### Reference Committee B — Health Care Delivery

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Item #: 1
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, 12/1/15

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 The federal mandate was repealed in 1987.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; 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

1 www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx
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

¹ [www.mercatus.org/publication/40-years-certificate-need-laws-across-america](http://www.mercatus.org/publication/40-years-certificate-need-laws-across-america)
² Ibid.
³ [www.mercatus.org/system/files/massachusetts_state_profile.pdf](http://www.mercatus.org/system/files/massachusetts_state_profile.pdf)
⁴ [www.mercatus.org/conlaws/massachusetts](http://www.mercatus.org/conlaws/massachusetts)
⁵ Ibid.
⁶ [www.hfma.org/content.aspx?id=52833](http://www.hfma.org/content.aspx?id=52833)
⁸ [www.mercatus.org/conlaws/massachusetts](http://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:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care; therefore, be it

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 (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. (D)

Fiscal Note: No Significant Impact

(Out-of-Pocket Expenses)

FTE: Existing Staff

(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
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DElegates

Item #: 2
Code: Resolution A-18 B-202
Title: Ensuring Prescription Drug Price Transparency from Retail Pharmacies
Sponsors: Nicholas Leonard
      Steven Krueger
      Adarsha Bajracharya, MD
Referred to: Reference Committee B
      Nicolas Argy, MD, JD, Chair

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 currently 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)
Appendix

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)
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8) How to Select PROMs (Page 89)
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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)
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

1 Item #: 3
2 Code: Report A-18 B-1
3 Title: CQMP Patient-Reported Outcome Measures: Current State and Proposed MMS Principles
4 Sponsor: Committee on the Quality of Medical Practice
5 Barbara Spivak, MD, Chair
6 Referred to: Reference Committee B
7 Nicolas Argy, MD, JD, Chair

1) Introduction
2 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
3 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.
\(^8\) Wagle. Patient-Reported Outcome Measures Presentation, March 2016.
\(^12\) 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 content 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-precise 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

FTE: 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

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.

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,\textsuperscript{19} 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 to see the toolkit.

\textbf{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.\textsuperscript{20} 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.\textsuperscript{21}
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.\textsuperscript{22} 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.\textsuperscript{23}

\textsuperscript{19} Ibid.
\textsuperscript{20} Robert Wood Johnson Foundation, “Foundations Unite to Support Access to Clinical Notes for
50 Million Patients Nationwide,” December 2015
\textsuperscript{21} Ibid.
\textsuperscript{22} Delbanco, T, et al., Health Expect., 2001
\textsuperscript{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. 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)

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

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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¹ Jayanthi K, Ellison A. 8 hospital finances hurt by EHR costs. Becker’s Hospital CFO


finances-hurt-by-ehr-costs.html.

² Landi H. Report: EHR installs carry significant financial risks for hospitals. Healthcare


installs-carry-significant-financial-risks-hospitals.

³ Wang T, Biedermann SE. Running the numbers on an EHR: Applying cost-benefit


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. 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)

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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 Professional Courtesy. 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 11.3.3 “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. 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. 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”).

(HP)

Fiscal Note: No Significant Impact

(Out-of-Pocket Expenses) Existing Staff

FTE: (Staff Effort to Complete Project)
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.
physicians.pdf.
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)
Item #: 8
Code: Resolution A-18 B-204
Title: Provision of Access to Third-Party Payer Medical Directors to Treating Providers to Facilitate Patient Care
Sponsors: David Kieff, MD
Charles River District Medical Society
Laura McCann, MD, President
Referred to: Reference Committee B
Nicolas Argy, MD, JD, Chair

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)
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 9
Code: Resolution A-18 B-205
Title: One Reimbursement Fee Schedule for All Medicaid ACOs
Sponsors: Kevin Moriarty, MD
Hampden District Medical Society
Nikhil Thakkar, MD, President

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

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)

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

FTE: Existing Staff
(Staff Effort to Complete Project)

¹ http://www.chiamass.gov/assets/docs/r/pubs/18/Final-CY16-S-RP.pdf
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

(D)

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
preparation 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
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
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. As a result of these publications, as well as the evidence from the University of Michigan’s program, and several others in the United States 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.

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, FAAFP
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. It concludes that the patient, his or her family, community, employer, and society all benefit from the patient’s employment.

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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 Return to Work. ACOEM Position Statement, JOEM. Volume 59, Number 6, 2017: e125-e129.
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: \(\text{One-Time Expense of 10,000}^{(\text{Out-of-Pocket Expenses})}\)
FTE: \(\text{Existing Staff}^{(\text{Staff Effort to Complete Project})}\)

Item #: 15
Title: Recognition of Out-of-State DNR/Physician Orders for Life Sustaining Treatment (POLST) Forms in Massachusetts
Sponsor: Committee on Geriatric Medicine
Eric Reines, MD, Chair
Report History: Resolution A-17 B-207
Original Sponsor: Keith Nobil, MD
Referred to: Reference Committee B
Nicolas Argy, MD, JD, Chair

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)