $0\textsuperscript{75}. Very few private foundations support gun violence prevention initiatives, and those that do focus on a policy agenda related to gun control. Other traditional, private sources of medical/public health research funding, such as biotech or pharmaceutical industries, do not have financial incentives for reducing firearm injuries. Consequently, there exists no reliable source of funding to study the medical and public health issues relevant to firearm injury prevention.

In October 2017, the Board of Trustees voted to adopt a position that supports the mission of AFFIRM:

That the MMS support the mission and goals of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) in so far as AFFIRM reflects the stated policies of the MMS as it reaches out to private and charitable funders to achieve its research aims.

That the MMS authorizes AFFIRM to use this resolution in seeking funding support.

\textbf{Opioid Abuse}

The opioid abuse epidemic continues to be the MMS' highest public health priority. Three priorities have been the focus this year: pain management, medication-assisted treatment, and access to naloxone.

\textbf{Pain Management}: Addressing the non-opioid treatment of pain is a priority. Physicians seeking other methods of treatment for their patients are desperate for resources to provide care for patients reflecting the best evidence-based practice. Incorporating treatments (where proven efficacious) such as acupuncture, physical therapy, and cognitive-behavioral therapy must be made accessible and affordable.

In October 2017, MMS President Dr. Henry Dorkin attended a meeting convened by BCBSMA team to discuss relevant policies and coverage relating to the challenge of living with chronic pain. Issues discussed included pharmacy coverage, integrative therapies, treatment interventions which can help with pain reduction and avoidance of opioids, and professional support and education.

The MMS Opioid Task Force is also engaged with the Massachusetts Health Quality Partners (MHQP). The MHQP has embarked on a project which seeks to find innovative ways to improve conversations between clinicians and their patients suffering from serious pain to enhance the ways pain is addressed in the outpatient setting. The project will involve the creation of tools to help guide pain assessment conversations. The MMS is supportive of MHQP's work and looks forward to meaningful progress.

In addition, the MMS sent a mailing to non-members to provide Massachusetts physicians with our guide to the new opioid prescribing guidelines and remind physicians about our free Pain Management and Opioid CME.

\textsuperscript{74} Stark D, and Shah N. Funding and publication of research on gun violence and other leading causes of death. JAMA 2017;317(1):84-5.

Medication-Assisted Treatment (MAT): Substance use disorder can be treated, and those efforts can begin in medical practice settings – whether it is a physician’s office, hospital, or academic setting. To improve access to medication-assisted treatment, the MMS needs to encourage and support all physicians in all specialties to care for patients by providing easily accessible professional education and mentoring. In addition, administrative burdens and barriers to MAT must be addressed. The MMS has discussed with representatives from some of the academic medical centers ways to support physicians in their practices, with many ideas being explored. In March 2018, the MMS will co-sponsor a course on the complications of substance use disorders, including a discussion of MAT.

Access to Naloxone: Massachusetts prescribing guidelines encourage the co-prescription of naloxone when prescribing an opioid. The MMS strongly advocates for affordable and consistent access to naloxone, and it is working with payers to include naloxone with minimal or no cost-sharing.

In addition, the MMS continues to seek new ways to decrease the rising opioid-related mortality in our Commonwealth. While increased naloxone availability is important, the more rapid onset of newer opioids such as synthetic fentanyl and carfentanil decrease substantially the time after opioid injection during which naloxone is effective. SIFs have lowered the absolute death rate in Canada, Australia, and parts of Europe. The MMS continues to advocate for the launch a pilot SIF program under the guidance of a state-led task force, as the MMS believes this program is one approach that will reduce overdose deaths in the Commonwealth. A coalition of groups in support of the establishment of SIFs has formed in Massachusetts, led by SIFMA NOW, AIDS Action, and others, working together to reduce accidental overdose deaths in Massachusetts.

Population Health/Social Determinants of Health

The MMS has long been a supporter of community-based programs that address the impact of physical, economic, environmental and social inequities on health outcomes. By working in partnership with public health, the medical community can help to shift the paradigm from treating disease to improving population health through prevention-based care that recognizes social determinants of health when caring for patients. One example of this partnership is the MMS’ engagement with the Massachusetts Food is Medicine State Plan (mentioned previously in this report). Improving access to food can improve health outcomes, decrease costs, and improve quality of life. Led by Harvard Law School’s Center for Health Law and Policy Innovation and Community Servings, the Food is Medicine State Plan is an initiative that will develop a report proposing concrete strategies that community-based organizations, health care providers, and state government can use to improve access to medically tailored nutrition interventions over time. This initiative complements the MMS’ commitment to raising awareness among physicians of the link between food insecurity and health.

CONCLUSION

As a leadership voice in health care, the Massachusetts Medical Society is dedicated to educating and advocating for the physicians of Massachusetts and patients locally and nationally. This report reflects the challenges present in today’s health care environment and summarizes the ways in which the MMS is responding to those challenges, by influencing health-related legislation at the state and federal levels, working in support of public health, providing expert advice on physician practice management, and addressing issues of physician well-being.
Item #: 24  
Code: CWIM Report A-18 C-2  
Title: Establishing a Women Physicians Section  
Sponsor: Committee on Women in Medicine  
Kathryn Hughes, MD, Chair  
Referred to: Reference Committee C  
Mangadhara Rao Madineedi, MD, Chair

**Background**

For the first time in history, there are more women entering US medical schools than men according to data released by the Association of American Medical Colleges. This is an impressive advance from a few decades ago when women represented less than a third of matriculants.¹

However, women remain a minority in medicine where there are nearly double the number of male physicians (623,054) as there are female physicians (326,902) across the country. In Massachusetts, there are 20,209 male physicians compared to 13,825 female physicians as of October 2017.²

The Committee on Women in Medicine, formerly the Committee of Women in Organized Medicine, was established in 1981 and its original mission was to assist women physicians in entering leadership positions in organized medicine, and in the profession in general. The Committee worked to promote the leadership of women physicians in a variety of ways, including leadership training, networking, and educational programs. Over time, the Committee’s mission expanded to include educating colleagues about medical topics effecting women patients.

The Committee realizes that women in medicine and women’s health are two unique topics that should be addressed separately and therefore are proposing that the MMS establish a Women Physicians Section and rename the Committee on Women in Medicine to the Committee on Women’s Health.

**MMS Policy**

The MMS has the following policy relating to this topic:

*Gender Parity*

The Massachusetts Medical Society endorses the American Medical Association’s policy, “Gender Disparities in Physician Income and Advancement” that reads as follows:


² Kaiser Family Foundation. Professionally active physicians by gender. October 2017. [https://www.kff.org/other/state-indicator/physicians-by-gender/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22,%22dir%22:1](https://www.kff.org/other/state-indicator/physicians-by-gender/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22,%22dir%22:1).
Gender Disparities in Physician Income and Advancement

1. That our American Medical Association encourage medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist;

2. That our AMA support physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations;

3. That our AMA urge medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession;

4. That our AMA collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession; and

5. That our AMA provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.

(HP)

The MMS will advocate and raise awareness for gender parity, equal pay, and advancement as a fundamental professional standard to ensure equal opportunity within the medical profession in Massachusetts. (D)

MMS House of Delegates, 5/21/11

Relevance to MMS Strategic Priorities

This report relates to enhanced membership value, which is an MMS strategic priority.

Introduction

For over 35 years, the Committee on Women in Medicine has continually strived to address the professional needs of MMS women physicians by serving as the primary advocate regarding issues of importance to women physicians in how they treat their patients. The Committee has served as a valuable resource to MMS leadership in matters related to policy development and strategic planning.

The Committee sponsors a variety of programs, including CME programs, that have addressed both professional and women’s health issues. Through these programs, it has become evident that there is inadequate training for women physicians relating to professional matters such as communication, leadership and advocacy skills. Women physicians are not proportionately represented in medical leadership roles and are paid less for comparable roles.3 The limited number of women and minority physicians in leadership positions provides a lack of mentors and role models for the growing women physician population.

In 2013, the American Medical Association’s Women Physicians Congress (WPC) transitioned to the Women Physicians Section. Reasoning for the change included that the AMA would benefit from a delegate’s voice to address specific issues of concern for

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women in medicine in the HOD. As with the MMS, female physicians remain under-
represented among delegates in the AMA HOD. A group, such as the WPC, with many
individuals was not guaranteed access to the HOD process. Consequently, the
perspectives of a group may not be truly represented as was the case with the WPC.
Unique concerns of a specific demographic group are also considered as part of the
rationale when creating a membership Section at the AMA. Women physicians bring a
distinct set of experiences related to medical practice and patient care.

Conclusion
Women physicians have made great strides, but there is still much progress to be made.
Women physicians are not advancing to the highest level of the profession and are
continuing to encounter discrimination during their training and subsequent careers,
including exclusion from leadership positions and discrepancy in income. The creation of
a Women Physician Section would reaffirm the MMS’s commitment to promote diversity
and address the concerns of an under-represented group in organized medicine. This
section would provide a valuable forum for networking, mentoring, advocacy and
leadership development for women physicians and medical students.

Renaming the Committee on Women in Medicine to the Committee on Women’s Health
would allow the committee to refine its mission to provide to address health issues that
disproportionately or uniquely affect women patients.

With the largest proportion of women entering medical school in history, the MMS has an
opportunity to strengthen the voice of women in medicine by providing a facilitatory role
in the leadership development of women members.

Recommendations:
1. That the Massachusetts Medical Society request that the Bylaws be amended
   as appropriate to create a Women Physicians Section (WPS). The Women
   Physicians Section would be composed of all women MMS members.
   Additionally, male MMS members would be welcome to “opt in” to become
   WPS members. The purpose of the Section would be to provide a forum for
   networking, mentoring, advocacy and leadership development for women
   physicians and medical students. The Section would be entitled to one
   delegate in the House of Delegates, and the delegate shall be elected annually
   by the section for a one-year term. (D)

2. That the Committee on Women in Medicine be renamed to the Committee on
   Women’s Health to refine its mission to address health issues that
disproportionately or uniquely affect women patients. (D)

Fiscal Note: Annual Expense of $5,000 (Beginning FY20)
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Background and Discussion

It is important to ensure that the Society stays relevant and is structured to maximize membership growth, diversity, and engagement. Currently, 5.2 to 9.5 million adults (2.2% to 4.4% of the adult population) in the United States identify as lesbian, gay, bisexual, and/or transgender (LGBT) of which approximately 266,000 live in the Commonwealth of Massachusetts.\(^1\)

Physician diversity that is reflective of patient demographic has been positively associated with improved patient health outcomes, reduced stigmatization of LGBT patients, and enhanced workforce development.\(^3\) Medical organizations (e.g. Association of American Medical Colleges) collect sexual orientation and gender identity demographics.\(^4\) Public policy research groups and research centers focused on LGBT health issues have developed best practices and guidelines for collecting this information in population-based surveys and the clinical setting.\(^5,6\) The MMS has policy dedicated to collecting specific demographic information of its membership, but does not have existing policy to collect sexual orientation and gender identity information of its membership.

Expanding the collection of demographic data to include members’ sexual orientation and gender identities will empower the MMS to identify and address professional needs and concerns of an often-marginalized minority population.\(^7,8\)

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Current MMS Policy

There is no specific policy addressing this topic.

Relevance to MMS Strategic Priorities

This initiative relates directly to the MMS strategic priority of creating opportunities to grow, diversify, and engage membership across all physician demographic segments and practice settings.

Recommendation:

That the MMS develop a plan to expand the demographics we collect about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and will be handled in a confidential manner. (D)

Fiscal Note: No Significant Impact

(Out-of-Pocket Expenses)

FTE: Existing Staff

(Staff Effort to Complete Project)
Background

At I-16, CWM Report I-16 C-3, MMS Leadership Promotion and Governance, was referred to the BOT for report back with recommendations at A-17. The BOT referred this report to the MMS Presidential Officers. The officers presented Report A-17 C-10 to the HOD, and it was referred for report back to the HOD with recommendations at A-18. The BOT referred the report to the MMS Presidential Officers.

The report states:

That the Massachusetts Medical Society adopt as amended CWM Report I-16 C-3 to read as follows:

1. That the Massachusetts Medical Society facilitate increased leadership opportunities on its special committees by limiting a special committee member’s service as chair to three consecutive years (not sum total). A committee member who has served as chair for three consecutive years may be re-elected as chair after not serving as chair for at least two presidential years. Years served as chair shall not include time served filling a vacancy in the position of chair. (D)

2. That a Massachusetts Medical Society member’s leadership service as chair be limited to not more than one special committee concurrently. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

Reference Committee and HOD Testimony

At A-17, the reference committee recommended that this report be adopted. The following is the reference committee’s rationale:

Limited testimony expressed concern about restricting the report to special committees and that the proposed language may have changed the intent of the original report.
proposed by the Committee on Women in Medicine at I-16. However, the testimony was
generally in favor of this report.

The report was extracted at the HOD second session. A motion was made to strike the
word “special” before committees in the resolves and the sentence “A committee
member who has served as chair for three consecutive years may be re-elected as chair
after not serving as chair for at least two presidential years.”

Testimony included the point that limiting the years an individual can serve as chair will
allow opportunities for others serving on the committee to serve as chair, as committee
members have term limits and may not have an opportunity to lead if a chair can serve
again after two years. Additional discussion ensued about the distinction between
standing committees and special committees and the importance of experience and
expertise needed on standing committees such as the Committees on Finance and
Legislation.

Following discussion, a motion was made to refer the report to the BOT for report back
at A-18. A point was made that referral would allow another look at the original report
that came from the Committee on Women in Medicine, commenting specifically
regarding the governance structure for the appointment to committees and appointments
to special committees to ascertain whether there are opportunities for improvement in
process, inclusion, diversity, and representation of best practices. It was also noted that
a Task Force on Governance was appointed to review the Society’s current governance
structure and should provide input.

Current MMS Policy
The following is MMS policy on this topic:

The MMS will continue to seek to broaden the diversity of its membership and
member participation in its activities. (D)  
MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15

The MMS promotes representation in its leadership and committees that reflects the
Society’s membership diversity, demographics, and gender. (D)  
MMS House of Delegates, 12/03/16

The MMS obtain secure and confidential race and ethnicity data for MMS members
by utilizing all available sources, including third-party vendors, in order to understand
the current composition of the MMS membership, and assist in the development of
future goals. (D)  
MMS House of Delegates, 12/03/16

Relevance to MMS Strategic Priorities
The resolution/report as submitted relates to the MMS strategic priority:
Governance:
➢ Ensure that the Society stays relevant and is structured to maximize membership
growth, diversity, and engagement.
➢ Look for ways to create meaningful local and remote participation and promote
physician engagement and leadership opportunities.

Discussion
The MMS Presidential Officers reviewed the original report from the Committee on
Women in Medicine (CWM) and comments made at the HOD, specifically the comment
regarding the governance structure for the appointment to committees and appointments

to special committees to ascertain whether there are opportunities for improvement in
process, inclusion, diversity, and representation of best practices, as well as mention of
the work underway by the Task Force on Governance (TFGOV).

The current MMS Presidential Officers serve as members of the TFGOV. The TFGOV is
currently working with a consultant in a multi-step process to accomplish its charge to
review the Society’s current governance structure and formulate a recommendation for a
governance structure that would best meet the needs of the membership now and into
the future to achieve the Society’s strategic goals.

Currently, the TFGOV is developing a set of conceptual governing principles, which will
serve as the guiding principles for the second phase in which they will review the current
governance structure and consideration of any redesign or improvement process. It is
through these governance principles that the values, history, culture, beliefs, and
traditions are balanced with changing conditions and strategies for a more effective and
sound governance structure. Before moving into phase two, the guiding principles will be
widely shared throughout the organization for review and approval.

The concepts and sentiments as expressed by the CWM and HOD have been brought to
the TFGOV as part of the development of the governing principles, stressing the
importance of inclusion, diversity, and representation.

Conclusion

In recognition of the importance of inclusion, diversity, and the value of creating
opportunities for a diverse audience of membership to participate in leadership and the
importance of developing guiding principles to assist in the systematic and holistic
review of the current structure and governance processes, the MMS Presidential
Officers recommend the following.

Recommendation:

That the Massachusetts Medical Society adopt in-lieu of OFFICERS Report A-17 C-
10 the following:

That the Massachusetts Medical Society, when reviewing the current
governance structure, consider the process for appointment to standing and
special committees and opportunities for committee leadership to ascertain
whether there are opportunities for improvement in process, inclusion,
diversity, and representation of best practices. (D)

Fiscal Note: No Significant Impact

(Out-of-Pocket Expenses)

FTE: Existing Staff

(Staff Effort to Complete Project)
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 5
Code: OFFICERS Report A-18 C-5
Title: Policy Sunset Process
Sponsors: MMS Presidential Officers:
Henry Dorkin, MD, FAAP
Alain Chaoui, MD, FAAFP
Maryanne Bombaugh, MD, MSc, MBA, FACOG
Reviewers: Various MMS Committees and Sections

Referred to: Reference Committee C
Mangadhara Rao Madineedi, MD, Chair

EXECUTIVE SUMMARY

Background
Per the MMS Procedures of the House of Delegates, “a sunset mechanism with a seven-year time horizon shall exist for all Massachusetts Medical Society policy positions and statements established by the MMS House of Delegates.” Previously, the Committee on Strategic Planning (CSP) oversaw the process of assigning policies to MMS committees to review, and committees would provide feedback to the CSP. At I-16, the House of Delegates adopted an amendment to the procedure to have the MMS Presidential Officers oversee the process. The updated procedure states, “Policies are assigned to the appropriate standing committee/MMS section(s) (in consultation with appropriate special committees) to review whether to reaffirm, sunset, reaffirm for one year, or amend the policy and provide recommendations to the MMS presidential officers for final review and submission to the House of Delegates.”

Fifty-seven policies were reviewed. The following report outlines policies scheduled to be sunset, reaffirmed, reaffirmed for one year, amended (minor amendments only) pending a possible new policy submission. Three policies — indicated with an * — were split between reaffirm for seven years and sunset, and one policy was split between reaffirm for one year and reaffirm for seven years.

Please note that policies approved by the HOD for sunset are placed in the MMS Sunset Compendium and can be found at massmed.org/policies.
POLICIES SCHEDULED TO BE SUNSET

ALLIED HEALTH PROFESSIONS AND SERVICES

* 1. Physicians and Nurse Practitioners
[*split between Sunset and Reaffirm]*

The Massachusetts Medical Society adopts the following guidelines regarding the relationships of physicians and nurse practitioners:

a) The physician is ultimately responsible for managing the health care of patients in all practice settings.

b) Health care services delivered in a collaborative practice must be within the scope of each practitioner’s professional license, as defined by state law.

c) In a collaborative practice with a nurse practitioner, the physician and nurse practitioner will coordinate care and ensure the quality of health care provided to patients.

d) The extent of involvement by the nurse practitioner in assessment and implementation of treatment will depend on the complexity and acuity of the patient’s condition, as determined by the physician and nurse practitioner.

e) The role of the nurse practitioner in the delivery of care should be defined through mutually agreed upon guidelines for care that are developed by the physician and the nurse practitioner.

f) These guidelines for care should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patient’s condition.

g) A physician must be available for consultation with the nurse practitioner at all times, either in person, through telecommunication systems, or other means.

h) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.

i) In a collaborative practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of and respect for each other’s contributions to patient care.

j) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other’s practice patterns.

(HP)

... MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

Rationale: The following policy was presented to the BOT in response to a resolution referred for decision, adopted at the October 2017BOT meeting, and subsequently approved at the 2017 Interim HOD Meeting. The Committee on Legislation advised that the new policy supersedes the above (portion of) the original policy:

The Massachusetts Medical Society will introduce and support legislation requiring that MassHealth will recognize the value of physician supervision of advanced practice nurses (APNs) and physician assistants (PAs), within a physician-led team-based practice, by paying the physicians for services, and especially for supervision, of APNs and PAs, equal to 100% of the physician’s reimbursement rate. (D)
The Massachusetts Medical Society encourage all payers to recognize the value of physician supervision of advanced practice nurses (APNs) and physician assistants (PAs), within a physician-led team-based practice, by continuing to pay for services, and supervision, of APNs and PAs equal to 100% of the physician’s reimbursement rate. (D)

The remaining portion regarding physicians and nurse practitioners is recommended for reaffirmation for seven years.

DRUGS AND PRESCRIPTIONS
2. Return of Unused and/or Expired Medications
The MMS will request that the AMA advocate to the FDA and Congress to require that all pharmacies have a “take back and disposal” policy for unused and expired medications and that disposal of the collected unused and expired medication is handled in an environmentally safe manner, such as incineration or other suitable method. (D)

MMS House of Delegates, 5/21/11

Rationale: Directives that call for AMA advocacy/action and the AMA has adopted policy: if the policy is congruent with the MMS’s position/request and there is nothing in conflict, the item may be sunset. Please see Appendix for AMA policy.

HEALTH CARE DELIVERY
3. Workers’ Compensation Coverage
The Massachusetts Medical Society supports legislative efforts to ensure provision of written information to temporary workers within 72 hours or fewer of hire detailing required personal protective equipment for the job and all information necessary to access workers’ compensation benefits in the event of a workplace injury. (HP)

MMS House of Delegates, 5/21/11

Rationale: Accomplished through legislation.

HEALTH INSURANCE/MANAGED CARE
4. Value-Based Insurance Design
The MMS will advocate that the AMA study value-based insurance design, its impact on the physician workforce, and patient access. (D)

Rationale: This directive is already being done as the AMA continues to study the impact on physician workforce and patient access from the various new insurance models arising all over the country.

5. Universal Access
The Massachusetts Medical Society will utilize existing research and data to explore various options for providing universal access to health care, including single-payer, and convey this information to Society members. (D)

MMS House of Delegates, 5/14/04

Item 2 of Original: Reaffirmed MMS House of Delegates, 5/21/11
(Item 1 of Original: Sunset)

Rationale: Resolution adopted at I-17 directs the following:
The Massachusetts Medical Society will conduct a comprehensive educational conference on Universal Health Care. (D)
HOSPITALS

6. Uniform Application
The Massachusetts Medical Society will work arduously and expeditiously to seek agreement with hospitals and the major managed care networks on the use of a single uniform credentialing form. (D)

The Massachusetts Medical Society will attempt to create some logical system, with the managed care plans, to create a system whereby the providers would receive their recredentialing applications according to a uniform schedule.

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

Rationale: This initiative of creating a single uniform credentialing form is underway and being done by the MassCollaborative, of which the MMS is a member.

MINORITIES

7. Minority and Immigrant Populations
[*Split between Reaffirm and Sunset]*

... The MMS endorses the Mission Statement and Vision Statement of the Commission to End Health Care Disparities, which reads as follows:

Commission to End Health Care Disparities

Mission Statement:
The Commission to End Health Care Disparities, inspired by the Institute of Medicine report, Unequal Treatment, recognizes that health care disparities exist due to multiple factors, including race and ethnicity. We will collaborate proactively to increase awareness among physicians and health professionals; use evidence-based and other strategies; and advocate for action, including governmental, to eliminate disparities in health care and strengthen the health care system.

Vision Statement:
Aided by the work of the Commission and its member organizations, physicians, health professionals, and health systems will provide quality care to all people.

(HP)

MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

Rationale: Commission no longer operational.

PHYSICIAN PAYMENT

8. CPT Codes
The Massachusetts Medical Society will encourage the American Medical Association to create a new CPT code for communication and transmission of data to the admitting hospitalist for timely coordination of care (via telephone, fax, e-mail, or face-to-face communication) and from the hospitalist to the outpatient doctor. (D)
The MMS will encourage the AMA to advocate for reasonable payment for the new handoff/admission/discharge coordination-of-care CPT code by the CMS-Medicare. (D)

The MMS will encourage the AMA and others to advocate for proper recognition of services of primary care physicians by hospitals and medical schools. (D)

MMS House of Delegates, 5/14/11

Rationale: Directives that call for AMA advocacy/action and the AMA has adopted policy: if the policy is congruent with the MMS’s position/request and there is nothing in conflict, the item may be sunset. Please see Appendix for AMA policy.

*9. [*Split between Sunset and Reaffirm]*

The Massachusetts Medical Society (MMS) will advocate to the American Medical Association (AMA) for increased effort to support the concept that third-party payers should provide more equitable reimbursement for physicians’ services, and that these efforts will be directed to achieve equitable compensation for all physicians. (D)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

Rationale: Directives that call for AMA advocacy/action and the AMA has adopted policy: if the policy is congruent with the MMS’s position/request and there is nothing in conflict, the item may be sunset. Please see Appendix for AMA policy.

PROFESSIONAL LIABILITY

10. ERISA

The Massachusetts Medical Society, working through its AMA Delegation together with other interested parties, will support appropriate Federal legislative initiatives to address the issue of ERISA preemption of state tort and contract law relating to the imposition of liability on self-insured health and welfare benefit plans. (HP)

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Amended and Reaffirmed MMS House of Delegates, 5/21/11

Rationale: Directives that call for AMA advocacy/action and the AMA has adopted policy: if the policy is congruent with the MMS’s position/request and there is nothing in conflict, the item may be sunset. Please see Appendix for AMA policy.

PUBLIC HEALTH

11. Full-Body Airport Scanners

The MMS will review and consider sharing any forthcoming AMA statements on the safety of full-body airport scanners with specialty societies and appropriate state agencies. (D)

MMS House of Delegates, 5/21/11

Rationale: Completed.

QUALITY OF CARE

12. Risk Contracts

The Massachusetts Medical Society will work with the health plans to develop a template with standardized language regarding what valid data should be made available to physicians in a timely manner to assist them as they undertake risk contracts and strive to improve quality and
provide cost effective care. This language would be reviewed by physicians and other experts who have experience with risk contracts for their input. Final language would be widely disseminated to MMS members. (D)

Rationale: Completed.
Recommendation:
A. That the Massachusetts Medical Society reaffirm for seven (7) years the following policies:

1a. ADVANCE CARE PLANNING/END-OF-LIFE CARE
The Massachusetts Medical Society supports patient dignity and the alleviation of pain and suffering at the end of life. *(HP)*

The Massachusetts Medical Society will provide physicians treating terminally ill patients with the ethical, medical, social, and legal education, training, and resources to enable them to contribute to the comfort and dignity of the patient and the patient’s family. *(D)*

*MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Amended and Reaffirmed MMS House of Delegates, 12/3/11
(Item 3 of Original: Rescinded, MMS House of Delegates, 12/2/17)*

ALLIED HEALTH PROFESSIONS AND SERVICES

2a. Physicians and Physician Assistants

[*Split between Sunset and Reaffirm]*

... The Massachusetts Medical Society adopts the following guidelines regarding the relationships of physicians and physician assistants:

a) The physician is ultimately responsible for managing the health care of patients in all settings.

b) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner’s authorized practice as defined by state law.

c) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.

d) The physician is responsible for the supervision of the physician assistant in all settings.

e) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines for care that are developed by the physician and the physician assistant, and based on the physician’s delegatory style.

f) The physician must be available for consultation with the physician assistant at all times either in person, through telecommunication systems, or other means.

g) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient’s condition and the training and experience and preparation of the physician assistant as adjudged by the physician.
h) Patients should be made clearly aware at all times whether they are being
cared for by a physician or a physician assistant.

i) There should be a professional and courteous relationship between physician
and physician assistant, with mutual acknowledgment of and respect for each
other's contributions to patient care.

j) The physician and physician assistant together should review all delegated
patient services on a regular basis, as well as the mutually agreed upon
guidelines for care.

k) The physician is responsible for clarifying and familiarizing the physician
assistant with the physician’s supervising methods and style of delegating
patient care.

(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

3a. Radiological Technologists
The MMS will express support of measures that promote patient protection and health
care workers safety in the appropriate and cost-effective use of fluoroscopic medical
services. (HP)

MMS House of Delegates, 5/14/04
Item 2 of Original: Reaffirmed MMS House of Delegates, 5/21/11
(Item 1 of Original: Sunset)

4a. Blood Donation
The Massachusetts Medical Society will continue its efforts to encourage the voluntary
donation of blood. (HP)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

Drugs and Prescriptions

5a. Biosimilar Medications
The MMS will advocate via regulatory or legislative avenues that so-called bioequivalent
(i.e., generic) substitutions for narrow therapeutic index agents (or those prescribed for
treatment of conditions where potential harm of variable bioavailability, prescription to
prescription, of said substitution is substantial) not be mandated and/or be limited to no
more frequently than once a year, especially for economic reasons alone. This should
apply not only to substitutions for branded agents, but also to other generic so-called
bioequivalent agents of the same molecular structure. (D)

The MMS will advocate via regulatory or legislative avenues that biosimilar medications
not be substituted without the express endorsement of the prescribing physician. (D)

MMS House of Delegates, 5/21/11

6a. Education Regarding Industry Marketing and Advertising
The MMS supports the concepts that (a) physicians maintain a heightened awareness at
all times of the implied and perceived obligations regarding all interactions with the
the pharmaceutical and medical device industry, and that (b) perception of physicians’ behavior
should be considered with each contact with industry representatives.  

MMS House of Delegates, 11/8/03
Reaffirmed MMS House of Delegates, 5/14/04
Item 2: Amended and Reaffirmed MMS House of Delegates, 5/21/11
(Item 1 of Original: Sunset)

7a. Prescription Writing/E-Prescribing
The Massachusetts Medical Society opposes psychologists obtaining prescription
privileges in Massachusetts.  (HP)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

8a. Return of Unused and/or Expired Medications
The Massachusetts Medical Society supports the policy that all unused nursing home
drugs, which are sealed and dated, be returned for credit.  (HP)

The Massachusetts Medical Society, in collaboration with the Massachusetts chapter of
the American Medical Directors Association and the Massachusetts chapter of the
American Geriatric Society, urges the Massachusetts Department of Public Health to
expand its current medication return list.  (D)

The Massachusetts Medical Society urges Massachusetts Congressional members to
draft legislation supporting the recycling of unused nursing home drugs, which are
sealed and dated.  (D)

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Item 1: Reaffirmed MMS House of Delegates, 5/14/10
Items 2 and 3: Amended and Reaffirmed MMS House of Delegates, 5/21/11

ETHICS

9a. Medical Education/Performing Procedures
The Massachusetts Medical Society urges medical schools to adopt and inform medical
students of the policy that they may refuse to perform procedures during medical
education that are contrary to their religious or moral beliefs without repercussions to
the student.  (HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

FIREARMS: SAFETY AND REGULATION

10a. Handguns
The Massachusetts Medical Society is strongly opposed to legislative interference in the
right of physicians and patients (or their parents or guardians) to discuss gun
ownership, storage, and safety in the home.  (HP)

The MMS records its opposition to any legislative or regulatory limits on a physician’s
ability to take a complete history and document relevant portions of the history into the
permanent medical record.  (HP)
The MMS will advocate that the AMA take a leadership role in opposing legislative
interference in the physician-patient relationship and the physician’s efforts to discuss
and record the patient’s history, including questions about gun safety. (D)
MMS House of Delegates, 5/21/11

HEALTH CARE DELIVERY

11a. Clinical Integration
The MMS will continuously monitor AMA activity regarding health care laws, regulations,
and model organizational information for physicians (including independent, small
groups) and medical staffs. This information will assist members with communicating,
organizing, and participating in care processes for the high quality and efficient service
delivery of health care that will permit independent physician practitioners and/or small
groups to clinically integrate and provide accountable care. (D)

The MMS will make AMA activity regarding legal and model organizational information on
practice integration available to MMS members, by electronic means — as well as on the
MMS website — and in hard copy upon request. (D)
MMS House of Delegates, 5/21/11

12a. Telemedicine
The Massachusetts Medical Society affirms that any physician practicing telemedicine
with a patient in Massachusetts should possess a full and unrestricted license in
Massachusetts. (HP)
MMS House of Delegates, 11/21/97
Reaffirmed, MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

HEALTH INSURANCE/MANAGED CARE

13a. Health Insurance
Individual Choice and Support for a Pluralistic System
The Massachusetts Medical Society supports an individual’s right to select, purchase,
and own his/her health insurance and to receive similar tax treatment for individually
purchased insurance as for employer purchased coverage. (HP)
MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

HOSPITALS

14a. Hospital and Health Care Facility Closings
The Massachusetts Medical Society adopts the following principles regarding Health
Care Facility Closure—

Physician Credentialing Records:
1. Governing Body to Make Arrangements
The governing body of the hospital, ambulatory surgery facility, nursing home, or
other health care facility shall be responsible for making arrangements for the
disposition of physician credentialing records or CME information upon the closing
of a facility. The governing body shall send notification of the impending closure to
all those physicians credentialed at that facility at least 30 days prior to the date of
closure.
2. Transfer to New or Succeeding Custodian

Such a facility shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information. In the alternative, the facility shall seek to make arrangements with a reputable commercial storage firm. The new or succeeding custodian shall be obligated to treat these records as confidential.

3. Documentation of Physician Credentials

The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.

4. Maintenance and Retention

Physician credentialing information and CME information transferred from a closed facility to another hospital, other entity, or commercial storage firm shall be maintained in a secure manner intended to protect the confidentiality of the records. The records shall be maintained for a period of at least two years from the date the facility closes.

5. Access and Fees

The new custodian of the records shall provide timely access at a reasonable cost and in a reasonable manner that maintains the confidential status of the records.

(MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

MASSACHUSETTS MEDICAL SOCIETY ADMINISTRATION AND ORGANIZATION

15a. Membership and Dues

The MMS will work with the district medical societies to initiate consistent discounts for both state and district dues, which would provide simplification of the billing process and deliver more comprehensive invoices to the member. (D)

(MMS House of Delegates, 5/21/11
(Item 1 of 3: Auto-Sunset)

16a. Student Dues

The Massachusetts Medical Society (MMS) will exempt dues for its Medical Student Membership. (D)

In order to offset expenses of exempt dues for Medical Student Membership, an alternative level of benefits will be provided for medical student members, including substitution of the New England Journal of Medicine (NEJM) Online for the printed NEJM subscription, and that medical students will no longer have MMS Internet account privileges. (D)

(MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

17a. Membership Pilot Projects

The House of Delegates delegates to the Board of Trustees the authority to approve the use of pilot membership recruitment/retention projects involving variations of no more than 50% on the current MMS dues structure, as proposed by the Committee on Membership. (D)
Such pilot projects shall be required to have a defined time limit, as well as having the prior approval of the Committee on Finance. (HP)

The Committee on Membership shall report annually to the House of Delegates as to the impact of all current pilot projects. (D)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

MEDICAID

18a. Preauthorizations
The Massachusetts Medical Society recommends to the Division of Medical Assistance that any requirements for preauthorizations by physicians be reviewed by MMS prior to implementation. (HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Amended and Reaffirmed MMS House of Delegates, 5/21/11

MEDICARE/ MEDICAID SERVICES

19a. Practice Expenses
HCFA [CMS] should make efforts to broadly survey medical practices for actual expense data. (HP)

The complex surveys needed for practice expense determination should be funded, reimbursing contributing practices for their time and effort. (HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

MINORITIES

20a. Minority and Immigrant Populations
The Massachusetts Medical Society, in its role as advocate for patients, will promote a coordinated strategy for: increasing access to medical care for minority populations; heightening awareness of cultural practices through education; and creating greater opportunities for minorities and immigrants within the medical profession, including participation in the Massachusetts Medical Society.

I. Increasing Access to Medical Care for Minority Populations

The Massachusetts Medical Society recognizes that access to medical care is the first step to ensuring quality and improved outcomes. Therefore, the Massachusetts Medical Society will continue to strive for universal access to medical care, regardless of race, ethnicity, socio-economic status or geographic location.

MMS will encourage and work with community outreach programs that address the health care needs of minority and immigrant communities. In addition, the Society will continue to develop links with community-based organizations and social service agencies to identify community-wide health problems and organize health education programs that are specifically tailored to the needs of those particular communities.
II. Heightening Awareness of Cultural Practices and Barriers through Education

The Massachusetts Medical Society should promote increased awareness and research among physicians and medical students on the ethnic and cultural differences between patients, physicians and other health care providers that can create barriers to good quality health care and research. The Massachusetts Medical Society supports the expansion of educational opportunities for medical students, residents, and physicians in the areas of cultural awareness and ethnic diversity.

III. Creating Opportunities for More Diversity within the Medical Profession

The Massachusetts Medical Society supports the expansion of educational opportunities in biomedical careers for minority and immigrant populations. The Society encourages physicians and health care organizations to employ culturally diverse staff, at all levels, in order to address the needs of the community.

*21a. [Split between Reaffirm and Sunset]

The Massachusetts Medical Society (MMS) will increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities. (D)

The MMS supports the elimination of racial and ethnic disparities in health care as an issue of high priority. (HP)

*23a. CPT Codes

[Split between Sunset and Reaffirm]

The MMS will continue to advocate for reimbursement for all physicians’ services as reflected in the AMA’s Current Procedural Terminology codebook. (D)
24a. Third Party Insurers
The Massachusetts Medical Society (MMS) will advocate for laws, regulations, or
directives for all insurance carriers, including Medicaid and Medicare, to pay for
mandated services required by law or regulation. (D)

25a. The Massachusetts Medical Society will advocate to payers and support legislation
to require payment to physicians and other health care providers for services rendered if
— at the time of the patient’s visit — the provider verified coverage through the insurer’s
available eligibility inquiry system(s), regardless of: future retroactive eligibility changes
by the employer or patient, or errors in the insurer’s eligibility system. (D)

PHYSICIANS
26a. Gender Parity
The Massachusetts Medical Society endorses the American Medical Association’s policy,
“Gender Disparities in Physician Income and Advancement” that reads as follows:

Gender Disparities in Physician Income and Advancement
1. That our American Medical Association encourage medical associations and other
relevant organizations to study gender differences in income and advancement
trends, by specialty, experience, work hours and other practice characteristics, and
develop programs to address disparities where they exist;
2. That our AMA support physicians in making informed decisions on work-life balance
issues through the continued development of informational resources on issues such
as part-time work options, job sharing, flexible scheduling, reentry, and contract
negotiations;
3. That our AMA urge medical schools, hospitals, group practices and other physician
employers to institute and monitor transparency in pay levels in order to identify and
eliminate gender bias and promote gender equity throughout the profession;
4. That our AMA collect and publicize information on best practices in academic
medicine and non academic medicine that foster gender parity in the profession; and
5. That our AMA provide training on leadership development, contract and salary
negotiations and career advancement strategies, to combat gender disparities as a
member benefit.

The MMS will advocate and raise awareness for gender parity, equal pay, and
advancement as a fundamental professional standard to ensure equal opportunity within
the medical profession in Massachusetts. (D)
PREAUTHORIZATIONS

27a. Preauthorizations
The MMS opposes the use of preauthorization where the medication or procedure prescribed is a common and indicated one or commonly used medication for the indication as supported by peer-reviewed medical publications. (HP)

Any reviewer at any level of the preauthorization process be fully identified by full name, title, and location; educational level; and contact information of supervisor. (HP)

Third parties should make available to the Massachusetts Medical Society meaningful, aggregate statistics in usable form in a timely fashion (e.g., broken down by specialty, medication, diagnostic test, or procedure; indication offered and reason for denial and outcomes analysis) of percentages of acceptance or denial as well as other relevant trending information. Individual medical group data should be made available upon request by each group. (D)

MMS House of Delegates, 5/14/11

28a. The Massachusetts Medical Society (MMS) opposes pre-certification programs of third-party payers that interfere with the physician-patient relationship, delay medically necessary care, or impose an undue administrative burden on physicians. (HP)

The MMS will work with third-party payers to develop meaningful hassle-free utilization review programs that are educational in design and enhance quality of patient care. (D)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

PROFESSIONAL LIABILITY

29a. Excess Professional Liability Insurance
In order to enhance freedom of choice in the selection of medical professional liability insurance coverage, the Massachusetts Medical Society will advocate with all health insurance plans, hospital staffs, and other pertinent health care entities that any mandatory malpractice insurance coverage limit requirement higher than the state minimum should be eliminated. (D)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

30a. The Massachusetts Medical Society will continue to advocate for legislation which requires that physician expert witnesses testifying in medical professional liability cases venued in the Commonwealth of Massachusetts must possess the following qualifications: (1) Hold a non-restricted medical license; (2) Be board certified in the same relevant specialty as the defendant physician; (3) Be actively practicing in the same specialty as the defendant physician; (4) Be available at trial if serving as the expert at the tribunal stage of the proceedings. (D)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

31a.
[*Split between Reaffirm and Reaffirm for One Year]
The MMS will collaborate with appropriate legal representatives, Massachusetts professional liability insurers, and the Massachusetts Board of Registration in Medicine for purposes of implementing the Expert Witness Testimony Standards in the form of MMS policy, an affirmation statement, and/or by other useful and effective means, to improve the quality of clinical evidence introduced at all stages of the litigation process. (D)

MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

RESEARCH

32a. Medical Research
The Massachusetts Medical Society in its program developments will take into consideration the importance of promoting and supporting medical research in the interest of the health and well-being of future generations. (HP)

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

SURGERY

33a. Standards of Care
The Massachusetts Medical Society (MMS) recognizes that minimum frequency standards may be appropriate for some surgical procedures. (HP)

The MMS will continue to monitor the literature and physician feedback concerning the impact and ethic of performing surgical procedures as it relates to surgical volume. (D)

The MMS will continue to monitor and provide feedback, when appropriate, to relevant agencies as they develop standards regarding surgical competency and minimum frequency. (D)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

TOBACCO/SMOKING

34a. Government Initiatives: Sale of Tobacco Products, Advertising, Prevention
The Massachusetts Medical Society strongly supports comprehensive prevention, education, cessation, and advocacy efforts to prevent morbidity and mortality associated with tobacco use. (HP)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

VIOLENCE

35a. Domestic Violence Detection Education
The Massachusetts Medical Society supports the establishment of child abuse and domestic violence detection educational programs for physicians, physicians in training and medical students. In addition, the Massachusetts Medical Society strongly encourages and facilitates the participation of physicians, physicians in training and medical students in these programs. It is further recommended that physicians be allowed to use their participation in these programs toward the risk management requirement for relicensure. (HP)

MMS House of Delegates, 5/20/94
Reaffirmed MMS House of Delegates, 5/21/11
36a. Hate Crimes

The Massachusetts Medical Society recognizes the significant negative health outcomes and health care disparities caused by discrimination and hate violence against transgender individuals based on their gender identity and expression. *(HP)*

The Massachusetts Medical Society strongly supports legal protections against discrimination and hate violence against transgender individuals based on their gender identity and expression. *(HP)*

*MMS House of Delegates, 5/21/11*
Recommendation:

B. That the following policies eligible for sunsetting be **amended and reaffirmed for seven (7) year** (added text shown as “text” and deleted text shown as “text”):

1b. **ADVANCE CARE PLANNING/END-OF-LIFE CARE**

   The Massachusetts Medical Society endorses and encourages statewide dissemination and adoption of the Massachusetts Medical Orders for Life Sustaining Treatment (MOLST) Program, which assists individuals in communicating their preferences for life-sustaining treatments near the end of life. *(HP)*

   The Massachusetts Medical Society will roll out **continue to support** continuing medical education appropriate for risk management credit that includes information to assure that clinicians can work with appropriate patients to communicate their preferences for life-sustaining treatment across health care settings, document these preferences on a Massachusetts Medical Orders for Life Sustaining Treatment (MOLST) form, and respond appropriately when they encounter a patient with a MOLST form. *(D)*

   **MMS House of Delegates, 5/21/11**

**DRUGS AND PRESCRIPTIONS**

2b. **Marijuana: Recreational Use of**

   The Massachusetts Medical Society affirms its opposition to smoking the use of marijuana for recreational purposes. *(HP)*

   The Massachusetts Medical Society recognizes the importance of clinical trials research on the medical use of marijuana and its derivatives. All such trials should be approved by an Institutional Review Board process. *(HP)*

   **MMS House of Delegates, 11/21/97**

   **Reaffirmed MMS House of Delegates, 5/14/04**

   **Reaffirmed MMS House of Delegates, 5/21/11**

**HEALTH EDUCATION**

3b. **Student Health**

   The MMS encourages local communities to provide age-appropriate comprehensive health education to students that incorporates information on the prevention of STIs, including HIV. *(D)*

   **MMS House of Delegates, 5/14/04**

   **Item 2 of 2: Reaffirmed MMS House of Delegates, 5/21/11**

**MENTAL HEALTH**

4b. **Mental Health Services: Gestation and Postpartum**

   The MMS supports a culture of awareness, destigmatization, and screening, referral, and treatment for psychiatric illnesses during gestation pregnancy and postpartum to ensure that patients have access to effective and affordable mental health services. *(HP)*

   The MMS will advocate for expanding health insurance coverage and reimbursement of medically necessary mental health services during gestation pregnancy and postpartum. *(D)*
The MMS will work with other appropriate organizations and specialty societies to support and promote awareness among patients, families, and providers of the risks of mental illness during gestation \textit{pregnancy} and postpartum. (D)

The MMS will work with all appropriate parties such as insurers, health care systems, providers, consumers, allied health care professionals, and the government to foster integration of mental health care with general medical care. (D)

\textit{MMS House of Delegates, 12/3/11}

\textbf{MINORITIES}

5b. Biomedical Sciences Career Project
The Massachusetts Medical Society will support and contribute to programs such as the Biomedical Sciences Career Project to expand educational opportunities in medicine and the biomedical sciences for underrepresented minorities. (D)

The Massachusetts Medical Society will work with Massachusetts medical schools to promote recruitment of underrepresented minorities into medicine. (D)

\textit{MMS House of Delegates, 11/21/97}
\textit{Reaffirmed MMS House of Delegates, 5/14/04}
\textit{Reaffirmed MMS House of Delegates, 5/21/11}

\textbf{PHYSICIAN PAYMENT}

6b. Recoupment Limitations
The MMS will immediately draft legislation that establishes a time limit for recoupment of payments which is equal to the time limit that is established by each payer for the submission of claims, only excepting demonstrably fraudulent or criminal activities and actively seek to have this legislation filed in the 2011–2012 state legislative session. (D)

\textit{MMS House of Delegates, 5/21/11}
**Recommendation:**

C. That the Massachusetts Medical Society reaffirm for one (1) year the following policies:

**ETHICS**

1c. Genetic Information and Patient Privacy

The Massachusetts Medical Society will adopt the following General Principles on Genetic Information and Patient Privacy:

1. Physicians should accord genetic information derived about their patients the highest possible confidentiality protection. Genetic information in the medical record should be handled so as to prevent inadvertent disclosure. Such information should be released to third parties only pursuant to the specific authorization of the patient. The possibility that genetic information derived about a patient might be of clinical importance to relatives or other third persons does not alter the physician’s duty of confidentiality to his or her patients. The physician should, however, inform patients who are considering a genetic test about the potential importance of the data that could be derived there from to relatives. On very rare occasions, a physician may reveal otherwise confidential genetic information to a third person if withholding the genetic information derived from the patient will likely cause imminent and serious harm, injury or danger to that particular third person.

2. Physicians should strive to become aware of the special ethical, legal, social, financial, and personal issues that may arise when they or others compile genetic information about their patients.

3. Physicians engaged in genetic testing for clinical, therapeutic or research purposes should engage in such testing only with the full informed consent of the patient or, when appropriate, with the informed consent of the patient’s legally authorized representative. Such informed consent should, at a minimum, involve a disclosure by the physician to the patient of the benefits, risks and costs associated with receiving the test, any appropriate alternative procedures or courses of treatment, the potential results of the test, any possible financial benefit to the physician, including any research interest, from either performing the test or utilizing the samples, and any other significant implications of receiving the test.

4. In cases where genetic samples have been intentionally donated for the purpose of genetics research in an anonymous manner (i.e., removed of or without identifiers), physicians need not obtain informed consent in order to engage in non-clinical use of such genetic testing results or samples.

5. Physicians should not order genetic testing of a child unless the test is intended to diagnose a disease or condition for which there is a recognized clinical benefit to acquiring the information before the child reaches the age of eighteen (18). Clinical benefit should be understood to include issues involving reproductive risks that are faced by adolescents (girls and boys), including those that arise in the context of an unplanned pregnancy. Such tests should be ordered only with the informed consent of the legally responsible person.
6. Physicians should participate in genetic research involving human subjects only if the research protocol has been approved by an institutional review board (IRB) or some comparable group that operates pursuant to federal guidelines involving human subjects research. They should satisfy themselves that adherence to the protocol will result in research subjects having adequate, fair disclosure concerning issues such as informational risk, long-term use and disposition of tissue samples, disclosure of research results to subjects, whether subjects will be recontacted if new information emerges, and relevant economic issues (such as whether the research is sponsored by a for-profit organization and/or whether a subject will or will not receive any economic benefit).

7. Genetic testing results can provide valuable information to be considered by individuals making reproductive choices. MMS opposes, however, the use of genetic testing results by persons or institutions, other than the patient[s] from whom the genetic information was derived, to influence the reproductive choice of the patient[s] from whom the genetic information was derived.

8. The Massachusetts Medical Society hereby affirms existing policy regarding genetic discrimination in insurance coverage which reads as follows:

The Massachusetts Medical Society adopts the AMA Policy H-185.972 regarding Genetic Information and Insurance Coverage, which reads as follows:

(1) Health insurance providers should be prohibited from using genetic information, or an individual’s request for genetic services, to deny or limit any health benefit coverage or establish eligibility, continuation, enrollment or contribution requirements.

(2) Health insurance providers should be prohibited from establishing differential rates or premium payments on genetic information or an individual’s request for genetic services.

(3) Health insurance providers should be prohibited from requesting or requiring collection or disclosure of genetic information.

(4) Health insurance providers and other holders of genetic information should be prohibited from releasing genetic information without express prior written authorization of the individual. Written authorization should be required for each disclosure and include to whom the disclosure be made.

(HP)
(MMS House of Delegates, 11/21/97)
(Reaffirmed MMS House of Delegates, 5/14/04)
(Reaffirmed (Entire Policy) MMS House of Delegates, 5/21/11)

9. The Massachusetts Medical Society hereby affirms existing policy regarding genetic discrimination in the workplace, which reads as follows:

The Massachusetts Medical Society adopts the AMA policy E-2.132 regarding Genetic Testing by Employers which reads:

As a result of the human genome project, physicians will be able to identify a greater number of genetic risks of disease. Among the potential uses of the tests that detect
these risks will be screening of potential workers by employers. Employers may want to
exclude workers with certain genetic risks from the workplace because these workers
may become disabled prematurely, impose higher health care costs, or pose a risk to
public safety. In addition, exposure to certain substances in the workplace may increase
the likelihood that a disease will develop in the worker with a genetic risk for the disease.

(1) It would generally be inappropriate to exclude workers with genetic risks of
disease from the workplace because of their risk. Genetic tests alone do not have
sufficient predictive value to be relied upon as a basis for excluding workers.
Consequently, use of the tests would result in unfair discrimination against
individuals who have positive test results. In addition, there are other ways for
employers to serve their legitimate interests. Tests of a worker’s actual capacity to
meet the demands of the job can be used to ensure future employability and
protect the public’s safety. Routine monitoring of a worker’s exposure can be
used to protect workers who have a genetic susceptibility to injury from a
substance in the workplace. In addition, employees should be advised of the risks
of injury to which they are being exposed.

(2) There may be a role for genetic testing in the exclusion from the workplace of
workers who have a genetic susceptibility to injury. At a minimum, several
conditions would have to be met:

(a) The disease develops so rapidly that serious and irreversible injury would
occur before monitoring of either the worker’s exposure to the toxic substance
or the worker’s health status could be effective in preventing harm.
(b) The genetic testing is highly accurate, with sufficient sensitivity and specificity
to minimize the risk of false negative and false positive test results.
(c) Empirical data demonstrate that the genetic abnormality results in an
unusually elevated susceptibility to occupational injury.
(d) It would require undue cost to protect susceptible employees by lowering the
level of the toxic substance in the workplace. The costs of lowering the level of
the substance must be extraordinary relative to the employer’s other costs of
making the product for which the toxic substance is used. Since genetic
testing with exclusion of susceptible employees is the alternative to cleaning
up the workplace, the cost of lowering the level of the substance must also be
extraordinary relative to the costs of using genetic testing.
(e) Testing must not be performed without the informed consent of the employee
or applicant for employment.

(3) That the Massachusetts Medical Society agrees that employers should be
prohibited from requesting, obtaining, or using genetic information to hire or fire
an employee, or set terms, conditions, privileges, or benefits of employment,
unless the employment organization can prove this information is job related and
consistent with CEJA opinion 2.132.

(4) That employers should be prohibited from disclosing genetic information.
(MMS House of Delegates, 11/21/97)
(Reaffirmed, MMS House of Delegates, 5/14/04)
(Reaffirmed MMS House of Delegates, 5/21/11)
10. Appreciating the acceleration of new information in the field of genetics, the Massachusetts Medical Society will develop a plan to educate physicians throughout the state (through venues such as conferences and interactive or online learning tools and curricula suitable for Grand Rounds, etc.), regarding the basic and current principles of genetic information and testing, and the clinical, social and legal implications of such advancing technologies.

(MMS House of Delegates, 11/6/99)

2C. HEALTH SYSTEM REFORM

The Massachusetts Medical Society adopts the following Principles for Health Care Reform:

1. **Physician leadership.** Physician leadership is seen as essential for the implementation of new payment reform models. Strong leadership from primary care and specialty care physicians in both the administrative structure of accountable care organizations (ACOs) and other payment reform models, as well as in policy development, cost containment and clinical decision-making processes, is key.

2. **One size will not fit all.** One single payment model will not be successful in all types of practice settings. Many physician groups will have a great deal of difficulty making a transition due to their geographic location, patient mix, specialty, technical and organizational readiness, and other factors.

3. **Deliberate and careful.** Efforts must be undertaken to guard against the risk of unintended consequences in any introduction of a new payment system.

4. **Fee-for-service payments have a role.** While a global payment model could encourage collaboration among providers, care coordination, and a more holistic approach to a patient's care, fee-for-service payments should be a component of any payment system.

5. **Infrastructure support.** Sufficient resources for a comprehensive health information technology infrastructure and hiring an appropriate team of physician assistants, nurse practitioners, and other relevant staff are essential across all payment reform models.

6. **Proper risk adjustment.** In order to take on a bundled, global payment or other related payment models, funding must be adequate, and adequate risk adjustment for patient panel sickness, socioeconomic status, and other factors is needed. Current risk adjustment tools have limitations, and payers must include physician input as tools evolve and provide enough flexibility regarding resources in order to ensure responsible approaches are implemented. In addition, ACOs and like entities must have the infrastructure in place and individuals with the skills to understand and manage risk.

7. **Transparency.** There must be transparency across all aspects of administrative, legal, measurement, and payment policies across payers regarding ACO structures and new payment models. There must also be transparency in the financing of physicians across specialties. Trust is a necessary ingredient of a successful ACO or other
payment reform model. The negotiations between specialists, primary care physicians, and payers will be a determining factor in establishing this trust.

8. *Proper measurements and good data.* Comprehensive and actionable data from payers regarding the true risks of patients is key to any payment reform model. Without meaningful, comprehensive data, it becomes impractical to take on risk. Nationally accepted, reliable, and validated clinical measures must be used to both measure quality performance and efficiency and evaluate patient experience. Data must be accurate, timely, and made available to physicians for both trending and the ability to implement quality improvement and cost effective care. The ability to correct inaccurate data is also important.

9. *Patient expectations.* Patient expectations need to be realigned to support the more realistic understanding of benefits and risks of tests and clinical services or procedures when considering new payment reform models. Physicians and payers must work together to provide a public health educational campaign, with an opportunity for patients to provide input as appropriate and engage in relevant processes.

10. *Patient incentives.* Patient accountability coupled with physician accountability will be an effective element for success with payment reform. An important aspect of benefit design by payers is to exclude cost sharing for preventive care and other selected services.

11. *Benefit design.* Benefit designs should be fluid and innovative. Any contemplation of regulation and legislation with regard to benefit design should balance mandating minimum benefits, administrative simplification, with sufficient freedom to create positive transparent incentives for both patients and physicians to maximize quality and value.

12. *Professional liability reform.* Defensive medicine is not in the patient’s best interest and increases the cost of healthcare. In an environment where physicians have the incentive to do less, but patients request more, physicians view litigation as an inevitable outcome unless there is effective professional liability reform.

13. *Antitrust reform.* As large provider entities, ACO definitions and behavior may collide with anti-trust laws. The state legislature may be the adjudicator of antitrust issues. Accountable care organizations and other relevant payment reform models should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.

14. *Administrative simplification.* Physicians and others who participate in new payment models, including ACOs, should work with payers to reduce administrative processes and complexities and related burdens that interfere with delivering care. Primary care physicians should be protected from undue administrative burdens or should be appropriately compensated for it.

15. *The incentives to transition.* In order to transition to a new model, incentives must be predominantly positive.
16. **Planning must be flexible.** Accommodations must be made to take into account the highly variable readiness of practices to move to a new system.

17. **Primary care physician.** All patients should be encouraged to have a primary care physician with whom they can build a trusted relationship and from whom they can receive care coordination.

18. **Patient access.** Health care reform must enable patient choice in access to physicians, hospitals and other services while recognizing economic realities.

(HP) 

**HOSPITALS**

3c. Mergers or Conversions

Statement of Principles for Conversions and Mergers

Statement of Principles for Conversions and Mergers

A. Community Health Impact:

(1) Any proposed merger or conversion should assure access to high quality patient care and medically necessary services appropriate to the community’s needs.

(2) The proposed new entity should be obligated to provide the same or enhanced levels of services in the following areas:

• care to the uninsured and other vulnerable populations
• community health
• education and teaching
• research

(3) The health services to be provided by the new entity should be defined prior to the approval of the conversion or merger and should be committed to for a defined period. Procedures should be established for effective independent monitoring of those services to assure compliance with the agreed upon commitments and assessment of their effect on the community health status.

(4) Public hearings should be held to assure full public discussion of the proposed new entity and community concerns should be given full hearing. The proposed new entity should develop a written plan which addresses those community concerns before final approval of the proposed conversion or merger.

B. Oversight Requirements

(1) There should be full compliance with all requirements set forth by the Office of the Massachusetts Attorney General and the Massachusetts Department of Public Health.

(2) An independent appraisal of assets should be completed prior to a for-profit conversion.

(3) Private inurement to officers, trustees, directors and employees of the converting or merging entities should be prohibited.
(4) All actual and potential conflicts of interest by officers, trustees, directors and employees of the converting or merging entities should be publicly disclosed.

(5) The mission of any charitable foundation that is established after a conversion should be limited to improving the health of the community. Such foundations should be governed by a local board of directors with meaningful community and physician participation.

(6) The level of compensation for officers, trustees, directors and employees of the newly formed entity and the charitable foundation, when applicable, should be at an appropriate market rate.

Implementation Strategies

(1) Issue: Staffing Levels – With respect to Principle A.1.: "Any proposed merger or conversion should assure access to high quality patient care . . ." One key determinant of the quality of patient care is the adequacy of medical staffing. Strategy: After the conversion or merger, staffing levels should be appropriate to provide high quality patient care.

(2) Issue: Service Changes – With respect to Principle A.3.: "The health services to be provided by the new entity should be defined prior to the approval of the conversion or merger . . ." Appropriate information needs to be made available to the community in a timely manner, so as to enable the community to provide effective input to the process. Strategy: The new entity should identify both current services and those services it proposes to provide. As further modifications of services are proposed, the community should be informed and their input sought.

(3) Issue: Monitoring – With respect to Principle A.3.: "Procedures should be established for effective independent monitoring . . ." Because the affected community has the most at stake, it should be given the mandate and resources needed to perform this task. Strategy: Effective monitoring may be achieved by a local advisory board with significant autonomy.

(4) Issue: Private Inurement – With respect to Principle B.3.: "Private inurement to officers, trustees, directors and employees of the converting or merging entities should be prohibited." Decisions regarding conversions and mergers should be made solely on the basis of the best interests of the converting or merging entity and the community it serves. Strategy: Such abuses of trust should be aggressively investigated and prohibited by law or regulation, with penalties for violations.

(5) Issue: Conflicts of Interest – With respect to Principle B.4.: "All actual and potential conflicts of interest by officers, trustees, directors and employees of the converting or merging entities should be publicly disclosed." The purpose of this recommendation is to inform the community about the possible motives of key decision-makers in the conversion or merger process. Strategy: All disclosures of conflicts of interest should be documented in writing.

(6) Issue: Charitable Foundations – With respect to Principle B.5.: "The mission of any charitable foundation that is established after a conversion should be limited to improving the health of the community. Such foundations should
be governed by a local board of directors with meaningful community and
physician participation." And, Principle B.6., states: "The level of
compensation for officers, trustees, directors and employees of . . . the
charitable foundation . . . should be at an appropriate market rate."
Charitable foundations formed with the assets of a converting entity have
great potential for being misused. Strategy: The mission, governance,
operations and management of such foundations should be subject to public
scrutiny and focused on health care.

(HP)

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

MINORITIES
4c. Race and Ethnicity data
The Massachusetts Medical Society, recognizing that race and ethnicity are concepts
that are sensitive and difficult to define, and yet important determinants of health
outcomes, supports the use of the uniform and standardized classification system of the
U.S. Bureau of the Census, during the voluntary collection of race and ethnicity data.

(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

PROFESSIONAL LIABILITY
5c. Physician Expert Witnesses
[*Split between Reaffirm for One Year and Reaffirm for Seven Years]
The Massachusetts Medical Society (MMS) adopts the following Expert Witness
Testimony Standards, applicable to all physicians who testify as expert witnesses in
professional liability cases in Massachusetts:

1. The physician expert witness must hold a current, valid, nonrestricted medical
license.

2. The physician expert witness must be board certified in the same specialty as
the defendant physician when providing expert testimony on the standard of
care provided by the defendant, or board certified in their specialty when
providing any other relevant expert testimony in the case. Board certification
shall be with a specialty board recognized by the American Board of Medical
Specialties or the American Osteopathic Association.

3. The physician expert witness must be actively engaged in the clinical practice
of medicine.

4. The physician expert witness must be aware of and comply with the American
Medical Association’s (AMA) policies on Medical Testimony, False Testimony,
Peer Review of Medical Expert Witness Testimony, Expert Witness Testimony,
AMA-ABA Statement on Interprofessional Relations for Physicians and
Attorneys, and other applicable expert witness testimony standards,
guidelines, principles, and codes of ethics established by the American
Medical Association.

5. The physician expert witness must acknowledge and comply with expert
witness testimony standards, guidelines, principles, and codes of ethics
established by the national specialty society for the testifying physician’s
specialty, and sign, if such exists, an affirmation of compliance.
6. The physician must be available at trial if rendering an opinion at the tribunal stage of the proceedings.

7. The physician expert witness must be aware that the Federation of State Medical Boards defines false, fraudulent, or deceptive testimony as unprofessional conduct, and that such testimony may be actionable by the Massachusetts Board of Registration in Medicine or any other state licensing boards with whom the physician expert witness holds licenses to practice medicine.

8. The physician expert witness must be willing to submit transcripts of depositions and courtroom testimony to independent peer review by the appropriate specialty society.

(HP)

PUBLIC HEALTH

6c. Human Medicine, Veterinary Medicine, and Environmental Sciences

The Massachusetts Medical Society supports and promotes collaboration among the health professions to improve the integration of human medicine, veterinary medicine, and the environmental sciences. (HP)

The MMS will engage in a dialogue with the Massachusetts Veterinary Medical Association and the Massachusetts Public Health Association to determine and implement strategies for enhancing collaboration among the human medical, veterinary medical, and environmental sciences professions in medical education, clinical care, public health, and biomedical research. (D)

MMS House of Delegates, 12/3/11

QUALITY OF CARE

7c. Quality Measurement/Quality Improvement

The Massachusetts Medical Society adopts the following principles, for quality of medical care initiatives that the Society should undertake or embrace:

I. Definition of Quality

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

B. Physicians’ perspective as patient advocates (in contrast with those of health plans, purchasers) focuses on appropriate clinical decision-making (related to knowledge and judgment) and performance skills

II. Individual Physician Responsibility for Quality Management

A. There are professional privileges granted from society to physicians. In return, physicians have a professional responsibility to understand and apply scientific and technical knowledge for the benefit of patients (i.e., quality medical care)

B. Physicians’ claims to the public trust are derived from our unique role as patient advocates

III. Responsibilities of the Massachusetts Medical Society (MMS)

A. Our mission states: “The purposes of the Massachusetts Medical Society shall be to do all things as may be necessary and appropriate to advance medical knowledge, to develop and maintain the highest professional and ethical
standards of medical practice and health care, and to promote medical institutions formed on liberal principles for the health, benefit, and welfare of the citizens of the Commonwealth.”

B. MMS is the primary “grassroots” organization representing Massachusetts physicians.

C. Our own past history demonstrates concern for quality in areas such as continuing medical education (CME), advancement of medical knowledge through the ownership of The New England Journal of Medicine, and participation in guideline promulgation and implementation.

D. MMS has broad experience and readily available expertise in patient care, research, and education.

IV. Many policy decisions regarding medical practice (e.g., legislative and regulatory) are at the state level. Therefore, a state medical society is the most appropriate arena for many policy decisions.

V. Role of American Medical Association

A. Promote physician involvement in continuous quality improvement (CQI): data collection, analyses, and feedback loops.

B. Promote standards for physician profiling.

C. Promote effective quality improvement models.

D. Encourage development and provision of educational and training opportunities to improve patient care.

E. Encourage outcomes research.

F. Evaluate quality assurance programs.

G. Advocate nationally for quality in medicine.

(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

8c. Quality of Medical Care Initiatives, which the Massachusetts Medical Society undertakes, should have the following characteristics:

I. Quality Measures from Physicians’ Perspective: i.e., Appropriate Clinical Decision-Making, Performance Skills, and Desired Outcomes

II. Medical Services Ranging from Those Performed for Individual Patients to Those Performed for the Public Health

III. Categories of specific physician groups as participants in quality initiatives

A. Geographic Area

B. Specialty

C. Impaired

D. Outlier Practice Patterns

E. Other Groups

IV. Conceptual Frameworks for Quality Initiatives

A. Measurement: Profiling

(1) System Focus

a) Structures: (e.g. credentialing, liability)

b) Processes: (e.g. compliance to guidelines)

c) Outcomes: (e.g. mortality, quality of life)

(2) Role of Massachusetts Medical Society

a) Set standards for agencies to measure through the development of a set of attributes or criteria by an expert clinical panel.
b) Direct role in the profiling of physicians

B. Substantive Medical Management: Knowledge Base, Judgment, Decision-Making

(1) Curricula
   a) Directly providing and organizing CME and Non-CME courses
   b) Accrediting Other Physician-Affiliated Organizations
   c) Implementing Scientific Advances in Physicians' Clinical Practices

(2) Mentoring

(3) Clinical Practice Guidelines: Refine, approve, implement, evaluate

(4) Other systems of support

V. Physicians Partnering with Patients, along with other Providers: Academic Consortia, Hospitals, and other Professional Organizations

VI. Establishment of a Quality of Medical Care Program

VII. Clarity of Design and Focus of the Quality of Medical Care Program

A. Substantive content of medical program

B. Program target population

C. Definition of program outcomes

D. Definition of program time-line

E. Program evaluation component

(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

Fiscal Note: No Significant Impact

(Out-of-Pocket Expenses)

FTE: Existing Staff

(Staff Effort to Complete Project)
APPENDIX

AMA Policy
(Sunset: Item 2)
Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs H-135.936
1. Our AMA supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications.
2. Our AMA will work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations.
3. Our AMA will work with other appropriate organizations to develop a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling.

(Sunset: Item 8)
Communication Between Hospitals and Primary Care Referring Physicians D-160.945
Our AMA:
(1) advocates for continued Physician Consortium for Performance Improvement? (PCPI) participation in the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM) work to develop principles and standards for care transitions that occur between the inpatient and outpatient settings;
(2) advocates for timely and consistent inpatient and outpatient communications to occur among the hospital and hospital-based providers and physicians and the patient's primary care referring physician; including the physician of record, admitting physician, and physician-to-physician, to decrease gaps that may occur in the coordination of care process and improve quality and patient safety;
(3) will continue its participation with the Health Information Technology Standards Panel (HITSP) and provide input on the standards harmonization and development process;
(4) continues its efforts with The Joint Commission, the Centers for Medicare & Medicaid Services, and state survey and accreditation agencies to develop accreditation standards that improve patient safety and quality; and
(5) will explore new mechanisms to facilitate and incentivize communication and transmission of data for timely coordination of care (via telephone, fax, e-mail, or face-to-face communication) between the hospital-based physician and the primary physician.

(Sunset: Item 9)
Reimbursement for Telephonic and Electronic Communications D-70.993
Our AMA will request proposals to the CPT Editorial Panel to create better reporting extensions of face-to-face physician work, recognizing a wide range of communications including telephone consultation, fax, e-mail, video or other evolving communication forms.

Fair Valuation of Physician Services in Third Party Payer Contracting with Hospitals and Health Care Systems D-383.985
Our AMA will:
(1) continue to advocate for fair payment for physician services regardless of the employment status of physicians on organized medical staffs;
(2) develop a new federal antitrust legislative strategy, and reopen a dialogue with the Department of Justice and the Federal Trade Commission concerning more flexible approaches to physician network joint ventures;
(3) continue to encourage all physicians who would like to report the unfair business practices of health insurers and other payers to complete the AMA online health plan complaint form; and
(4) work to ultimately eliminate the need for cross subsidization practices between third party
payers and hospital systems that result in: (a) a decrease in physician market power, (b) a
devolution of physician services, and (c) harm to competition.

(Sunset: Item 10)

ERISA H-285.915

1. Our AMA will seek, through amendment of the ERISA statute, through enactment of separate
federal patient protection legislation, through enactment of similar state patient protection
legislation that is uniform across states, and through targeted elimination of the ERISA
preemption of self-insured health benefits plans from state regulation, to require that such self-
insured plans: (a) Ensure that plan enrollees have access to all needed health care services; (b)
Clearly disclose to present and prospective enrollees any provisions restricting patient access to
or choice of physicians, or imposing financial incentives concerning the provision of services on
such physicians; (c) Be regulated in regard to plan policies and practices regarding utilization
management, claims submission and review, and appeals and grievance procedures; (d)
Conduct scientifically based and physician-directed quality assurance programs; (e) Be legally
accountable for harm to patients resulting from negligent utilization management policies or
patient treatment decisions through all available means, including proportionate or comparative
liability, depending on state liability rules; (f) Participate proportionately in state high-risk
insurance pools that are financed through participation by carriers in that jurisdiction; (g) Be
prohibited from indemnifying beneficiaries against actions brought by physicians or other
providers to recover charges in excess of the amounts allowed by the plan, in the absence of
any provider contractual agreement to accept those amounts as full payment; (h) Inform
beneficiaries of any discounted payment arrangements secured by the plan, and base
beneficiary coinsurance and deductibles on these discounted amounts when providers have
agreed to accept these discounted amounts as full payment; (i) Be subject to breach of contract
actions by providers against their administrators; and (j) Adopt coordination of benefits
provisions applying to enrollees covered under two or more plans.

2. Our AMA will continue to advocate for the elimination of ERISA preemption of self insured
health plans from state insurance laws consistent with current AMA policy.
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 6
Code: CPH Report A-18 C-6 [A-17 C-2]
Title: Prescription Marketing Policy
(Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsor: The Committee on Public Health
Steven Ringer, MD, Chair

Report History: OFFICERS Report A-17 C-2 (Section C)
Original Sponsor: MMS Presidential Officers
Referred to: Reference Committee C
Mangadhara Rao Madineedi, MD, Chair

Background
At A-17, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on Public Health. The policy for review states:

PRESCRIPTION AND NON-PRESCRIPTION DRUGS
Prescription Marketing
The Massachusetts Medical Society disapproves of the direct product specific advertising of prescription drugs to the public. *(HP)*

Reaffirmed, MMS House of Delegates, 11/8/96
Reaffirmed, MMS House of Delegates, 5/2/03
Reaffirmed, MMS House of Delegates, 5/14/10

Reference Committee Testimony
The reference committee heard testimony in support of the report recommendation.

Relevance to MMS Strategic Priorities
Provide a leadership voice through its advocacy, collaboration, and public health efforts, and will continue to carefully monitor the impact of the rapidly transforming health care landscape on Massachusetts physicians and patients.

Discussion
The Committee on Public Health discussed the prescription marketing policy in relation to existing similar policy on direct-to-consumer advertising as well as MMS engagement regarding drug price transparency by pharmaceutical companies. The committee felt it was not necessary to have two policies with the same intent.

Existing Related Policy
The MMS will advocate for Massachusetts and federal legislation to ban direct-to-consumer drug ads in Massachusetts and in the United States. *(D)*

MMS House of Delegates, 5/2/15
The Medical Society is a strong advocate at the federal level to enact measures which will protect consumers from direct pharmaceutical marketing, assure transparency, and safeguard the availability of pharmaceuticals at fair and reasonable prices.

Conclusion
The committee recommends the following.

Recommendation:
That the Massachusetts Medical Society sunset the prescription marketing policy reaffirmed at A-10, which reads as follows:

The Massachusetts Medical Society disapproves of the direct product specific advertising of prescription drugs to the public. (HP)

MMS House of Delegates, 11/8/96
Reaffirmed, MMS House of Delegates, 5/2/03
Reaffirmed, MMS House of Delegates, 5/14/10

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)
FTE: Existing Staff
(Staff Effort to Complete Project)
EXECUTIVE SUMMARY

At A-17, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on Ethics, Grievances, and Professional Standards (EGPS) and the Committee on the Quality of Medical Practice (CQMP).

The MMS policy on Ethics and Managed Care is adapted primarily from American Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA) opinions. The AMA completed a comprehensive update of its Code of Medical Ethics in 2016 to ensure the language of the code applies to contemporary medical practice. As part of the update, the AMA amended or replaced the CEJA opinions upon which the MMS’s policy is based. The topics from the CEJA opinions referenced throughout MMS’s existing policy are now found in the AMA Code of Medical Ethics Chapter 11 — Financing and Delivery of Health Care. Chapter 11 was crafted to be applicable to all payment models and incentive mechanisms, rather than exclusively managed care.

Considering the changes in the practice environment since the adoption of the MMS’s current policy on Ethics and Managed Care, CQMP and EGPS were in support of the AMA’s approach of replacing the current policy on managed care with a comprehensive policy on the ethics of financing and delivery of health care. CQMP and EGPS reviewed the MMS’s current policy in light of the changes to the AMA Code of Medical Ethics, and recommend that the MMS adopt-in-lieu of the Ethics and Managed Care policy, a policy entitled Ethics of Financing and Delivery of Health Care.
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 7
Code: CEGPS/CQMP Report A-18 C-7 [A-17 C-2]
Title: Ethics and Managed Care Policy
(Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsors: Committee on Ethics, Grievances, and Professional Standards
Ronald Arky, MD, Chair
Committee on the Quality of Medical Practice
Barbara Spivak, MD, Chair
Report History: OFFICERS Report A-17 C2
Original Sponsor: MMS Presidential Officers (and Reviewing Committees)
Referred to: Reference Committee C
Mangadhara Rao Madineedi, MD, Chair

Background
At A-17, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on Ethics, Grievances, and Professional Standards and the Committee on the Quality of Medical Practice. The policy for review states:

ETHICS
Ethics and Managed Care
The Massachusetts Medical Society Policy Statement on Ethics and Managed Care states:

Ethics and Managed Care
Preamble:

The medical profession has long subscribed to a body of ethical standards. Initially developed for the benefit of the patient, ethical principles must also serve to guide the physician in his or her relationship with colleagues as well as other entities in the health care arena. Several relevant principles adopted by the American Medical Association and the Massachusetts Medical Society remain constant:

- A physician shall be dedicated to providing competent medical services with compassion and respect for human dignity, in a cost effective manner.
- A physician shall deal honestly with patients and colleagues.
- A physician shall respect the law and also recognize a responsibility to seek changes in those requirements that are contrary to the best interests of the patient.
- A physician shall make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
A physician shall, in the provision of appropriate patient care, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

Changes in the practice environment now require physicians to examine their professional relationships even more closely. The following principles are offered to reaffirm the primacy of the traditional physician-patient relationship and the standards of conduct between and among colleagues. They also seek to clarify appropriate conduct between physicians and health care organizations that challenge traditional models of medical practice.

PHYSICIAN TO PATIENT RELATIONSHIP

(1) Patient Advocacy Is Fundamental
The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interest of their patients first. (AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(2) Advocacy for Patient Benefit
Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for care they believe will materially benefit their patients. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care).

(3) Primacy of Patient Welfare over Physicians’ Financial Interests
While physicians should be conscious of costs and not provide or prescribe unnecessary services, concern for the quality of care the patient receives should be the physician’s first concern. Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity: Reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician’s financial benefit is unethical. Similarly, to limit appropriate diagnostic tests, referrals, hospitalization, or treatment, for the physician’s financial benefit is unethical. If a conflict develops between the physician’s financial interest and the physician’s responsibilities to the patient, the conflict must be resolved to the patient’s benefit. (Adapted from AMA CEJA Opinion 8.03 Conflicts of Interest: Guidelines, Adapted from AMA CEJA Opinion 2.09 Costs)

(4) Physician Participation in Allocation Process
Practicing physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create organizational structures that allow practicing physicians to have meaningful input into the plan’s development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis, be evidence based whenever feasible, and updated to reflect advances in medical knowledge and changes in relative costs. (Adapted from AMA Policy 285.982: Ethical Issues in Managed Care; AMA CEJA Opinion 8.13 Managed Care Guidelines)
Appeals from Denials of Care

Adequate and timely appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in denial of care that, in the physician’s judgment, would materially benefit the patient. In such cases, the physician’s duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise when a health plan has an allocation guideline that is generally unfair in its operation. In such cases, the physician’s duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan’s policy-making level to seek an elimination or modification of the guideline. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

A physician should be able to assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient’s best interests. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

Disclosure of Financial Incentives to Patients by Plan and by Physician

Health Plans must disclose any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or restrict referral or treatment options. Physicians must clearly and adequately respond to inquiries by patients regarding any financial incentives. The health plans must make adequate disclosure to patients enrolled in the plan at enrollment and annually thereafter. Physicians must also inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage. (Adapted from MA Policy 285.998: Managed Care #4, Financial Incentives)

PHYSICIAN TO PHYSICIAN

(1) Negotiating Contracts between Physicians

Negotiating contracts between physicians in a health plan is ethical and appropriate only if the standard of care is the same for all patients and there is disclosure to the patients of the financial arrangements that may affect their care.

(2) Referrals to Specialists

Patients are entitled to all the benefits outlined in their insurance plan. Therefore, it is unethical for a referring physician to restrict the referral options of patients who have chosen a plan that provides for access to an unlimited or broad selection of specialist physicians. It is also unethical to base the referral of these patients on a discount for the capitated patients in a primary care physician’s practice. Physicians should not be restricted from informing their patients of out-of-plan specialists, when their expertise may offer important advantages to the patient. (Adapted from AMA CEJA Opinion 8.052 Negotiating Discounts for Specialty Care; MMS Policy)
(3) **Financial Inducements**

Payment by or to a physician solely for the referral of a patient is fee splitting and is unethical. (AMA CEJA Opinion 6.02 Fee Splitting)

A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source. (AMA CEJA Opinion 6.02 Fee Splitting)

These payments violate the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed. (Adapted from AMA CEJA Opinion 6.02 Fee Splitting)

**PHYSICIAN TO HEALTH CARE ORGANIZATION**

(1) **Non-participation in Unprofessional Care**

Physicians should not participate in any organization that encourages or requires care at below minimum professional standards, unless actively involved in trying to change and improve the deficient standards. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

Physicians who have administrative and/or executive responsibilities in health care organizations should be knowledgeable about medical ethics and should encourage the health care organization to make ethically appropriate medical decisions. (Task Force on Ethical Standards in Managed Care, MMS 1996)

(2) **Incentives to Limit Care**

Health plans should not establish financial incentives or quotas that interfere with appropriate clinical management such as limiting diagnostic tests, services, referrals, or access to care. (MMS Policy)

When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians’ personal financial interests and the needs of their patients. Efforts to contain health care costs should not place patient welfare at risk. Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care. (AMA Policy 285.982: Ethical Issues in Managed Care; AMA CEJA Opinion 8.13 Managed Care Guidelines)

Physician payments that provide an incentive to limit the utilization of services should not link financial rewards with individual treatment decisions over periods of time insufficient to identify patterns of care or expose the physician to excessive financial risk for services provided by physicians or institutions to whom he or she refers patients for diagnosis or treatment. When risk sharing arrangements are relied upon to deter excess utilization, physician incentive payments should be based on performance of groups of physicians rather than individual physicians, and should not be based on performance over short
periods of time. (AMA Policy 285.982: Ethical Issues in Managed Care; Adapted from AMA CEJA Opinion 8.054 Financial Incentives and the Practice of Medicine)

The magnitude of fee withholds, bonuses and other financial incentives should not affect provision of appropriate care. (Adapted from AMA Policy 285.982: Ethical Issues in Managed Care; AMA CEJA Opinion 8.13 Managed Care Guidelines)

(3) Allocation Guidelines and Policy Making

Any broad allocation guidelines that restrict care and choices, which go beyond the cost/benefit judgments made by physicians as part of their normal professional responsibilities, should be established at a policy-making level so that individual physicians are not asked to engage in ad hoc bedside rationing. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for care they believe will materially benefit their patients. (Adapted from AMA CEJA Opinions 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(4) Physician Participation in Allocation Process

Practicing physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create organizational structures that allow practicing physicians to have meaningful input into the plan’s development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(5) Appeals from Denials of Care

Adequate and timely appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in denial of care that, in the physician’s judgment, would materially benefit the patient. In such cases, the physician’s duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise in which a health plan has an allocation guideline that is generally unfair in its operation. In such cases, the physician’s duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan’s policy-making level to seek an elimination or modification of the guideline. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)
A physician should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient’s best interests. (AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(6) Informed Consent and Plan Disclosure
Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that managed care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan and on annual re-enrollment. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(7) Full Disclosure to Patients
Physicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician’s obligation to disclose treatment alternatives to patients is not altered by a limitation in the coverage provided by the patient’s managed care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the managed care plan. Patients may then determine whether an appeal is appropriate, or whether they wish to seek care outside the plan for treatment alternatives that are not covered. (AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(8) Disclosure of Incentives to Patients, by Plan and by Physician
Health Plans must disclose any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or restrict referral or treatment options. Physicians must clearly and adequately respond to inquiries by patients regarding any financial incentives. Health plans must make adequate disclosure to patients enrolled in the plan at enrollment and annually thereafter. Physicians must also inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage. (Adapted from AMA Policy 285.998: Managed Care)

(9) Medical Judgments and Plan Administration
Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. In the operation of such plans, physicians should not be subjected to lay interference in professional medical matters and their primary responsibility should be to the patients they serve. Assuming a title or position that removes the physician from direct patient-physician relationships, such as the title of Medical Director, does not override professional ethical obligations. (AMA CEJA Opinion 8.05 Contractual Relationships, AMA CEJA Opinion 8.021 Ethical Obligations of Medical Directors.)

(10) Physician Contracts and Plan Administration
Physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary, but should be aware of the potential for some types of systems to create conflicts of interest because of financial incentives to withhold medically indicated services. Physicians must not allow such financial incentives to influence their judgment of
appropriate therapeutic alternatives or deny their patient’s access to appropriate
services based on such inducements. (Adapted from AMA Policy 285.998: 
Managed Care)

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

Reference Committee Testimony
The reference committee heard testimony only in support of the report; therefore,
recommended adoption of the recommendation to reaffirm for one year.

Relevance to MMS Strategic Priorities
The statement of principles below, reaffirming the primacy of the physician-patient
relationship and physicians’ role in modern health care delivery systems, supports the
MMS strategic priority of physician and patient advocacy. This policy reaffirms the
MMS’s position on many elements of the ongoing debate on health care reform,
promotes transparency, and addresses barriers that impede access to quality care.

Discussion
The MMS policy on Ethics and Managed Care is adapted primarily from the American
Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA) opinions,
including but not limited to, CEJA Opinion 8.13 Managed Care Guidelines, CEJA
Opinion 8.03 Conflicts of Interest: Guidelines, CEJA Opinion 8.054 Financial Incentives
and the Practice of Medicine; CEJA Opinion 8.05 Contractual Relationships, and CEJA
Opinion 8.021 Ethical Obligation of Medical Directors. The AMA completed a
comprehensive update of its Code of Medical Ethics on June 13, 2016. This update was
undertaken to ensure that the language of the code applies to contemporary medical
practice, and to improve the code’s clarity and consistency. As part of the update, the
AMA amended or replaced the CEJA opinions upon which the MMS’s policy on Ethics
and Managed Care is based.

The Committee on Quality of Medical Practice (CQMP) and the Committee on Ethics,
Grievances, and Professional Standards (EGPS) reviewed the MMS’s current policy in
light of the changes to the AMA Code of Medical Ethics. The most notable change was
the AMA’s deletion of CEJA Opinion 8.13 — Managed Care Guidelines, which is the
primary source of 12 of the 18 sections of the MMS’s policy on Ethics and Managed
Care. The concepts from CEJA Opinion 8.13, and majority of the CEJA opinions
referenced throughout MMS’s existing policy, are now found in the AMA Code of Medical
Ethics Chapter 11 — Financing and Delivery of Health Care. Rather than focus only on
managed care, the principles set forth in this Chapter 11 are crafted to be applicable to
all payment models and incentive mechanisms.

Conclusion
Considering the changes in the practice environment since the adoption of the MMS’s
current policy on Ethics and Managed Care, CQMP and EGPS were in support of the
AMA’s approach of replacing the managed care policy with a comprehensive policy on
the ethics of financing and delivery of health care. Both committees met on several
occasions to review the existing MMS policy and the new CEJA opinions. The
committees worked to adapt the relevant CEJA opinions to ensure the resulting MMS
policy recommendation represented appropriate and consistent guidelines for
Massachusetts physicians. At its March 5, 2018, meeting, CQMP provided its final
comments to EGPS on the language of the proposed policy. EGPS met on March 7,
2018, to review and incorporate CQMP’s comments, and voted to recommend the
following statement of ethical principles which provide guidance with respect to
relationships between physicians and their patients and between physicians and health
care institutions and payers. The recommended policy continues to affirm that a
physician’s primary ethical obligation is to promote the well-being of individual patients.
Both EGPS and CQMP felt strongly that these principles should be offered as ethics
guidance for physicians and are not intended to establish clinical practice guidelines or
rules of law.

**Recommendation:**
That the Massachusetts Medical Society adopt-in-lieu of the Ethics and Managed
Care policy reaffirmed at A-10 the following:

**Ethics of Financing and Delivery of Health Care**

**Preamble:**
The medical profession has long subscribed to a body of ethical standards.
Initially developed for the benefit of the patient, ethical principles must also
serve to guide the physician in his or her relationship with colleagues as well
as other entities in the health care arena. Several relevant principles adopted
by the American Medical Association and the Massachusetts Medical Society
remain constant:

- A physician shall be dedicated to providing competent medical services
  with compassion and respect for human dignity, in a cost-effective
  manner.
- A physician shall deal honestly with patients and colleagues.
- A physician shall respect the law and also recognize a responsibility to
  seek changes in those requirements that are contrary to the best
  interests of the patient.
- A physician shall make relevant information available to patients,
  colleagues, and the public, obtain consultation, and use the talents of
  other health professionals when indicated.
- A physician shall, in the provision of appropriate patient care, be free to
  choose whom to serve, with whom to associate, and the environment in
  which to provide medical services.

Changes in the practice environment require physicians to examine their
professional relationships even more closely. As health care has become more
complex and costlier, new challenges have emerged. Payment models and
incentive mechanisms intended to contain costs and improve quality may
create conflicts of interest that work against the goal of providing care that is
responsive to the unique needs, values, and preferences of individual patients.

The following principles are offered to reaffirm the primacy of the physician-
patient relationship and the standards of conduct between and among
colleagues. Further, they provide general recommendations related to
physicians’ ethical responsibilities to address questions of access to care, for
individuals and for populations of patients, in their role as practicing
clinicians, as leaders of health care organizations and institutions, and
collectively as a profession.
These principles are offered as ethics guidance for physicians and are not intended to establish clinical practice guidelines or rules of law.

**PROFESSIONALISM IN HEALTH CARE SYSTEMS (Adapted from AMA CEJA Opinion 11.2.1)**

Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism, are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients’ choices, the patient-physician relationship, and physicians’ relationships with fellow health care professionals.

Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians’ exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations should ensure that practices for financing and organizing the delivery of care:

- (a) Are transparent.
- (b) Reflect input from key stakeholders, including physicians and patients.
- (c) Recognize that over reliance on financial incentives may undermine physician professionalism.
- (d) Ensure ethically acceptable incentives that:
  - (i) are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethics guidance;
  - (ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
  - (iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
  - (iv) mitigate possible conflicts between physicians’ financial interests and patient interests by minimizing the financial impact of patient...
care decisions and the overall financial risk for individual
physicians.
(e) Encourage, rather than discourage, physicians (and others) to:
   (i) provide care for patients with difficult to manage medical
       conditions;
   (ii) practice at their full capacity, but not beyond.
(f) Recognize physicians' primary obligation to their patients by enabling
    physicians to respond to the unique needs of individual patients and
    providing avenues for meaningful appeal and advocacy on behalf of
    patients.
(g) Are routinely monitored to:
    (i) identify and address adverse consequences;
    (ii) identify and encourage dissemination of positive outcomes.

All physicians should:

(h) Hold physician-leaders accountable to meeting conditions for
    professionalism in health care systems.
(i) Advocate for changes in health care payment and delivery models to
    promote access to high-quality care for all patients.

PHYSICIAN STEWARDSHIP OF HEALTH CARE RESOURCES (Adapted from
AMA CEJA Opinion 11.2.2)
Physicians’ primary ethical obligation is to promote the well-being of
individual patients. Physicians’ have a secondary obligation to promote public
health and access to care. Part of this secondary obligation includes physician
awareness of health care resource limitations. It is incumbent upon physicians
to consider these limitations when making medical decisions. With this in
mind, physicians should:

(a) Base recommendations and decisions on patients’ medical needs.
(b) Use scientifically grounded evidence to inform professional decisions
    when available.
(c) Help patients articulate their health care goals and help patients and
    their families form realistic expectations about whether a particular
    intervention is likely to achieve those goals.
(d) Endorse recommendations that offer reasonable likelihood of achieving
    the patient’s health care goals.
(e) Choose the course of action that requires fewer resources when
    alternative courses of action offer similar likelihood and degree of
    anticipated benefit compared to anticipated harm for the individual
    patient but require different levels of resources.
(f) Be transparent about alternatives, including disclosing when resource
    constraints play a role in decision making.
(g) Participate in efforts to resolve persistent disagreement about whether
    a costly intervention is worthwhile.

Physicians are in a unique position to affect health care spending. But
individual physicians alone cannot and should not be expected to
address the systemic challenges of wisely managing health care
resources. Medicine as a profession must create conditions for practice
that make it feasible for individual physicians to be prudent stewards
by:

(h) Encouraging health care administrators and organizations, including
insurance companies, to make cost data transparent (including cost
accounting methodologies) so that physicians can exercise well-

(i) Ensuring that physicians have the training they need to be informed
about health care costs and how their decisions affect overall health
care spending.

(j) Advocating for policy changes, such as medical liability reform, that
promote professional judgment and address systemic barriers that
impede responsible stewardship.

ALLOCATING LIMITED HEALTH CARE RESOURCES (Adapted from AMA CEJA
Opinion 11.1.3)
Physicians' primary ethical obligation is to promote the well-being of their
patients. Policies for allocating scarce health care resources may impede
physicians' ability to fulfill that obligation.

As professionals dedicated to protecting the interests of their patients,
physicians thus have a responsibility to contribute their expertise to
developing allocation policies that are fair and safeguard the welfare of
patients.

Individually and collectively through the profession, physicians should
advocate for policies and procedures that allocate scarce health care
resources fairly among patients.

Allocation policies should be based on criteria relating to medical need,
including urgency of need, likelihood and anticipated duration of benefit, and
change in quality of life and use of lower cost alternatives of equal quality. In
limited circumstances, it may be appropriate to take into consideration the
amount of resources required for successful treatment. It is not appropriate to
base allocation policies on social worth, perceived obstacles to treatment,
patient contribution to illness, past use of resources, or other non-medical
characteristics.

FINANCIAL BARRIERS TO HEALTH CARE ACCESS (Adapted from AMA CEJA
Opinion 11.1.4)
Health care is a fundamental human good because it affects our opportunity to
pursue life goals, reduces our pain and suffering, helps prevent premature
loss of life, and provides information needed to plan for our lives. As
professionals, physicians individually and collectively have an ethical
responsibility to ensure that all persons have access to needed care
regardless of their economic means.

In view of this obligation:

(a) Individual physicians should help patients obtain needed care through
public or charitable programs when patients cannot do so themselves.
(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.

(c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to appropriate health services.

(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure necessary access to appropriate health care for all people.

CONFLICTS OF INTEREST IN PATIENT CARE (AMA CEJA Opinion 11.2.2)
The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may physicians place their own financial interests above the welfare of their patients.

Treatment or hospitalization that is willfully excessive or inadequate constitutes unethical practice. Physicians should not provide wasteful and unnecessary treatment that may cause needless expense solely for the physician’s financial benefit or for the benefit of a hospital or other health care organization with which the physician is affiliated.

Where the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority.

CONTRACTS TO DELIVER HEALTH CARE SERVICES (AMA CEJA Opinion 11.2.3)
Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires them to consider carefully the terms and conditions of contracts to deliver health care services before entering into such contracts to ensure that those contracts do not create untenable conflicts of interests.

Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes may be intended to enhance quality, efficiency, and safety in health care, they may also put at risk physicians’ ability to uphold professional ethical standards of informed consent and fidelity to patients and can impede physicians’ freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

As physicians enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, or other entities—they should be mindful that while many arrangements have the potential to promote desired improvements in care, some arrangements also have the potential to impede patients’ interests.
When contracting to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts or have a representative do so on their behalf to assure themselves that the arrangement:

(i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians’ treatment recommendations or direct what care patients receive, in keeping with ethics guidance;
(ii) does not compromise the physician’s own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;
(iii) allows the physician to appropriately exercise professional judgment;
(iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;
(v) permits disclosure to patients.

(b) Negotiate modification or removal of any terms that unduly compromise physicians’ ability to uphold ethical standards.

TRANSPARENCY IN HEALTH CARE (AMA CEJA Opinion 11.2.4)

Respect for patients’ autonomy is a cornerstone of medical ethics. Patients must rely on their physicians to provide information that patients would reasonably want to know to make informed, well-considered decisions about their health care. Thus, physicians have an obligation to inform patients about all appropriate treatment options, the risks and benefits of alternatives, and other information that may be pertinent, including the existence of payment models, financial incentives; and formularies, guidelines or other tools that influence treatment recommendations and care. Restrictions on disclosure can impede communication between patient and physician and undermine trust, patient choice, and quality of care.

Although health plans and other entities have primary responsibility to inform patient-members about plan provisions that will affect the availability of care, physicians may share in this responsibility.

Individually, physicians should:

(a) Disclose any financial and other factors that could affect the patient’s care.
(b) Disclose relevant treatment alternatives, including those that may not be covered under the patient’s health plan.
(c) Encourage patients to be aware of the provisions of their health plan. Collectively, physicians should advocate that health plans with which they contract disclose to patient-members.
(d) Plan provisions that limit care, such as formularies or constraints on referrals.
(e) Plan provisions for obtaining desired care that would otherwise not be provided, such as provision for off-formulary prescribing.

(f) Plan relationships with pharmacy benefit management organizations and other commercial entities that have an interest in physicians’ treatment recommendations.

CONSULTATION, REFERRAL, SECOND OPINIONS (AMA CEJA Opinion 1.2.3)

Physicians’ fiduciary obligation to promote patients’ best interests and welfare can include consulting other physicians for advice in the care of the patient or referring patients to other professionals to provide care. When physicians seek or provide consultation about a patient’s care or refer a patient for health care services, including diagnostic laboratory services, they should:

(a) Base the decision or recommendation on the patient’s medical needs, as they would for any treatment recommendation, and consult or refer the patient to only health care professionals who have appropriate knowledge and skills and are licensed to provide the services needed.

(b) Share patients’ health information in keeping with ethics guidance on confidentiality.

(c) Assure the patient that he or she may seek a second opinion or choose someone else to provide a recommended consultation or service. Physicians should urge patients to familiarize themselves with any restrictions associated with their individual health plan that may bear on their decision, such as additional out-of-pocket costs to the patient for referrals or care outside a designated panel of providers.

(d) Explain the rationale for the consultation, opinion, or findings and recommendations clearly to the patient.

(e) Respect the terms of any contractual relationships they may have with health care organizations or payers that affect referrals and consultation. Physicians may not terminate a patient-physician relationship solely because the patient seeks recommendations or care from a health care professional whom the physician has not recommended.

FEE SPLITTING (Adapted from AMA CEJA Opinion 11.3.4)

Patients must be able to trust that their physicians will be honest with them and will make treatment recommendations, including referrals, based on medical need, the skill of other health care professionals or facilities to whom the patient is referred, the quality of products or services provided, and consistent with all federal and state laws.

Payment by or to a physician or health care institution solely for referral of a patient is fee splitting and is unethical.

Physicians may not accept:

(a) Any payment of any kind, from any source for referring a patient other than distributions of a health care organization’s revenues as permitted by law.

(b) Any payment of any kind, from any source for prescribing a specific
drug, product, or service.

(c) Payment for services relating to the care of a patient from any health care facility/organization to which the physician has referred the patient.

(d) Payment for referring a patient to a research study.

Physicians in a capitated primary care practice may not refer patients based on whether the referring physician has negotiated a discount for specialty services.

(HP)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
EXECUTIVE SUMMARY

At A-17, through the sunset policy review process, the MMS policy, *Principles on Medical Professional Peer Review*, was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on the Quality of Medical Practice (CQMP) and the Committee on Ethics, Grievances, and Professional Standards (EGPS).

The MMS's *Principles on Medical Professional Review of Physicians* were developed in accordance with, and with guidance from, Massachusetts and federal law, American Medical Association (AMA) Council on Judicial and Ethical Affairs (CEJA) opinions, and standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission). Prompted by the AMA's comprehensive update to the AMA Code of Medical Ethics, completed on June 13, 2016, EGPS and CQMP undertook a review of the relevant laws and policies, specifically with regard to changes that have taken place since these principles were last reviewed and amended at A-10.

The most notable change since 2010, which is not already addressed in the principles, is in the updated CEJA Opinion 9.4.1 *Peer Review and Due Process*, which includes the recommendation that physicians and medical students who are involved in reviewing the conduct of fellow professionals, medical students, residents or fellows should disclose relevant conflicts of interest and, when appropriate, recuse themselves from a hearing.

EGPS and CQMP support emphasizing the role of physicians on a peer review committee in mitigating conflicts of interest in peer review, and recommend that the MMS *Principles of Professional Review of Physicians* be amended to include language to this effect.
Background
At A-17, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on the Quality of Medical Practice and the Committee on Ethics, Grievances, and Professional Standards. The policy for review states:

Principles on Medical Professional Review of Physicians
The Massachusetts Medical Society adopts the following amended policy and Principles on Medical Professional Review of Physicians within Health Insurance Companies and Medical Professional Review of Physicians within Health Care Facilities.

These principles are separate from the model principles that apply to medical peer review of physicians for health care facilities. The following principles include an independent appeal and review process for disputed peer review outcomes by a health insurance company.

Massachusetts Medical Society Policy on Medical Professional Review of Physicians within Health Insurance Companies

Introduction:
Activities conducted by health insurance companies to evaluate the performance of physicians may or may not constitute “peer review” or “professional review activity” under Massachusetts or federal law, depending on whether or not such activities fall within the requisite statutory definitions. The MMS believes that all such activities, however, should follow a fair, evidence-based, ethical, and coherent process, and has therefore adopted the following Model Principles for Professional Review of Physicians within Health Insurance Companies as guidance for such activities as may be applicable to their setting.
The following recommendations are made based on the above considerations in order to enhance:

- Quality improvement
- Credibility in the process of medical professional/peer review of physicians
- Fairness and due process
- Patient access — by not inappropriately terminating, removing or sanctioning physicians
- System approaches to patient safety and quality of care

Model Principles for Medical Professional Review of Physicians within Health Insurance Companies

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event should include not only pre-event factors, but also the contributory effects of the health care system.
3. All the relevant information should be obtained promptly from the subject physician on a confidential basis. In addition, relevant information from other sources should be obtained and made available to the subject physician to the fullest extent legally permissible followed by early discussion with the subject physician to evaluate the “incident” and explore alternate courses of action, all on a confidential basis.
4. The process should be mindful of, and attuned to, prevention; and the outcome should include recommendations, if appropriate, for individual remediation.
5. Triggers that initiate a medical professional review within a health plan should be valid, transparent and available to all credentialed, participating provider or contracted physicians and should be uniformly applied, with objective and evidence-based pre-screening, to all cases and physicians.
6. Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process. Such cases should be referred to Physician Health Services, Inc., or another appropriate physician health or wellness program.
7. At a minimum, the standards set by the Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity for “professional review bodies” should be followed if a disciplinary process is engaged during medical professional review. These standards are the most elementary safeguards of due process for medical professional review activities.

Section 11112 Standards for professional review actions
“a. In general…professional review action must be taken—
(1) in the reasonable belief that the action was in the furtherance of quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)."
"Adequate notice and hearing–A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating –

(A) (i) that a professional review action has been proposed to be taken against a physician

(ii) reasons for the proposed action

(B) (i) that the physician has the right to request a hearing on the proposed action

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing–If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating –

(A) the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice–If a hearing is requested on a timely basis under paragraph (1)(B) –

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) –

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right –

(i) to representation by an attorney or other person of the physician’s choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right–

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision."

In addition, the notice of hearing should contain a summary of the allegations and of the episodes of care under evaluation.
8. Summary termination of credentials or of participating provider contract or status (or, if applicable, suspension or restriction of clinical privileges) should only be used to prevent “imminent danger to the health of any individual.” Such summary actions should be followed by adequate notice and hearing procedures prior to becoming final.

9. All parties involved in the medical professional review process must preserve the confidentiality of all records, information and proceedings. However, all of the facts obtained for and in the medical professional review process should be available to the subject physician to the fullest extent legally permissible.

10. A medical professional review panel or peer review committee, engaged in a formal medical professional/peer review, corrective action or disciplinary proceeding, should not include direct economic competitors of the subject physician or those for whom there may be bias or lack of objectivity vis-à-vis the subject physician, and should, whenever feasible, include a fair representation of specialists/subspecialists from the subject physician’s specialty/subspecialty from among credentialed, participating provider or contracted physicians within the health plan. The subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to the commencement of the proceedings. Such challenge would be part of the procedure specified in the health insurance company bylaws outside of peer review protections and not a part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

11. Health plans should employ mechanisms to rotate service on their medical professional review panels or peer review committees among their credentialed, participating provider or contracted physicians.

12. Membership on the medical professional panel or peer review committee should be open to all credentialed, participating provider or contracted physicians in the health plan and not be restricted to one or more groups such as employed or salaried physicians only. The committee should include more than just medical directors, medical officers or other administrative officers of the health plan.

13. Only physicians are peers of the subject physician, and only physicians should be voting members of committees conducting medical professional review of physicians.

14. Whenever a medical professional review panel or peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the health plan while excluding direct economic competitors, or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution (e.g., medical specialty society) authorized to conduct peer review of physicians should be appointed in accordance with the health plan’s bylaws if such actions fall within statutory medical professional/peer review protections.

15. Physicians serving on the medical professional review panel or peer review committee should receive information and, where available, training, in the elements and essentials of medical professional/peer review.

16. The health plan should ensure that the physicians serving on any medical professional review panel or peer review committee are provided with
appropriate indemnification and insurance for medical professional/peer review acts taken in good faith. The health plan should also provide assistance to the panel or committee in abiding by the requirements of HCQIA to be eligible for federal immunity if applicable.

17. The medical professional review panel or peer review committee of a health plan should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination on matters of quality care or professional competency. When the matter before the medical professional review panel or peer review committee involves professional conduct, such as an allegation of disruptive behavior, the medical professional review panel or peer review committee should be guided by applicable professional ethical principles (e.g., MMS Code of Ethics, AMA Principles of Medical Ethics, relevant specialty society ethical codes). Those guidelines, standards, practices and principles should be made available in a timely manner to the subject physician before any hearing on the matter.

18. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.

19. Wherever feasible, structured assessment instruments and, if available, multiple reviewers should be used to increase reliability.

20. Where feasible, statistical analysis to compare with peers’ performance should be used with appropriate case mix adjustment.

21. Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.

22. All the pertinent information obtained by the medical professional review panel or peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.

23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.

24. Any conclusion reached or action recommended or taken should be based upon the information presented to the medical professional review panel or peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a “reasonably prudent person” standard.

25. If the conclusion reached is that improvement is necessary, any action recommended by a health plan should include, as an important focus, steps for remediation, as needed, for the subject physician.

26. The findings, recommendations and actions of the medical professional review panel or peer review committee of a health plan should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician’s act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it should address what specific remediation, if any, is recommended for the physician (whenever feasible, in terms that permit measurement and validation of remediation, when completed).

27. A process should be available to appeal any disciplinary finding of a health plan following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An
appeals process before a disinterested third party, not connected to the health
plan, should be made available to the subject physician within statutory medical
professional/peer review protections. If the original action was part of a peer-
review protected process, the appeal should be part of the peer-review protected
process as well.

28. In all instances of medical professional review activities conducted within health
insurance companies, the applicable processes and procedures should be
clearly stated, with specific detail, in health plan provider manuals or written
policies, of uniform application, made available in advance to the subject
physician. Such processes and procedures should contain the particular due
process, hearing and appeals rights available to the subject physician, and, to
the extent that medical professional review or peer review privilege,
confidentiality and immunity legal protections are available to such medical
professional review activities, such processes and procedures should conform to
the requirements of federal and state law. In conformity with Principle No. 12, to
avoid or at least mitigate conflicts of interest, or the perception thereof, the
medical professional review panels or peer review committees of health
insurance companies should include as members with full participation and
voting rights physicians who are not employees or contractors (other than
contracting as a participating provider) of the health insurer.

29. The Society recognizes that when a physician performs a medical peer review
function he/she should render the same opinions that would pertain if he/she
were the treating physician with responsibility to provide appropriate patient care.
These opinions should not be rendered solely on the basis of cost containment.
(MMS Council, 5/17/91; Reaffirmed, House of Delegates, May 7, 1999)

30. These Model Principles for Medical Professional Review of Physicians within
Health Insurance Companies are intended to apply to all medical professional
review activities conducted by health insurance companies of their credentialed,
participating provider or contracted physicians, however designated: e.g.,
professional review, peer review, credentialing appeals, corrective actions or
otherwise.
(MMS House of Delegates, 5/08/09)

The Massachusetts Medical Society amends its existing Model Principles for
Incident-Based Peer Review for Health Care Facilities to include an independent
appeal and review process for disputed peer review outcomes by a hospital and
to update the principles to account for changes in regulations and standards
developed since the principles were created in 2003 as to read as follows:

Massachusetts Medical Society Policy
Model Principles for Medical Peer Review of Physicians for Health Care Facilities

The following recommendations are made based on the above considerations in
order to enhance:
• Quality improvement
• Credibility in the process of medical peer review of physicians for health care
facilities
• Fairness and due process
• Patient access — by not inappropriately removing or sanctioning physicians
• System approaches to patient safety and quality of care

That the Massachusetts Medical Society Model Principles for Medical Peer Review of Physicians for Health Care Facilities are as follows:

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event in a health care facility must not only include pre-event factors, but also the contributory effects of the health care system.
3. All the relevant information should be obtained promptly from the subject physician. In addition, relevant information from other sources should be obtained and made available to the subject physician to the fullest extent legally permissible followed by early discussion with the subject physician to evaluate the “incident” and explore alternate course of action.
4. The process must be mindful and attuned to prevention and recommend appropriate individual and system changes for remediation.
5. Triggers that initiate a medical peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied, with objective and evidence-based pre-screening, to all cases and physicians.
6. Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process.
7. At a minimum, the standards set by Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity must be followed if a disciplinary process is engaged during professional review. These standards are the most elementary safeguards of due process in a health care facility.

Section 1112 Standards for professional review actions

“a. In general…professional review action must be taken—

(1) in the reasonable belief that the action was in the furtherance of quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).”

“Adequate notice and hearing—A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action
   The physician has been given notice stating—
   (A) (i) that a professional review action has been proposed to be taken against a physician
   (ii) reasons for the proposed action
   (B) (i) that the physician has the right to request a hearing on the proposed action
(ii) any time limit (of not less than 30 days) within which to request such a
hearing, and
(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing—If a hearing is requested on a timely basis under paragraph
(1) (B), the physician involved must be given notice stating—
(A) the place, time and date of the hearing, which date shall not be less than
30 days after the date of the notice, and
(B) a list of the witnesses (if any) expected to testify at the hearing on behalf
of the professional review body.

(3) Conduct of hearing and notice—If a hearing is requested on a timely basis
under paragraph (1)(B)—
(A) subject to subparagraph (B), the hearing shall be held (as determined by
the health care entity)—
(i) before an arbitrator mutually acceptable to the physician and the health
care entity,
(ii) before a hearing officer who is appointed by the entity and who is not
in direct economic competition with the physician involved, or
(iii) before a panel of individuals who are appointed by the entity and are
not in direct economic competition with the physician involved;
(B) the right to the hearing may be forfeited if the physician fails, without good
cause, to appear;
(C) in the hearing the physician involved has the right—
(i) to representation by an attorney or other person of the physician's
choice,
(ii) to have a record made of the proceedings, copies of which may be
obtained by the physician upon payment of any reasonable charges
associated with the preparation thereof,
(iii) to call, examine, and cross-examine witnesses,
(iv) to present evidence determined to be relevant by the hearing officer,
regardless of its admissibility in a court of law, and
(v) to submit a written statement at the close of the hearing; and
(D) upon completion of the hearing, the physician involved has the right—
(i) to receive the written recommendation of the arbitrator, officer, or
panel, including a statement of the basis for the recommendations, and
(ii) to receive a written decision of the health care entity, including a
statement of the basis for the decision."

In addition, the notice of hearing should contain a summary of the allegations and the
episodes of care under evaluation.

8. Summary suspension or restriction of clinical privileges may only be used to
prevent "imminent danger to the health of any individual." Such summary actions
must be followed by adequate notice and hearing procedures prior to becoming
final.

9. All parties involved in the peer review process must preserve the confidentiality
of all records, information and proceedings. However, all of the facts obtained for
and in the peer review process shall be available to the subject physician to the
fullest extent legally permissible.

10. A peer review committee, engaged in a formal peer review or disciplinary
proceeding, may not include direct economic competitors of the subject physician
or those for whom there may be bias or lack of objectivity vis-à-vis the subject
physician and should include a fair representation of specialists/subspecialists
from the subject physician's specialty/subspecialty whenever feasible. The subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to commencement of the proceedings. Such challenge would be a part of the procedures specified in the health care facility bylaws, outside of peer review protections and not part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

11. Physicians should rotate service on the peer review committee (round robin).

12. Membership on the peer review committee must be open to all physicians on the medical staff and not be restricted to one or more groups such as those practicing exclusively at a given institution, salaried physicians only or faculty physicians only.

13. Only physicians should be voting members of committees conducting medical peer review of physicians.

14. Whenever a peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the institution while excluding direct economic competitors or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution authorized to conduct peer review of physicians should be appointed in accordance with the medical staff bylaws and medical peer review protection statutes.

15. Physicians serving on the peer review committee should receive information and where available, training, in the elements and essentials of medical peer review.

16. The hospital or the organization on whose behalf the peer review is done must ensure that the physicians serving on any peer review committee are provided with appropriate indemnification and insurance for peer review acts taken in good faith. The organization must also provide assistance to the committee in abiding by the requirements of HCQIA to be eligible for federal immunity.

17. The peer review committee of a health care facility should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination. When the matter before the peer review committee involves professional conduct such as an allegation of disruptive behavior, the peer review committee should be guided by applicable professional ethical principles (e.g., the MMS Code of Ethics, the AMA Principles of Medical Ethics, relevant specialty society ethical codes). Those guidelines, standards and practices must be made available in a timely manner to the subject physician before any hearing on the matter.

18. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.

19. Wherever feasible, structured assessment instruments and multiple reviewers should be used to increase reliability.

20. Where feasible, statistical analysis to compare with peers' performance must be used with appropriate case mix adjustment.

21. Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.
22. All the pertinent information obtained by the peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.

23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.

24. Any conclusion reached or action recommended or taken should be based upon the information presented to the peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a "reasonably prudent person" standard.

25. If the conclusion reached is that improvement is necessary, any action recommended by a health care facility should include, as an important focus, steps for remediation, as needed, for the subject physician and for the system.

26. The findings, recommendations and actions of the peer review committee of a health care facility should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician’s act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it must address what specific remediation, if any, is recommended for the physician and what, if any, for the system (whenever feasible, in terms that permit measurement and validation of remediation, when completed).

27. A process should be available to appeal any disciplinary finding of a health care facility following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An appeals process before a disinterested third party, not connected to the medical staff or the hospital, should be made available to the subject physician within statutory peer review protections. If the original action was part of a peer-review protected process, the appeal should be part of the peer-review protected process as well.

(MMS House of Delegates, November 8, 2003; Amended, 5/14/10)

(MMS Council, 5/17/91; reaffirmed House of Delegates, May 7, 1999)

(HP)

(MMS House of Delegates, 11/08/03)

*Health Care Facilities Principles Amended and Reaffirmed, MMS House of Delegates, 5/08/09

Amended and Reaffirmed, MMS House of Delegates, 5/14/10

(Item 2 of Original: Sunset)

Reference Committee Testimony

The reference committee heard only support for this report and therefore, recommended adoption of the recommendation to reaffirm for one year.
Relevance to MMS Strategic Priorities

Providing principles on medical professional review of physicians by insurance companies and within health care facilities supports the MMS’s strategic priority on physician and patient advocacy. A fair, evidence-based, and ethical peer review process helps to improve patient care and outcomes, as well as the physician practice environment in general.

Discussion

The MMS’s Principles on Medical Professional Review of Physicians were developed in accordance with, and with guidance from, Massachusetts and federal law, American Medical Association (AMA) Council on Judicial and Ethical Affairs (CEJA) opinions, and standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission). Prompted by the AMA’s comprehensive update to the AMA Code of Medical Ethics, completed on June 13, 2016, the Committee on Ethics, Grievances, and Professional Standards (EGPS) and the Committee on Quality of Medical Practice (CQMP) undertook a review of the relevant laws and policies which underlie the MMS’s Principles on Medical Professional Review of Physicians. In consultation with MMS legal counsel, EGPS and CQMP reviewed peer review requirements and recommendations from the law, CEJA opinions and the Joint Commission, specifically with regard to changes that have taken place since these principles were last reviewed and amended at A-10.

The most notable change since 2010, which is not already addressed in the principles, is in the updated CEJA Opinion 9.4.1 Peer Review and Due Process. This opinion includes language stating that:

Individually, physicians and medical students who are involved in reviewing the conduct of fellow professionals, medical students, residents or fellows should:

[...]

Disclose relevant conflicts of interest and, when appropriate, recuse themselves from a hearing.

The AMA’s updated opinion is in line with Joint Commission standards from 2007, which place a greater emphasis on identifying and mitigating conflicts of interest in medical professional peer review.

Conclusion

The current Principles on Medical Professional Review of Physicians state that a peer review proceeding should be free of bias, and that the subject physician has the right to challenge the participation of anyone on the peer review committee who lacks objectivity vis-à-vis the subject physician. EGPS, at its March 7, 2018, meeting, and CQMP, at its March 5, 2018, meeting, voted to recommend emphasizing the role of physicians on a peer review committee in mitigating conflicts of interest in the peer review process.

Proposed Amendments

EGPS and CQMP proposes amending the MMS Principles of Medical Professional Review of Physicians as follows (added text shown as “text” and deleted text shown as “text”):
Massachusetts Medical Society Policy on Medical Professional Review of Physicians within Health Insurance Companies

10. A medical professional review panel or peer review committee, engaged in a formal medical professional/peer review, corrective action or disciplinary proceeding, should not include direct economic competitors of the subject physician or those for whom there may be bias or lack of objectivity vis-à-vis the subject physician, and should, whenever feasible, include a fair representation of specialists/subspecialists from the subject physician’s specialty/subspecialty from among credentialed, participating provider or contracted physicians within the health plan. Participants on a medical professional review panel or peer review committee should disclose relevant conflicts of interest and, when appropriate, recuse themselves from the corrective action or disciplinary proceeding. Additionally, the subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to the commencement of the proceedings. Such challenge would be part of the procedure specified in the health insurance company bylaws outside of peer review protections and not a part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

Massachusetts Medical Society Policy
Model Principles for Medical Peer Review of Physicians for Health Care Facilities

10. A peer review committee, engaged in a formal peer review or disciplinary proceeding, may not include direct economic competitors of the subject physician or those for whom there may be bias or lack of objectivity vis-à-vis the subject physician and should include a fair representation of specialists/subspecialists from the subject physician’s specialty/subspecialty whenever feasible. Participants on a peer review committee should disclose relevant conflicts of interest and, when appropriate, recuse themselves from the peer review or disciplinary proceeding. Additionally, the subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to commencement of the proceedings. Such challenge would be a part of the procedures specified in the health care facility bylaws, outside of peer review protections and not part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

Recommendation:
That the Massachusetts Medical Society adopt as amended the Principles on Medical Professional Review of Physicians policy amended and reaffirmed at A-10 to reads as follows: [amending item 10 of Massachusetts Medical Society Policy on...
Introduction:
Activities conducted by health insurance companies to evaluate the
performance of physicians may or may not constitute “peer review” or
“professional review activity” under Massachusetts or federal law, depending
on whether or not such activities fall within the requisite statutory definitions.
The MMS believes that all such activities, however, should follow a fair,
evidence-based, ethical, and coherent process, and has therefore adopted the
following Model Principles for Professional Review of Physicians within Health
Insurance Companies as guidance for such activities as may be applicable to
their setting.

The following recommendations are made based on the above considerations
in order to enhance:
- Quality improvement
- Credibility in the process of medical professional/peer review of
  physicians
- Fairness and due process
- Patient access — by not inappropriately terminating, removing or
  sanctioning physicians
- System approaches to patient safety and quality of care

Model Principles for Medical Professional Review of Physicians within Health
Insurance Companies

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event should
   include not only pre-event factors, but also the contributory effects of
   the health care system.
3. All the relevant information should be obtained promptly from the
   subject physician on a confidential basis. In addition, relevant
   information from other sources should be obtained and made available
to the subject physician to the fullest extent legally permissible
followed by early discussion with the subject physician to evaluate the
“incident” and explore alternate courses of action, all on a confidential
basis.

4. The process should be mindful of, and attuned to, prevention; and the
outcome should include recommendations, if appropriate, for individual
remediation.

5. Triggers that initiate a medical professional review within a health plan
should be valid, transparent and available to all credentialed,
participating provider or contracted physicians and should be uniformly
applied, with objective and evidence-based pre-screening, to all cases
and physicians.

6. Physician health and impairment issues should be identified and
managed by a medical peer review committee which is separate from
the disciplinary process. Such cases should be referred to Physician
Health Services, Inc., or another appropriate physician health or
wellness program.

7. At a minimum, the standards set by the Healthcare Quality Improvement
Act of 1986 (HCQIA) for eligibility to federal immunity for “professional
review bodies” should be followed if a disciplinary process is engaged
during medical professional review. These standards are the most
elementary safeguards of due process for medical professional review
activities.

Section 11112 Standards for professional review actions

“a. In general…professional review action must be taken–
(1) in the reasonable belief that the action was in the furtherance of
quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the
physician involved or after such other procedures as are fair to the
physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts
known after such reasonable effort to obtain facts and after
meeting the requirement of paragraph (3).”

“Adequate notice and hearing–A health care entity is deemed to have met
the adequate notice and hearing requirement of subsection (a)(3) of this
section with respect to a physician if the following conditions are met (or
are waived voluntarily by the physician):
(1) Notice of proposed action
   The physician has been given notice stating –
   (A) (i) that a professional review action has been proposed to be taken
       against a physician
       (ii) reasons for the proposed action
   (B) (i) that the physician has the right to request a hearing on the
       proposed action
       (ii) any time limit (of not less than 30 days) within which to request
       such a hearing, and
(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing—If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating—

(A) the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice—If a hearing is requested on a timely basis under paragraph (1)(B) —

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) —

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right—

(i) to representation by an attorney or other person of the physician’s choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right—

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.”

In addition, the notice of hearing should contain a summary of the allegations and of the episodes of care under evaluation.

8. Summary termination of credentials or of participating provider contract or status (or, if applicable, suspension or restriction of clinical privileges) should only be used to prevent “imminent danger to the health of any individual.” Such summary actions should be followed by adequate notice and hearing procedures prior to becoming final.

9. All parties involved in the medical professional review process must preserve the confidentiality of all records, information and proceedings. However, all of the facts obtained for and in the medical professional review process should be available to the subject physician to the fullest extent legally permissible.

10. A medical professional review panel or peer review committee, engaged in a formal medical professional/peer review, corrective action or disciplinary proceeding, should not include direct economic
competitors of the subject physician or those for whom there may be bias or lack of objectivity vis-à-vis the subject physician, and should, whenever feasible, include a fair representation of specialists/subspecialists from the subject physician’s specialty/subspecialty from among credentialed, participating provider or contracted physicians within the health plan. Participants on a medical professional review panel or peer review committee should disclose relevant conflicts of interest and, when appropriate, recuse themselves from the corrective action or disciplinary proceeding. Additionally, the subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to the commencement of the proceedings. Such challenge would be part of the procedure specified in the health insurance company bylaws outside of peer review protections and not a part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

11. Health plans should employ mechanisms to rotate service on their medical professional review panels or peer review committees among their credentialed, participating provider or contracted physicians.

12. Membership on the medical professional panel or peer review committee should be open to all credentialed, participating provider or contracted physicians in the health plan and not be restricted to one or more groups such as employed or salaried physicians only. The committee should include more than just medical directors, medical officers or other administrative officers of the health plan.

13. Only physicians are peers of the subject physician, and only physicians should be voting members of committees conducting medical professional review of physicians.

14. Whenever a medical professional review panel or peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the health plan while excluding direct economic competitors, or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution (e.g., medical specialty society) authorized to conduct peer review of physicians should be appointed in accordance with the health plan’s bylaws if such actions fall within statutory medical professional/peer review protections.

15. Physicians serving on the medical professional review panel or peer review committee should receive information and, where available, training, in the elements and essentials of medical professional/peer review.

16. The health plan should ensure that the physicians serving on any medical professional review panel or peer review committee are provided with appropriate indemnification and insurance for medical professional/peer review acts taken in good faith. The health plan should also provide assistance to the panel or committee in abiding by
the requirements of HCQIA to be eligible for federal immunity if applicable.

17. The medical professional review panel or peer review committee of a health plan should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination on matters of quality care or professional competency. When the matter before the medical professional review panel or peer review committee involves professional conduct, such as an allegation of disruptive behavior, the medical professional review panel or peer review committee should be guided by applicable professional ethical principles (e.g., MMS Code of Ethics, AMA Principles of Medical Ethics, relevant specialty society ethical codes). Those guidelines, standards, practices and principles should be made available in a timely manner to the subject physician before any hearing on the matter.

18. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.

19. Wherever feasible, structured assessment instruments and, if available, multiple reviewers should be used to increase reliability.

20. Where feasible, statistical analysis to compare with peers’ performance should be used with appropriate case mix adjustment.

21. Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.

22. All the pertinent information obtained by the medical professional review panel or peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.

23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.

24. Any conclusion reached or action recommended or taken should be based upon the information presented to the medical professional review panel or peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a “reasonably prudent person” standard.

25. If the conclusion reached is that improvement is necessary, any action recommended by a health plan should include, as an important focus, steps for remediation, as needed, for the subject physician.

26. The findings, recommendations and actions of the medical professional review panel or peer review committee of a health plan should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician’s act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it should address what specific remediation, if any, is recommended for the physician
(whenever feasible, in terms that permit measurement and validation of remediation, when completed).

27. A process should be available to appeal any disciplinary finding of a health plan following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An appeals process before a disinterested third party, not connected to the health plan, should be made available to the subject physician within statutory medical professional/peer review protections. If the original action was part of a peer-review protected process, the appeal should be part of the peer-review protected process as well.

28. In all instances of medical professional review activities conducted within health insurance companies, the applicable processes and procedures should be clearly stated, with specific detail, in health plan provider manuals or written policies, of uniform application, made available in advance to the subject physician. Such processes and procedures should contain the particular due process, hearing and appeals rights available to the subject physician, and, to the extent that medical professional review or peer review privilege, confidentiality and immunity legal protections are available to such medical professional review activities, such processes and procedures should conform to the requirements of federal and state law. In conformity with Principle No. 12, to avoid or at least mitigate conflicts of interest, or the perception thereof, the medical professional review panels or peer review committees of health insurance companies should include as members with full participation and voting rights physicians who are not employees or contractors (other than contracting as a participating provider) of the health insurer.

29. The Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on the basis of cost containment. (MMS Council, 5/17/91; Reaffirmed, House of Delegates, May 7, 1999)

30. These Model Principles for Medical Professional Review of Physicians within Health Insurance Companies are intended to apply to all medical professional review activities conducted by health insurance companies of their credentialed, participating provider or contracted physicians, however designated: e.g., professional review, peer review, credentialing appeals, corrective actions or otherwise. (HP) (MMS House of Delegates, 5/08/09)

The Massachusetts Medical Society amends its existing Model Principles for Incident-Based Peer Review for Health Care Facilities to include an independent appeal and review process for disputed peer review outcomes by a hospital and to update the principles to account for changes in regulations and standards developed since the principles were created in 2003 as to read as follows:
Massachusetts Medical Society Policy

Model Principles for Medical Peer Review of Physicians for Health Care Facilities

The following recommendations are made based on the above considerations in order to enhance:

• Quality improvement
• Credibility in the process of medical peer review of physicians for health care facilities
• Fairness and due process
• Patient access — by not inappropriately removing or sanctioning physicians
• System approaches to patient safety and quality of care

That the Massachusetts Medical Society Model Principles for Medical Peer Review of Physicians for Health Care Facilities are as follows:

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event in a health care facility must not only include pre-event factors, but also the contributory effects of the health care system.
3. All the relevant information should be obtained promptly from the subject physician. In addition, relevant information from other sources should be obtained and made available to the subject physician to the fullest extent legally permissible followed by early discussion with the subject physician to evaluate the “incident” and explore alternate course of action.
4. The process must be mindful and attuned to prevention and recommend appropriate individual and system changes for remediation.
5. Triggers that initiate a medical peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied, with objective and evidence-based pre-screening, to all cases and physicians.
6. Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process.
7. At a minimum, the standards set by Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity must be followed if a disciplinary process is engaged during professional review. These standards are the most elementary safeguards of due process in a health care facility.

Section 1112 Standards for professional review actions
“a. In general...professional review action must be taken—
(1) in the reasonable belief that the action was in the furtherance of quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts
known after such reasonable effort to obtain facts and after meeting the
requirement of paragraph (3).”

“Adequate notice and hearing–A health care entity is deemed to have met
the adequate notice and hearing requirement of subsection (a)(3) of this
section with respect to a physician if the following conditions are met (or
are waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating –

(A) (i) that a professional review action has been proposed to be taken
against a physician
(ii) reasons for the proposed action

(B) (i) that the physician has the right to request a hearing on the
proposed action
(ii) any time limit (of not less than 30 days) within which to request
such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing–If a hearing is requested on a timely basis under
paragraph (1) (B), the physician involved must be given notice stating –
(A) the place, time and date of the hearing, which date shall not be less
than 30 days after the date of the notice, and
(B) a list of the witnesses (if any) expected to testify at the hearing on
behalf of the professional review body.

(3) Conduct of hearing and notice–If a hearing is requested on a timely
basis under paragraph (1) (B) –

(A) subject to subparagraph (B), the hearing shall be held (as
determined by the health care entity) –
(i) before an arbitrator mutually acceptable to the physician and the
health care entity,
(ii) before a hearing officer who is appointed by the entity and who is
not in direct economic competition with the physician involved, or
(iii) before a panel of individuals who are appointed by the entity and
are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails,
without good cause, to appear;

(C) in the hearing the physician involved has the right –
(i) to representation by an attorney or other person of the
physician’s choice,
(ii) to have a record made of the proceedings, copies of which may
be obtained by the physician upon payment of any reasonable
charges associated with the preparation thereof,
(iii) to call, examine, and cross-examine witnesses,
(iv) to present evidence determined to be relevant by the hearing
officer, regardless of its admissibility in a court of law, and
(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right
(i) to receive the written recommendation of the arbitrator, officer, or
panel, including a statement of the basis for the recommendations,
(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.”

In addition, the notice of hearing should contain a summary of the allegations and the episodes of care under evaluation.

8. Summary suspension or restriction of clinical privileges may only be used to prevent “imminent danger to the health of any individual.” Such summary actions must be followed by adequate notice and hearing procedures prior to becoming final.

9. All parties involved in the peer review process must preserve the confidentiality of all records, information and proceedings. However, all of the facts obtained for and in the peer review process shall be available to the subject physician to the fullest extent legally permissible.

10. A peer review committee, engaged in a formal peer review or disciplinary proceeding, may not include direct economic competitors of the subject physician or those for whom there may be bias or lack of objectivity vis-à-vis the subject physician and should include a fair representation of specialists/subspecialists from the subject physician’s specialty/subspecialty whenever feasible. Participants on a peer review committee should disclose relevant conflicts of interest and, when appropriate, recuse themselves from the peer review or disciplinary proceeding. Additionally, the subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to commencement of the proceedings. Such challenge would be a part of the procedures specified in the health care facility bylaws, outside of peer review protections and not part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

11. Physicians should rotate service on the peer review committee (round robin).

12. Membership on the peer review committee must be open to all physicians on the medical staff and not be restricted to one or more groups such as those practicing exclusively at a given institution, salaried physicians only or faculty physicians only.

13. Only physicians should be voting members of committees conducting medical peer review of physicians.

14. Whenever a peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the institution while excluding direct economic competitors or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution authorized to conduct peer review of physicians should be appointed in accordance with the medical staff bylaws and medical peer review protection statutes.

15. Physicians serving on the peer review committee should receive information and where available, training, in the elements and essentials of medical peer review.
16. The hospital or the organization on whose behalf the peer review is done must ensure that the physicians serving on any peer review committee are provided with appropriate indemnification and insurance for peer review acts taken in good faith. The organization must also provide assistance to the committee in abiding by the requirements of HCQIA to be eligible for federal immunity.

17. The peer review committee of a health care facility should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination. When the matter before the peer review committee involves professional conduct such as an allegation of disruptive behavior, the peer review committee should be guided by applicable professional ethical principles (e.g., the MMS Code of Ethics, the AMA Principles of Medical Ethics, relevant specialty society ethical codes). Those guidelines, standards and practices must be made available in a timely manner to the subject physician before any hearing on the matter.

18. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.

19. Wherever feasible, structured assessment instruments and multiple reviewers should be used to increase reliability.

20. Where feasible, statistical analysis to compare with peers’ performance must be used with appropriate case mix adjustment.

21. Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.

22. All the pertinent information obtained by the peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.

23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.

24. Any conclusion reached or action recommended or taken should be based upon the information presented to the peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a “reasonably prudent person” standard.

25. If the conclusion reached is that improvement is necessary, any action recommended by a health care facility should include, as an important focus, steps for remediation, as needed, for the subject physician and for the system.

26. The findings, recommendations and actions of the peer review committee of a health care facility should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician’s act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it must address what specific remediation, if any, is recommended for the physician and
what, if any, for the system (whenever feasible, in terms that permit measurement and validation of remediation, when completed).

27. A process should be available to appeal any disciplinary finding of a health care facility following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An appeals process before a disinterested third party, not connected to the medical staff or the hospital, should be made available to the subject physician within statutory peer review protections. If the original action was part of a peer-review protected process, the appeal should be part of the peer-review protected process as well.

(MMS House of Delegates, November 8, 2003; Amended, 5/14/10)

28. The Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on the basis of cost containment. (MMS Council, 5/17/91; reaffirmed House of Delegates, May 7, 1999)

MMS House of Delegates, 11/08/03
*Health Care Facilities Principles Amended and Reaffirmed, MMS House of Delegates, 5/08/09
Amended and Reaffirmed, MMS House of Delegates, 5/14/10
(Item 2 of Original: Sunset)

(HP)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 9
Code: CQMP Report A-18 C-9 [A-17 C-2]
Title: Physician Call Policy
(Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsor: Committee on the Quality of Medical Practice
Barbara Spivak, MD, Chair

Report History: OFFICERS Report A-17 C-2
Original Sponsor: MMS Presidential Officers
(and Reviewing Committees)
Referred to: Reference Committee C
Mangadhara Rao Madineedi, MD, Chair

Background
At A-17, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on the Quality of Medical Practice (CQMP). (The CQMP also consulted the Committee on Legislation.) The policy for review states:

PHYSICIANS
Physician Call
1. The Massachusetts Medical Society adopts the following principles:

MMS On-Call Principles:
The MMS On-Call Principles apply to all physicians. These principles are separate and distinct from the formal regulations governing resident work hours that must be followed by hospitals for residency program accreditation by the Accreditation Council for Graduate Medical Education (ACGME).

1. The MMS opposes government regulation of physician work hours.
2. The MMS opposes uniform limits or any other consecutive time constraints, as these can compromise patient care and limit flexibility of scheduling within individual physician practices. Furthermore, the broad diversity of specialty practices indicates that a uniform or standardized approach to regulation of physician work hours would not be appropriate.
3. Physicians have an ethical duty to their patients and profession to provide safe, compassionate, quality medical care. These duties depend on a safe and healthy working environment for all physicians. To this end, clinical responsibilities must be organized in such a way as to prevent excessive patient care responsibilities, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation.
4. The individual physician can most appropriately determine whether the clinical schedule allows the physician to meet her/his ethical obligations to the patient.

5. There should be adequate backup if sudden, unexpected patient care needs create fatigue sufficient to jeopardize patient care during or following the on-call period. Institutions and other practice organizations should ensure that such backup is available if required. No institution or call system should require a physician to provide clinical care when the physician believes that she/he will not be able to meet her/his ethical obligations to the patient.

6. Health care delivery systems must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment.

7. As there are different duties defined by each specialty, guidelines for work-hour responsibilities should be made in consultation with each physician, given that responsibilities vary by setting, region, and specialty. In addition, what constitutes excessive fatigue and sleep deprivation will vary by physician.

8. Each specialty department should determine who among its members are required to serve on-call for the emergency department, subject to appropriate compensation to be determined at the local level. In making the determination for who is required to serve on-call, the specialty department may exempt from call service members above a certain age, or with a certain number of years service to the medical staff, or those serving in medical staff leadership positions. Other individual exemptions, for hardship, temporary disability, or other reasons may be granted by the chair on a case-by-case basis.

9. Physicians and hospitals should work collaboratively to develop solutions to on-call needs for emergency departments; adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage; the organization and function of on-call services should be determined through hospital policy and medical staff by-laws; and include methods for monitoring and assuring appropriate on-call performance.

10. It is in the best interests of patients when physicians practice in a fair, equitable, safe, healthy, and supportive environment.

(HP)

2. The MMS will explore working with the Massachusetts Hospital Association (MHA) to develop systems for on-call coverage. (D)

3. The MMS will explore other solutions to on-call coverage, including the development of a "surgicalist" or "acute care surgery" specialty, locum tenens, and assistance from larger medical centers for smaller hospitals. (D)

4. The MMS will advocate for malpractice reform to specifically address increased liability associated with emergency call coverage. (D)
Reference Committee Testimony
The reference committee heard only support for the complete sunset report and, therefore, recommended to reaffirm this policy for one year.

Relevance to MMS Strategic Priorities
An MMS strategic priority is to advocate to improve the physician practice environment and work toward improved patient care and outcomes.

Discussion
After reviewing work done since A-11, the Committee on Quality Medical Practice recommends reaffirming the on-call principles and removing directives 2 and 3. Prior reports have demonstrated that sufficient work has been done to complete these directives. Informational Report A-11–27 details the Society’s current activities on directives 2 and 3. The MMS had previously talked with the MHA regarding a system of on-call coverage. Additionally, the A-11 informational report explored the benefits and challenges of different solutions to on-call coverage, including a surgicalist specialty, locum tenens, and assistance from larger medical centers for smaller hospitals. These prior reports confirm that the MMS has sufficiently explored this issue.

During discussion at the January 29, 2018, CQMP meeting, a point was made to distinguish between “on-call,” “working,” and “awake.” For instance, being “on-call” does not mean the physician is necessarily awake or actually working (directly caring for patients). The CQMP recognizes that delivering care to patients (working) for extended hours of time can be detrimental to the effectiveness of the provider and the safety of the patient. Nevertheless, work hour restrictions alone will be ineffective if, when working nights, for example, providers do not also limit daytime activities to obtain adequate rest. Therefore, the individual provider is ethically obligated to restrict or extend his own work hours as he sees fit.

Conclusion/Proposed Amendments
The CQMP recommends amending and reaffirming the policy to read as follows (added text shown as “text” and deleted text shown as “text”):

1. The Massachusetts Medical Society adopts the following principles:

MMS On-Call Principles:
The MMS On-Call Principles apply to all physicians. These principles are separate and distinct from the formal regulations governing resident work hours that must be followed by hospitals for residency program accreditation by the Accreditation Council for Graduate Medical Education (ACGME). The term on-call includes hours providing patient care as well as administrative duties and hours awaiting call.

1. The MMS opposes government regulation of physician work hours.
2. The MMS opposes uniform limits or any other consecutive time constraints, as these can compromise patient care and limit flexibility of scheduling within individual physician practices. Furthermore, the broad diversity of specialty practices indicates that a uniform or standardized approach to regulation of physician work hours would not be appropriate.
3. Physicians have an ethical duty to their patients and profession to provide safe, compassionate, quality medical care. These duties depend on a safe and healthy working environment for all physicians. To this end, clinical responsibilities must be organized in such a way as to prevent excessive patient care responsibilities, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation.

4. The individual physician can most appropriately determine whether the clinical schedule allows the physician to meet her/his ethical obligations to the patient.

5. There should be adequate backup if sudden, unexpected patient care needs create fatigue sufficient to jeopardize patient care during or following the on-call period. Institutions and other practice organizations should ensure that such backup is available if required. No institution or call system should require a physician to provide clinical care when the physician believes that she/he will not be able to meet her/his ethical obligations to the patient.

6. Health care delivery systems must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment.

7. As there are different duties defined by each specialty, guidelines for work-hour responsibilities should be made in consultation with each physician, given that responsibilities vary by setting, region, and specialty. In addition, what constitutes excessive fatigue and sleep deprivation will vary by physician.

8. Each specialty department should determine who among its members are required to serve on-call for the emergency department, subject to appropriate compensation to be determined at the local level. In making the determination for who is required to serve on-call, the specialty department may exempt from call service members above a certain age, or with a certain number of years service to the medical staff, or those serving in medical staff leadership positions. Other individual exemptions, for hardship, temporary disability, or other reasons may be granted by the chair on a case-by-case basis.

9. Physicians and hospitals should work collaboratively to develop solutions to on-call needs for emergency departments; adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage; the organization and function of on-call services should be determined through hospital policy and medical staff by-laws; and include methods for monitoring and assuring appropriate on-call performance.

10. It is in the best interests of patients when physicians practice in a fair, equitable, safe, healthy, and supportive environment.

(HP)

2. The MMS will explore working with the Massachusetts Hospital Association (MHA) to develop systems for on-call coverage. (D)
3. The MMS will explore other solutions to on-call coverage, including the development of a “surgicalist” or “acute care surgery” specialty, locum tenens, and assistance from larger medical centers for smaller hospitals. (D)

4. The MMS will advocate for malpractice reform to specifically address increased liability associated with emergency call coverage. (D)

MMS House of Delegates, 5/14/10

Recommendation:
That the Massachusetts Medical Society adopt as amended the physician call policy adopted at A-10 to reads as follows:

1. The Massachusetts Medical Society adopts the following principles:

   **MMS On-Call Principles:**
   The MMS On-Call Principles apply to all physicians. These principles are separate and distinct from the formal regulations governing resident work hours that must be followed by hospitals for residency program accreditation by the Accreditation Council for Graduate Medical Education (ACGME). The term on-call includes hours providing patient care as well as administrative duties and hours awaiting call.

1. The MMS opposes government regulation of physician work hours.
2. The MMS opposes uniform limits or any other consecutive time constraints, as these can compromise patient care and limit flexibility of scheduling within individual physician practices. Furthermore, the broad diversity of specialty practices indicates that a uniform or standardized approach to regulation of physician work hours would not be appropriate.
3. Physicians have an ethical duty to their patients and profession to provide safe, compassionate, quality medical care. These duties depend on a safe and healthy working environment for all physicians. To this end, clinical responsibilities must be organized in such a way as to prevent excessive patient care responsibilities, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation.
4. The individual physician can most appropriately determine whether the clinical schedule allows the physician to meet her/his ethical obligations to the patient.
5. There should be adequate backup if sudden, unexpected patient care needs create fatigue sufficient to jeopardize patient care during or following the on-call period. Institutions and other practice organizations should ensure that such backup is available if required. No institution or call system should require a physician to provide clinical care when the physician believes that she/he will not be able to meet her/his ethical obligations to the patient.
6. Health care delivery systems must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment.
7. As there are different duties defined by each specialty, guidelines for work-hour responsibilities should be made in consultation with each physician, given that responsibilities vary by setting, region, and specialty. In addition, what constitutes excessive fatigue and sleep deprivation will vary by physician.

8. Each specialty department should determine who among its members are required to serve on-call for the emergency department, subject to appropriate compensation to be determined at the local level. In making the determination for who is required to serve on-call, the specialty department may exempt from call service members above a certain age, or with a certain number of years service to the medical staff, or those serving in medical staff leadership positions. Other individual exemptions, for hardship, temporary disability, or other reasons may be granted by the chair on a case-by-case basis.

9. Physicians and hospitals should work collaboratively to develop solutions to on-call needs for emergency departments; adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage; the organization and function of on-call services should be determined through hospital policy and medical staff by-laws; and include methods for monitoring and assuring appropriate on-call performance.

10. It is in the best interests of patients when physicians practice in a fair, equitable, safe, healthy, and supportive environment.

(HP)

4. The MMS will advocate for malpractice reform to specifically address increased liability associated with emergency call coverage. (D)

MMS House of Delegates, 5/14/10

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 10
Code: CQMP Report A-18 C-10 [A-17 C-2]
Title: Third-Party Insurers Policy
(Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsors: The Committee on the Quality of Medical Practice
Barbara Spivak, MD, Chair
Committee on Legislation
Theodore Calianos, MD, Chair

Report History: OFFICERS Report A-17 C2
Original Sponsor: MMS Presidential Officers
(and Reviewing Committees)
Referred to: Reference Committee C
Mangadhara Rao Madineedi, MD, Chair

Background
At A-17, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on the Quality of Medical Practice and the Committee on Legislation. The policy for review states:

PHYSICIAN PAYMENT
Third Party Insurers
The Massachusetts Medical Society (MMS) will continue to communicate to the health plans that a uniform minimum time allowance for the submission and resubmission of nonfederal claims would enhance physicians’ ability to meet administrative requirements. (D)

The MMS will advocate for a uniform minimum time allowance for nonfederal claims of at least 90 days for:
(a) the initial submission of claims;
(b) the resubmission or initial submission of claims to another health plan, in which 90 days would be calculated from the date of the first insurer’s remittance advice;
(c) the submission of additional information, in which 90 days would be calculated from the date the physician receives a communication from the health plan requesting additional information; and
(d) the submission of a claim to a new insurer after retroactive notification of loss of eligibility due to insurer change. (D)

The MMS will monitor health plans’ adherence to their filing-limit policies and communicate noncompliance to the appropriate parties. (D)

The MMS will continue to utilize administrative and legislative activities to promote the establishment of equitable physician recoupment policies at health plans. (D)
Reference Committee Testimony
The reference committee heard only support for the entire sunset report and therefore, recommended to reaffirm this policy for one year.

Relevance to MMS Strategic Priorities
An MMS strategic priority is physician and patient advocacy: advocate to improve the physician practice environment and work toward improved patient care and outcomes.

Discussion
The CQMP met on January 29, 2018, and reaffirmed the MMS policy and also amended it. The amendment supports the need to allow time for claims to be submitted given unforeseen circumstances.

The Committee on Legislation noted that through its legislative and regulatory advocacy, the MMS will continue to promote the establishment of equitable physician recoupment policies at health plans.

Conclusion/Proposed Amendments
The CQMP and COL recommend that the policy be amended as follows and reaffirmed (added text shown as "text"): The Massachusetts Medical Society (MMS) will continue to communicate to the health plans that a uniform minimum time allowance for the submission and resubmission of nonfederal claims would enhance physicians' ability to meet administrative requirements. (D)

The MMS will advocate for a uniform minimum time allowance for nonfederal claims of at least 90 days for:
(a) the initial submission of claims;
(b) the resubmission or initial submission of claims to another health plan, in which 90 days would be calculated from the date of the first insurer's remittance advice;
(c) the submission of additional information, in which 90 days would be calculated from the date the physician receives a communication from the health plan requesting additional information; and
(d) the submission of a claim to a new insurer after retroactive notification of loss of eligibility due to insurer change; and (D)
(e) the submission of claim that was hindered by unforeseen circumstances. (D)

The MMS will monitor health plans’ adherence to their filing-limit policies and communicate noncompliance to the appropriate parties. (D)

The MMS will continue to utilize administrative and legislative activities to promote the establishment of equitable physician recoupment policies at health plans. (D)
Recommendation:
That the Massachusetts Medical Society adopt as amended the third-party insurers policy reaffirmed at A-10 to reads as follows:

The Massachusetts Medical Society (MMS) will continue to communicate to the health plans that a uniform minimum time allowance for the submission and resubmission of nonfederal claims would enhance physicians’ ability to meet administrative requirements. (D)

The MMS will advocate for a uniform minimum time allowance for nonfederal claims of at least 90 days for:
   (a) the initial submission of claims;
   (b) the resubmission or initial submission of claims to another health plan, in which 90 days would be calculated from the date of the first insurer’s remittance advice;
   (c) the submission of additional information, in which 90 days would be calculated from the date the physician receives a communication from the health plan requesting additional information;
   (d) the submission of a claim to a new insurer after retroactive notification of loss of eligibility due to insurer change; and
   (e) the submission of claim that was hindered by unforeseen circumstances. (D)

The MMS will monitor health plans’ adherence to their filing-limit policies and communicate noncompliance to the appropriate parties. (D)

The MMS will continue to utilize administrative and legislative activities to promote the establishment of equitable physician recoupment policies at health plans. (D)

MMS House of Delegates, 11/9/02
Amended MMS House of Delegates, 11/8/03
Reaffirmed and Item 1 Amended and Reaffirmed MMS House of Delegates, 5/14/10

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Item #: 11  
Code: CQMP Report A-18 C-11 [A-17 C-3]  
Title: Patient Safety Policy  
(Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)  
Sponsor: The Committee on the Quality of Medical Practice  
Barbara Spivak, MD, Chair  

Report History: OFFICERS Report A-17 C-3  
Original Sponsors: MMS Presidential Officers  
(and Reviewing Committees)  

Referred to: Reference Committee C  
Mangadhara Rao Madineedi, MD, Chair  

Background  
At A-17, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on the Quality of Medical Practice. The policy for review states:  

QUALITY OF CARE  
8c. Patient Safety  
The Massachusetts Medical Society accepts the Institute of Medicine’s (IOM) recommendations on Identifying Priority Areas for Quality Improvement, IOM Report *Priority Areas for National Action, Transforming Health Care Quality* (2003):  

1. That the priority areas collectively:  
   • Represent the U.S. population’s health care needs across the lifespan, in multiple health care settings involving many types of health care professionals.  
   • Extend across the full spectrum of health care, from keeping people well and maximizing overall health; to providing treatment to cure people of disease and health problems as often as possible; to assisting people who become chronically ill to live longer, more productive, and comfortable lives; to providing dignified care at the end of life that is respectful of the values and preferences of individuals and their families.  

2. Use of the following criteria for identifying priority areas:  
   • Impact – the extent of the burden – disability, mortality, and economic costs – imposed by a condition, including effects on patients, families, communities, and societies.  
   • Improvability – the extent of the gap between current practice and evidence-based best practice and the likelihood that the gap can be closed through change in an area; and the opportunity to achieve dramatic improvements in the six national quality aims identified in the Quality Chasm report (safety, effectiveness, patient-centeredness, timeliness, efficiency and equity).
Inclusiveness – the relevance of an area to a broad range of individuals with regard to age, gender, socioeconomic status, and ethnicity/race (equity); the generalizability of associated quality improvement strategies to many types of conditions and illnesses across the spectrum of health care (representativeness); and the breadth of change effected through such strategies across a range of health care settings and providers (reach).

3. That DHHS, along with other public and private entities, focus on the following areas for transforming health care:

- Care coordination (cross-cutting)
- Self-management/health literacy (cross-cutting)
- Asthma – appropriate treatment for persons with mild/moderate persistent asthma
- Cancer screening that is evidence-based – focus on colorectal and cervical cancer
- Children with special health care needs
- Diabetes – focus on appropriate management of early disease
- End of life with advanced organ system failure – focus on congestive heart failure and chronic obstructive pulmonary disease
- Frailty associated with old age – preventing falls and pressure ulcers, maximizing functions, and developing advanced care plans
- Hypertension – focus on appropriate management of early disease
- Immunization – children and adults
- Ischemic heart disease – prevention, reduction of recurring events, and optimization of functional capacity
- Major depression – screening and treatment
- Medication management – preventing medication errors and overuse of antibiotics
- Nosocomial infections – prevention and surveillance
- Pain control in advanced cancer
- Pregnancy and childbirth – appropriate prenatal and intrapartum care
- Severe and persistent mental illness – focus on treatment in the public sector
- Stroke – early intervention and rehabilitation
- Tobacco dependence treatment in adults
- Obesity (emerging area)

4. That the Agency for Healthcare Research and Quality (AHRQ), in collaboration with other private and public organizations, be responsible for continuous assessment of progress and updating of the list of priority areas. These responsibilities should include:

- Developing and improving data collection and measurement systems for assessing the effectiveness of quality improvement efforts.
- Supporting the development and dissemination of valid, standardized measures of quality.
- Measuring key attributes and outcomes and making this information available to the public.
- Revising the selection criteria and the list of priority areas.
- Reviewing the evidence base and results, and deciding on updated priorities every 3 to 5 years.
• Assessing changes in the attributes of society that affect health and health care and could alter the priority of various areas.

• Disseminating the results of strategies for quality improvement in the priority areas.

5. That data collection in the priority areas:
   • Go beyond the usual reliance on disease – and procedure-based information – to include data on the health and functioning of the U.S. population.
   • Cover relevant demographic and regional groups, as well as the population as a whole, with particular emphasis on identifying disparities in care.
   • Be consistent within and across categories to ensure accurate assessment and comparison of quality enhancement efforts.

6. That the Congress and the Administration provide the necessary support for ongoing process of monitoring progress in the priority areas and updating the list of areas. This support should encompass:
   • The administrative costs borne by the AHRQ.
   • The costs of developing and implementing data collection mechanisms and improving the capacity to measure results.
   • The costs of investing strategically in research aimed at developing new evidence on interventions that improve the quality of care and at creating additional, accurate, valid, and reliable measures of quality.
   Such research is especially critical in areas of high importance in which either the scientific evidence for effective interventions is lacking or current measures of quality are inadequate.

(MMS House of Delegates, 5/2/03)
Reaffirmed MMS House of Delegates, 5/14/10

Reference Committee Testimony
At A-17, the Reference Committee agreed that this policy be reaffirmed for one year.

Relevance to MMS Strategic Priorities
Sustainable health care delivery is an MMS strategic priority.

Discussion
Since the IOM’s seminal report in 2003, no updates have been issued except an IOM’s Committee on Quality of Health Care in America evaluation on the existing knowledge about diagnostic error as a quality of care challenge. The IOM examined definitions of diagnostic error and illustrative examples; the epidemiology, burden of harm, and costs associated with diagnostic error; and efforts to improve diagnosis. This report was a continuation of the IOM’s Quality Chasm Series.

The IOM developed recommendations to reduce diagnostic error in health care. Action items for key stakeholders focused on education, the culture of health care, information technology, systems engineering, measurement approaches, changes in payment, and further research.

The Committee on the Quality of Medical Practice has decided to reaffirm this policy and during the 2018–19 fiscal year will review the report on diagnostic error issued in 2015 by the IOM’s Committee on Quality Health Care in America and make appropriate recommendations.
Conclusion

CQMP recommends that this policy be reaffirmed for seven years.

Recommendation:
That the Massachusetts Medical Society reaffirm the patient safety policy reaffirmed at A-10 and which reads as follows:

QUALITY OF CARE
Patient Safety

The Massachusetts Medical Society accepts the Institute of Medicine’s (IOM) recommendations on Identifying Priority Areas for Quality Improvement, IOM Report *Priority Areas for National Action, Transforming Health Care Quality* (2003):

1. That the priority areas collectively:
   - Represent the U.S. population’s health care needs across the lifespan, in multiple health care settings involving many types of health care professionals.
   - Extend across the full spectrum of health care, from keeping people well and maximizing overall health; to providing treatment to cure people of disease and health problems as often as possible; to assisting people who become chronically ill to live longer, more productive, and comfortable lives; to providing dignified care at the end of life that is respectful of the values and preferences of individuals and their families.

2. Use of the following criteria for identifying priority areas:
   - Impact – the extent of the burden – disability, mortality, and economic costs – imposed by a condition, including effects on patients, families, communities, and societies.
   - Improvability – the extent of the gap between current practice and evidence-based best practice and the likelihood that the gap can be closed through change in an area; and the opportunity to achieve dramatic improvements in the six national quality aims identified in the Quality Chasm report (safety, effectiveness, patient-centeredness, timeliness, efficiency and equity).
   - Inclusiveness – the relevance of an area to a broad range of individuals with regard to age, gender, socioeconomic status, and ethnicity/race (equity); the generalizability of associated quality improvement strategies to many types of conditions and illnesses across the spectrum of health care (representativeness); and the breadth of change effected through such strategies across a range of health care settings and providers (reach).

3. That DHHS, along with other public and private entities, focus on the following areas for transforming health care:
   - Care coordination (cross-cutting)
   - Self-management/health literacy (cross-cutting)
   - Asthma – appropriate treatment for persons with mild/moderate persistent asthma
• Cancer screening that is evidence-based – focus on colorectal and cervical cancer
• Children with special health care needs
• Diabetes – focus on appropriate management of early disease
• End of life with advanced organ system failure – focus on congestive heart failure and chronic obstructive pulmonary disease
• Frailty associated with old age – preventing falls and pressure ulcers, maximizing functions, and developing advanced care plans
• Hypertension – focus on appropriate management of early disease
• Immunization – children and adults
• Ischemic heart disease – prevention, reduction of recurring events, and optimization of functional capacity
• Major depression – screening and treatment
• Medication management – preventing medication errors and overuse of antibiotics
• Nosocomial infections – prevention and surveillance
• Pain control in advanced cancer
• Pregnancy and childbirth – appropriate prenatal and intrapartum care
• Severe and persistent mental illness – focus on treatment in the public sector
• Stroke – early intervention and rehabilitation
• Tobacco dependence treatment in adults
• Obesity (emerging area)

4. That the Agency for Healthcare Research and Quality (AHRQ), in collaboration with other private and public organizations, be responsible for continuous assessment of progress and updating of the list of priority areas. These responsibilities should include:
   • Developing and improving data collection and measurement systems for assessing the effectiveness of quality improvement efforts.
   • Supporting the development and dissemination of valid, standardized measures of quality.
   • Measuring key attributes and outcomes and making this information available to the public.
   • Revising the selection criteria and the list of priority areas.
   • Reviewing the evidence base and results, and deciding on updated priorities every 3 to 5 years.
   • Assessing changes in the attributes of society that affect health and health care and could alter the priority of various areas.
   • Disseminating the results of strategies for quality improvement in the priority areas.

5. That data collection in the priority areas:
   • Go beyond the usual reliance on disease – and procedure-based information – to include data on the health and functioning of the U.S. population.
• Cover relevant demographic and regional groups, as well as the population as a whole, with particular emphasis on identifying disparities in care.

• Be consistent within and across categories to ensure accurate assessment and comparison of quality enhancement efforts.

6. That the Congress and the Administration provide the necessary support for ongoing process of monitoring progress in the priority areas and updating the list of areas. This support should encompass:

• The administrative costs borne by the AHRQ.

• The costs of developing and implementing data collection mechanisms and improving the capacity to measure results.

• The costs of investing strategically in research aimed at developing new evidence on interventions that improve the quality of care and at creating additional, accurate, valid, and reliable measures of quality.

Such research is especially critical in areas of high importance in which either the scientific evidence for effective interventions is lacking or current measures of quality are inadequate.

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

(HP)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 12
Code: BOT Report A-18 C-12
Title: Delegates-at-Large
Sponsor: Board of Trustees
Henry Dorkin, MD, FAAP, Chair

Referred to: Reference Committee C
Mangadhara Rao Madineedi, MD, Chair

Background

The Massachusetts Medical Society (MMS) Bylaws, Chapter 6.00, Section 6.02, (9), provides that delegates-at-large, as recommended by the Board of Trustees (BOT), may be elected by the House of Delegates. Item number 9 further provides that delegates-at-large must be members of the MMS, must be elected individually, and will have the right to vote.

Historically, the MMS has provided delegate-at-large status to the deans of the Commonwealth of Massachusetts’ medical and public health schools. At its January 17, 2018, meeting, the BOT voted to make the following recommendation for election to delegate-at-large status for consideration by the House.

Recommendation:

That the following individuals be recommended to the House of Delegates at Annual 2018 as Delegates-at-Large:

Karen H. Antman, MD, Provost, Medical Campus and Dean, Boston University School of Medicine;

Sandro Galea, MD, MPH, DrPH, Dean, Boston University School of Public Health;

George Q. Daley, MD, PhD, Dean, Harvard Medical School;

Harris A. Berman, MD, Dean, Tufts University School of Medicine; and

Terence R. Flotte, MD, Dean, School of Medicine and Provost and Executive Deputy Chancellor, University of Massachusetts Medical School.

(D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)
FTE: Existing Staff
(Staff Effort to Complete Project)
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 13  
Code: COF Report A-18 C-13  
Title: Membership Dues for Calendar Year 2019  
Sponsor: Committee on Finance  
Lee Perrin, MD, Chair

Referred to: Reference Committee C  
Mangadhara Rao Madineedi, MD, Chair

Background  
The Committee on Finance met on February 15, 2018, and in conjunction with the Committee on Membership, presents the following schedule of membership dues for calendar year 2019.

Recommendation:  
That the House of Delegates approve the proposed membership dues for calendar year 2019, with no changes from 2018.

Physicians:

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introductory</td>
<td>$100</td>
</tr>
<tr>
<td>Family (two phys. in same household)</td>
<td>$225</td>
</tr>
<tr>
<td>Regular (second year and beyond)</td>
<td>$300</td>
</tr>
<tr>
<td>Military: Current member price of NEJM*</td>
<td></td>
</tr>
<tr>
<td>Out-of-state</td>
<td>$150</td>
</tr>
<tr>
<td>Life Membership</td>
<td>Calculated based on age</td>
</tr>
<tr>
<td>Senior/Emeritus</td>
<td>Free</td>
</tr>
</tbody>
</table>

Residents:

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
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<td>One-year resident membership</td>
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</tr>
<tr>
<td>Three-year resident membership</td>
<td>$90</td>
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<tr>
<td>Residency/Fellowship Programs</td>
<td>Free</td>
</tr>
<tr>
<td>Out-of-state resident membership</td>
<td>$40</td>
</tr>
</tbody>
</table>

Medical Students:  
Free

Multi-year Membership:

<table>
<thead>
<tr>
<th>Duration</th>
<th>Discount</th>
</tr>
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<tbody>
<tr>
<td>Pre-paid enrollment for 2 years</td>
<td>5% discount</td>
</tr>
<tr>
<td>Pre-paid enrollment for 3 years</td>
<td>10% discount</td>
</tr>
<tr>
<td>Pre-paid enrollment for 5 years</td>
<td>20% discount</td>
</tr>
<tr>
<td>Pre-paid enrollment for 10 years</td>
<td>30% discount</td>
</tr>
</tbody>
</table>

Group Enrollment:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Discount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groups with 75% to 79% participation</td>
<td>5% discount</td>
</tr>
<tr>
<td>Groups with 80% to 89% participation</td>
<td>10% discount</td>
</tr>
<tr>
<td>Groups with 90% to 99% participation</td>
<td>20% discount</td>
</tr>
</tbody>
</table>
Groups with 100% participation

30% discount

Additional rates may apply for large group enrollment using Board of Trustee approved guidelines.

Residency/Fellowship Programs: Free

(D)

Fiscal Note: No Significant Impact

(Out of Pocket Expenses)

FTE: Existing Staff

(Staff Effort to Complete Project)
(No fiscal notes in reference committee A)

FISCAL NOTE COMPONENTS — REFERENCE COMMITTEE B

<table>
<thead>
<tr>
<th>Item #:</th>
<th>3</th>
</tr>
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<tbody>
<tr>
<td>Code:</td>
<td>Report I-17 B-1</td>
</tr>
<tr>
<td>Title:</td>
<td>Patient-Reported Outcome Measures: Current State and Proposed MMS Principles</td>
</tr>
<tr>
<td>Sponsor:</td>
<td>Committee on the Quality of Medical Practice Barbara Spivak, MD, Chair</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Research and Webinar</th>
<th>Cost</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$5,000</td>
<td>One-Time Expense</td>
</tr>
<tr>
<td>Total</td>
<td>$5,000</td>
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<table>
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<tr>
<th>Item #:</th>
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<tbody>
<tr>
<td>Code:</td>
<td>Report A-18 B-2</td>
</tr>
<tr>
<td>Title:</td>
<td>Current State of OpenNotes Medical Records</td>
</tr>
<tr>
<td>Sponsor:</td>
<td>Committee on the Quality of Medical Practice Barbara Spivak, MD, Chair</td>
</tr>
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<table>
<thead>
<tr>
<th>Research and Webinar</th>
<th>Cost</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$5,000</td>
<td>One-Time Expense</td>
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<tr>
<td>Total</td>
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<table>
<thead>
<tr>
<th>Item #:</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>Code:</td>
<td>OMSS Report A-18 B-3</td>
</tr>
<tr>
<td>Title:</td>
<td>Impact of the High Capital Cost of Hospital EMRs on the Medical Staff</td>
</tr>
<tr>
<td>Sponsor:</td>
<td>Organized Medical Staff Section Frank Carbone, Jr, MD, Chair</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consultant for Study (to monitor fiscal impact of EHR implementation in Mass. health care system.)</th>
<th>Cost</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$20,000</td>
<td>One-Time Expense</td>
</tr>
<tr>
<td>Total</td>
<td>$20,000</td>
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</table>
### Item #: 11
**Code:** OMSS Report A-18 B-5  
**Title:** Hospital Disaster Plans and Medical Staffs  
**Sponsor:** Organized Medical Staff Section  
*Frank Carbone Jr, MD, Chair*

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update to MMS Model Staff Bylaws</td>
<td>$5,000</td>
<td>One-Time Expense</td>
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<tr>
<td><strong>Total</strong></td>
<td>$5,000</td>
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### Item #: 12
**Code:** CPL Report A-18 B-6  
**Title:** Transforming the Medical Liability Environment  
**Sponsor:** Committee on Professional Liability  
*Stephen Metz, MD, Chair*

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution to Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI)</td>
<td>$25,000</td>
<td>Annual Expense for Two Years</td>
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<td><strong>Total</strong></td>
<td>$50,000</td>
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### Item #: 14
**Code:** CPH/CME Report A-18 B-8 [A-17 A-111]  
**Title:** Maximizing Function and Minimizing Disability  
**Sponsors:** Committee on Public Health  
Steven Ringer, MD, Chair  
Committee on Medical Education  
Kevin Hinchey, MD, Chair

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research and Webinar</td>
<td>$10,000</td>
<td>One-Time Expense</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$10,000</td>
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</table>
## FISCAL NOTE COMPONENTS — REFERENCE COMMITTEE C

**Item #:** 2  
**Code:** CWIM Report A-18 C-2  
**Title:** Establishing a Women Physicians Section  
**Sponsor:** Committee on Women in Medicine  
  Kathryn Hughes, MD, Chair

<table>
<thead>
<tr>
<th>Establishment of New Membership Section</th>
<th>Cost</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$5,000</td>
<td>Annual Expense (Beginning FY20)</td>
</tr>
</tbody>
</table>

**Total**  
$5,000