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Item #: 1
Title: Establishment of a Pilot Medically-Supervised Injection Facility in MA
Sponsor: Board of Trustees
James Gessner, MD, Chair
Referred to: Reference Committee A
Kevin O’Callaghan, Chair
Recommendation:

Mister speaker, your reference committee recommends that the recommendation contained in BOT Report A-17 A-1 [A-16 A-104] be adopted and the remainder of the report be filed.

That the MMS advocate for a pilot supervised injection facility (SIF) program in Massachusetts under the direction and oversight of a state-led task force convened by a state authority, such as the MA Department of Public Health, to discuss the legal considerations and paths forward, and that the task force:

- Advocate for an exemption from federal drug laws for the pilot SIF program as well as pursue state legislation legalizing the pilot SIF program, and consider partnering with other states or entities in seeking such a waiver of the applicable federal laws.
- Include an advisory board of experts, which includes experts from the Vancouver SIF as well as state and federal government officials if possible, under the jurisdiction of the task force, to design the evaluation protocol (including careful design of informed consent protocols regarding research) for the pilot.
- Consider building on a program such as a supportive place for observation and treatment (SPOT), given its expertise providing comprehensive, high-quality, harm-reduction services to populations that would be served by SIFs, and its reputation with government officials and other stakeholders in Boston.
- Consider harm-reduction strategies (counseling, referral, and placement on demand for all types of drug treatment) as a component of the pilot beyond SIFs to ensure comprehensive health care is available to marginalized persons who inject drugs.

(D)

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

FTE: Existing Staff
(Staff Effort to Complete Project)

Your reference committee heard overwhelmingly supportive testimony both online and in person including from addiction specialists, districts, sections, and caucuses for the report and its recommendations. Testimony outlined many of the positive benefits of SIFs including a significant reduction in overdose deaths and improved access to treatment. However, there was limited testimony opposing the recommendations based on concerns about the potential public and law enforcement opposition to SIFs, the unintended consequences of focusing resources on currently illegal harm reduction methods, and overall financial impact. Most testified that the benefits of SIFs far outweigh the risks, especially for marginalized populations who inject drugs in unsafe, unclean public places. The reference committee noted that there is no evidence that SIFs will detract from the utilization of other harm reduction services but will instead provide an
opportunity for Massachusetts to provide the full continuum of care to all patients regardless of their living situation or stage of addiction.

House Vote: ________________________________
Mister speaker, your reference committee recommends that Resolution A-17 A-101 be adopted as amended by addition and deletion to read as follows:

1. RESOLVED, That the MMS work with relevant organizations to promote awareness of the naloxone standing order to physicians, pharmacists, and patients; and, be it further (D)

2. RESOLVED, That the MMS encourage physicians to sign a pharmacy naloxone standing order; and, be it further (D)

3. RESOLVED, That the MMS encourage private and public payers to include naloxone on their preferred drug lists and formularies with minimal or no cost sharing; and, be it further (D)

4. RESOLVED, That the MMS strongly advocate for affordable access to naloxone for all people in the Commonwealth of Massachusetts. (HPD)

5. RESOLVED, That the MMS strongly urge the AMA to advocate for affordable access to naloxone. (D)

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

FTE: Existing Staff (Staff Effort to Complete Project)

Your reference committee heard broad testimony supporting this resolution. Testimony was also presented recommending two amendments to further promote access to naloxone and other services for patients with substance use disorder. One proposed amendment urged strong advocacy by MMS and the AMA for rolling back the price of naloxone, which has escalated dramatically in recent years. Your reference committee felt this was addressed by amendments to the current resolution, as proposed here. The second proposed amendment urged broadening the resolution to promote needle exchange and a Drug Overdose Prevention and Education project, which would distribute naloxone, and educate users, public safety officials, and the public on overdose signs and treatment. Your reference committee recognizes these
are important issues, but beyond the scope of this resolution, and recommends a future
resolution on this topic to enhance existing policy.

House Vote: _______________________________
Item #: 3
Code: Resolution A-17 A-102
Title: Access to Medication-Assisted Treatment for Prisoners with Opioid Use Disorders
Sponsors: Jessica Fortin
Jonathan Gammel
Alexander Walley, MD
Committee on Public Health
Steven Ringer, MD, Chair
Task Force on Opioid Therapy and Physician Communication
Dennis Dimitri, MD, Chair
Medical Student Section
Caroline Yang, Chair

Referred to: Reference Committee A
Kevin O’Callaghan, MD, Chair

Recommendation:

Mister speaker, your reference committee recommends that Resolution A-17 A-102 be adopted as amended by addition and deletion to read as follows:

1. RESOLVED, That the MMS advocate that state and county inmates in Massachusetts with opioid use disorders have access to the full spectrum of evidenced-based recovery support services, including all evidence-based medication-assisted treatments covered on the MassHealth formulary and transition plans for post-release care; and, be it further (D)

2. RESOLVED, That the MMS work with the AMA and any relevant organizations to advocate for access to the full spectrum of evidenced-based recovery support services, including all evidence-based medication-assisted treatments for federal inmates with opioid use disorders and transition plans for post-release care. (D)

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

Your reference committee heard overwhelmingly positive testimony in support of this resolution. Testimony emphasized that opioid overdose is the leading cause of death in persons recently released from prison and noted that many patients in recovery are forced to cease treatment when they are jailed for past offenses, given the lack of prison addiction services. We also heard testimony in favor of extending available addiction services beyond medically-assisted treatment to include the full spectrum of evidence-based addiction treatment and services and to address the importance of post-release transition planning. While testimony included a suggestion to amend the recommendation to explicitly include pregnant and postpartum women, your reference committee believes that the current language is sufficient to encompass all prisoners regardless of gender or health status.

House Vote: _______________________________
Mister speaker, your reference committee recommends that the recommendations contained in OMSS Report A-17 A-2 be adopted as amended by addition and deletion to read as follows and the remainder of the report be filed:

1. That the MMS advocate to the Massachusetts state legislature and/or relevant state agencies for medical facilities and public restrooms to increase public access to install and increase the number of needle/syringe disposal devices with theft-proof and tamper-proof properties. (D)

2. That the MMS encourage Massachusetts communities with significant IV drug abuse populations to establish and expand needle exchange programs. (D)

Fiscal Note: No Significant Impact

(Out-of-Pocket Expenses)

FTE: Existing Staff

(Staff Effort to Complete Project)

Your reference committee heard significant testimony broadly in favor of the report as written. Several testified in favor of ensuring that disposal devices include destruction capabilities to guard against theft of used, disposed needles. Some testimony was in favor of striking references to medical facilities and restrooms in order to increase public access beyond these facilities. At the same time, the importance of flexibility was stressed to allow communities to determine the most appropriate locations for these receptacles. Finally, testimony indicated that language relegating these disposal devices to only those communities with significant IV drug use populations would prevent communities from addressing a problem that is ubiquitous across the Commonwealth.
Mister speaker, your reference committee recommends that Resolution A-17 A-103 be referred to the Board of Trustees for report back at A-18.

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

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

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

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

FTE: Existing Staff
(Staff Effort to Complete Project)

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

There remained confusion about the intent of “undisclosed HIV testing” in Resolved 1, leading to disparate interpretations about whether this implied a lack of disclosure to the patient, to the health care worker, or to the institution. Testimony also indicated substantial variability of relevant hospital policy in Massachusetts, indicating confusion even about settled Massachusetts laws. Additionally, testimony highlighted the need to protect patients who may be exposed by health care workers, and to expand the policy to all health care facilities and not just hospitals.
Ultimately, in recognizing the importance and complexity of this issue, your reference committee recommends that this resolution be referred to the Board of Trustees for report back at A-18.

House Vote: _______________________________
Item #: 6
Code: Resolution A-17 A-104
Title: Perfluorochemical (PFC) Drinking Water Contamination
Sponsors: Karl D'Silva, MD
Frank Carbone Jr., MD

Referred to: Reference Committee A
Kevin O'Callaghan, MD, Chair

Recommendation:
Mister speaker, your reference committee recommends that Resolution A-17 A-104 be referred to the Board of Trustees for decision.

RESOLVED, That the MMS encourage relevant state agencies and municipalities to monitor the perfluorochemicals (PFC) level in the drinking water sources from the Commonwealth’s towns to ensure the accepted levels of PFCs for the health of the community. (D)

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

FTE: Existing Staff
(Staff Effort to Complete Project)

Your reference committee heard testimony indicating member interest and concern about this issue. Members testified that more information is needed on potential risks of PFCs on the public’s health, the pervasiveness of the problem in MA, and the overall cost to test and mitigate, in order to recommend policy. Your reference committee recommends that the resolution be referred to the Board of Trustees for decision in order to further investigate these issues.

House Vote: _______________________________
Mister speaker, your reference committee recommends that the recommendations contained in CEOH Report A-17 A-3 be adopted and the remainder of the report be filed.

1. That the MMS adopt the following adapted from American Medical Association policies:

   The MMS recognizes noise pollution as a public health hazard, with respect to hearing loss, and supports initiatives to increase awareness of the health risks of loud noise exposure. *(HP)*

   The MMS urges the maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants. *(HP)*

2. That the MMS acknowledges the increased risk of adverse health consequences to workers and general public from gas-powered leaf blowers including hearing loss and cardiopulmonary disease. *(HP)*

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

FTE:  Existing Staff
(Staff Effort to Complete Project)

Your reference committee heard testimony almost unanimously in support of this report. Some testimony recommended expanding it to cover all small engines, such as ATVs and lawnmowers, all two cycle engines, or some combination thereof. However, the references in the report as well as testimony made it clear that the evidence used to support these recommendations is specific to gasoline powered leaf blowers, and the health effects associated with the high decibels, volatile organic compounds (VOCs), and particulates elaborated by gasoline powered leaf blowers.

House Vote: _______________________________
Mister speaker, your reference committee recommends that Resolution A-17 A-105 be adopted as amended by addition and deletion to read as follows:

1. RESOLVED, That the MMS adopt the following adapted from AMA policy:

   That the MMS recognizes the potential impact on human health associated with natural gas infrastructure. (HP)

   ; and, be it further

2. RESOLVED, That the MMS advocate to appropriate agencies and the Massachusetts state legislature to require ongoing independent Comprehensive Health Impact Assessments to assess the human health risks of all existing and proposed new or expanded natural gas infrastructure in Massachusetts.; and, be it further (D)

3. RESOLVED, That if Comprehensive Health Impact Assessments of natural gas infrastructure (NGI) are found to have detrimental effects on human health, that the MMS advocate for a moratorium on all new or expanded NGI projects until these health concerns have been addressed. (D)

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

Your reference committee heard testimony indicating strong support for Resolveds 1 and 2 to establish policy recognizing the potential health impacts of, and to promote Comprehensive Health Impact Assessments of, natural gas infrastructure. Many testifying felt that Resolved 3, calling for a moratorium on natural gas infrastructure if the assessments indicate concern, was beyond the scope of the Medical Society’s priorities. Testimony also recognized the health effects of substitute energy sources, such as coal, must be taken into consideration.

Your reference committee therefore recommends to adopt as amended by addition and deletion to slightly modify Resolved 2 to ensure health assessment of new and existing natural gas projects, and to strike Resolved 3.
Mister speaker, your reference committee recommends that the recommendation contained in CGM/CPH Report A-17 A-4 [A-16 A-6] be adopted as amended by deletion to read as follows and the remainder of the report be filed:

That the Massachusetts Medical Society adopt as amended CGM Report A-16 A-6 to read as follows:

1. That the Massachusetts Medical Society disseminate information to primary care physicians and the public, through its existing communications vehicles, about services offered by the state Executive Office of Elder Affairs for frail elders. *D*

2. That the Massachusetts Medical Society educate its members, through existing communications channels, about challenges faced by family caregivers. *D*

Fiscal Note: No Significant Impact

Out-of-Pocket Expenses

FTE: Existing Staff

(Staff Effort to Complete Project)

Your reference committee heard unanimous testimony both online and in person in support of this report. The Massachusetts Office of Elder Affairs administers many programs to address socio-economic factors at no cost to the patients, as well as case management to assist with medical home care. It was noted that frail elders often receive healthcare from specialists beyond their primary care provider. Given that the information offered in this report is valuable beyond primary care physicians, the first recommendation was amended to strengthen this report.

House Vote: _______________________________
Mister speaker, your reference committee recommends that the recommendations contained in CNPA Report A-17 A-5 be adopted and the remainder of the report be filed.

1. The MMS recognizes the health benefits of non-exercise activity thermogenesis (NEAT), in addition to regular physical activity and appropriate diet. (HP)

2. The MMS recommends that physicians educate themselves and their patients about non-exercise activity thermogenesis (NEAT), in order to promote health. (HP)

3. The MMS encourages non-exercise thermogenesis (NEAT) be incorporated as part of the work place environment. (HP)

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

FTE: Existing Staff (Staff Effort to Complete Project)

Your reference committee, while seated, heard testimony strongly and unanimously in favor of this report of the Committee on Nutrition and Physical Activity, which promotes the benefits of informal physical activity, such as moving more, taking walking and standing breaks at work, etc., in addition to recommended planned physical activity. Testimony reflected the benefits of this type of activity to all patients, including those with limited mobility.

House Vote: _______________________________
Item #:  11
Code:  Resolution A-17 A-106
Title:  Support of Reach Out and Read Literacy Program
Sponsors:  Christopher Garofalo, MD, FAAFP
           Bristol North District Medical Society
           Eric Ruby, MD, President
Referred to:  Reference Committee A
             Kevin O'Callaghan, MD, Chair
Recommendation:
Mister speaker, your reference committee recommends that Resolution A-17 A-106 be adopted.

1. RESOLVED, That the MMS affirms that early exposure to books and literacy-rich environments has a positive effect on language development and literacy skills, which may reduce health care disparities; and, be it further (HP)

2. RESOLVED, That the MMS advocate that the Governor, State Legislature, and relevant state agencies continue to support significant funding of the Reach Out and Read program. (D)

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

Your reference committee heard testimony unanimously in support of this resolution, including from the Committee on Legislation and the Massachusetts Chapter of the American Academy of Pediatrics, as well as from members who implement this program in their own practices. Members testified to the benefit of these reading programs to the children, as well as their families, underscoring the importance of ensuring state funding of this worthwhile program.

House Vote:  _______________________________
Recommendation:

Mister speaker, your reference committee recommends that Resolution A-17 A-107 be adopted.

RESOLVED, That the MMS adopt as amended its policy on Health Care Needs of the Lesbian, Gay, Bisexual, and Transgender (LGBT) Population, reaffirmed at A-15, to read as follows:

The MMS will educate physicians regarding:

(a) the need for women who have sex exclusively with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions;

(b) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and

(c) the need for regular cervical cancer screening for female-to-male transgender patients when medically indicated. (D)

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

FTE: Existing Staff (Staff Effort to Complete Project)

Your reference committee heard testimony strongly and unanimously in support of this resolution. Several committees and districts offered praise for the strong work by the authors.

House Vote: _______________________________
Mister speaker, your reference committee recommends that Resolution A-17 A-108 be adopted.

1. RESOLVED, That the MMS acknowledges the psychological, emotional, and physical harm to transgender individuals inherent in obligating the use of a public restroom inconsistent with their gender identity; and, be it further (HP)

2. RESOLVED, That the MMS support transgender individuals’ use of public restrooms in accordance with their gender identity; and, be it further (HP)

3. RESOLVED, That the MMS support state and federal legislation to extend protections to transgender individuals to use the restroom in accordance with their gender identity. (D)

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

FTE: Existing Staff (Staff Effort to Complete Project)

Your reference committee heard unanimously positive testimony in support of this resolution. Therefore we recommend the resolveds be adopted as written.

House Vote: _______________________________
Item #: 14  
Code: OMSS Report A-17 A-6  
Title: Improving Mental Health at Colleges and Universities for Student Populations  
Sponsor: Organized Medical Staff Section  
Frank Carbone Jr., MD, Chair  
Referred to: Reference Committee A  
Kevin O’Callaghan, MD, Chair  
Recommendation:  
Mister speaker, your reference committee recommends that the recommendation contained in OMSS Report A-17 A-6 be adopted and the remainder of the report be filed.  
That the Massachusetts Medical Society adopt the following American Medical Association policies:  
1. That the MMS supports accessibility and destigmatization as strategies in mental health measures implemented by colleges and universities, in order to improve the provision of care and increase its use by those in need. (HP)  
2. That the MMS supports colleges and universities in publicizing the importance of mental health resources, with an emphasis on the availability and efficacy of such resources. (HP)  
3. That the MMS supports collaborations of university mental health specialists and local health centers in order to provide a larger pool of resources, such that any student be able to access care in a timely and affordable manner. (HP)  
Fiscal Note:  No Significant Impact (Out-of-Pocket Expenses)  
FTE: Existing Staff (Staff Effort to Complete Project)  
Your reference committee heard testimony both online and in person providing overwhelming support for this report. Therefore we recommend the recommendation be adopted as written.  
House Vote: _______________________________
RESOLVED, That the MMS supports policy adapted from the American Academy of Pediatrics (AAP) policy:

Do not use home cardiorespiratory monitors as a strategy to reduce the risk of SIDS.

(HP)

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

FTE: Existing Staff
(Staff Effort to Complete Project)

Your reference committee heard mixed testimony on this resolution. Testimony expressed concern about the fact that there was no evidence that these products are either harmful or beneficial, or potentially harmful or beneficial, and therefore no evidence on which to base a policy statement. Others testified that it is beyond the purview of MMS to advocate against a product, which, like many others, is not a medical device. Although no fiscal note is listed, the Committee on Finance suggested a fiscal note may be necessary in order to develop guidance to advise physicians about how to counsel patients. Your reference committee recommends a substitute resolved adapted from the American Academy of Pediatrics policy to reframe this important issue.

House Vote: ____________________________
Item #: 16
Code: Resolution A-17 A-110
Title: CPR as a Requirement to Graduate High School
Sponsor: Keith Nobil, MD
Referred to: Reference Committee A
Kevin O'Callaghan, MD, Chair

Recommendation:
Mister speaker, your reference committee recommends that Resolution A-17 A-110 be adopted.

RESOLVED, That the MMS advocate at a statewide level that CPR training be required as a condition of graduation for all high schools in the Commonwealth. (D)

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

Your reference committee heard testimony mostly in support of this resolution. Opposing testimony noted concerns that the recommendation may be an overreach of the Society as it imposes mandates on non-medical education. Information included the impact of a similar mandate in Washington state that resulted in a significant decrease in fatal cardiac events. Reference committee members realize that it will be up to the relevant state agencies to determine the details including opt-out language. Reference committee members also point out that this resolution calls only for the provision of training, and does not mandate certification as a requirement for graduation.

House Vote: _______________________________
Item #: 17
Title: Supporting Repeal of Anti-Camping Ordinance in MA
Sponsors: Committee on Legislation
Hugh Taylor, MD, Chair
Committee on Public Health
Steve Ringer, MD, Chair

Report History: Resolution A-16 A-107
Original Sponsors: Ms. Haiyan Huang, Mr. Nicholas Chiu

Referred to: Reference Committee A
Kevin O’Callaghan, MD, Chair

Recommendation:
Mister speaker, your reference committee recommends that the recommendation contained in COL Report A-17 A-7 [A-16 A-107] **be adopted as amended by addition and deletion to read as follows and the remainder of the report be filed:**

That the Massachusetts Medical Society adopt as amended Resolution A-16 A-107 to read as follows:

That the Massachusetts Medical Society supports the repeal or revision of anti-camping ordinances in Massachusetts **in order** to protect the health of homeless individuals. *(HP)*

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

FTE: Existing Staff
(Staff Effort to Complete Project)

Your reference committee heard testimony that unanimously supported the concept of amending anti-camping ordinances in order to decriminalize homelessness and to promote the health of homeless individuals. Since many testifying did indicate that well-crafted ordinances could promote public health and the health of homeless individuals, your reference committee recommends revising, rather than repealing, anti-camping ordinances.

House Vote: _______________________________
Item #: 18
Code: Resolution A-17 A-111
Title: Maximizing Function and Minimizing Disability
Sponsors: Janet Limke, MD
Norfolk South District Medical Society
Melody Eckardt, MD, President

Referred to: Reference Committee A
Kevin O’Callaghan, MD, Chair

Recommendation:

Mister speaker, your reference committee recommends that Resolution A-17 A-111 be not adopted.

1. RESOLVED, That the MMS recognizes the important role it can play in mitigating the adverse health effects of chronic disability; and, be it further (HP)

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

3. RESOLVED, 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)

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.

House Vote: ______________________________
Item #:  19
Code:  CPH Report A-17 A-8
Title:  Public Health Campaign for Environmental Health
Sponsors:  Louis Fazen, MD
          Committee on Public Health
          Steven Ringer, MD, Chair
Referred to:  Reference Committee A
              Kevin O’Callaghan, MD, Chair

Recommendation:
Mister speaker, your reference committee recommends that the recommendations
contained in CPH Report A-17 A-8 be adopted and the remainder of the report be
filed.

1. That the MMS recognizes the inextricable link between environmental health,
animal health, and human health, and the importance of scientific research in
informing policies that protect human health from environmental toxins. (HP)

2. That the MMS will initiate a public health campaign to promote public
awareness of the potential sources of pollutants and toxins in the environment
and their impact on human health. (D)

3. That the MMS will advocate for policies, regulations, and legislation that protect
and promote environmental and human health and that are aligned with MMS
strategic and public health priorities. (D)

Fiscal Note:  $15,000 per year for three years
(Out-of-Pocket Expenses)
FTE:  Existing Staff
(Staff Effort to Complete Project)

Your reference committee heard testimony fully in support of this report with the
exception of the Committee on Finance, which supported items 1 and 3 and opposed
item 2 due to the fiscal note. Testimony stated emphatically that the campaign
recommended by this report is timely, important, and a core responsibility of the MMS,
and that the fiscal note is justified.

House Vote:  ____________________________
Mister speaker, this concludes the report of Reference Committee A. My thanks to reference committee members Heidi Foley, MD, Ronald Newman, MD, Luis Sanchez, MD, Ann Spires, MD, Ludwik Szymanski, MD, and Simone Wildes, MD; staff coordinators Robyn Alie, Therese Fitzgerald, PhD, Karen Harrison, and Candace Savage; legal counsel Brendan Abel, Esq.; and all those who testified before the committee.

For the reference committee,

Kevin O’Callaghan, MD, Chair
### REFERENCE COMMITTEE B: Health Care Delivery

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Mister speaker, your reference committee recommends that Resolution A-17 B-201 be adopted as amended by deletion to read as follows:

1. RESOLVED, That the Massachusetts Medical Society recognizes the importance of Medicaid to covering our Commonwealth’s children, disadvantaged, and disabled; and, be it further (HP)

2. RESOLVED, That the Massachusetts Medical Society supports the continuation of Medicaid as a federal entitlement program and opposes state or national measures that would further limit Medicaid enrollment. (HP)

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

Your reference committee heard extensive testimony regarding this resolution, the general purpose of which is to ensure that adequate health care remains accessible to the populations covered by Medicaid. Most of those testifying opposed the idea of the block grants currently being considered at the federal level, and favored retaining Medicaid’s status as an entitlement. A few of those testifying voiced concerns over the downstream impact on cost. One delegate testified support for the concept but specified a concern with regard to some potential negative unintended consequences upon implementation that could result in some employers not providing insurance. The Committee on Legislation proposed an amendment on the grounds that there may be health-care payment or delivery models outside of Medicaid that would provide equivalent or better coverage and care to the current Medicaid populations. Other testimony supported the Committee on Legislation’s suggestion, arguing that removing the language would allow for interesting new approaches to coverage under private insurance that might succeed in covering current Medicaid participants. Your reference committee found this argument persuasive, and therefore recommends that the resolution be adopted as amended.

House Vote: _______________________________
Mister speaker, your reference committee recommends that Resolution A-17 B-202 be referred to the Board of Trustees for report back at I-17.

RESOLVED, 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)

Your reference committee heard significant testimony on this resolution in person and online which highlighted the importance of the concept of healthcare 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’ 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 healthcare system. Additionally, there was some concern that stating that healthcare 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 healthcare, so that the right would only extend to “basic” healthcare, and not necessarily to all healthcare. 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.

House Vote: _______________________________
Mister speaker, your reference committee recommends that Resolution A-17 B-203 be not adopted.

RESOLVED, That the Massachusetts Medical Society advocate to the Massachusetts legislature to examine the likely effects of implementation of a single-payer plan in Massachusetts. *(D)*

Fiscal Note: No Significant Impact

(Out-of-Pocket Expenses)

FTE: Existing Staff

(Staff Effort to Complete Project)

Your reference committee heard significant, and divided, testimony both in person and online. Many testified to favoring the concept of a single payer system but there were others, including the Resident and Fellow Section, that indicated support for single-payer but also noted the need for flexibility with regard to consideration for other emerging payment models as well. Additionally, a member of the COL testified that while that committee stands ready to implement the will of the house, this particular resolution should not be considered lightly as it could result in a change of advocacy position which could later hamper the efforts of the Medical Society on a number of other legislative initiatives. There was also reference to existing MMS policy in this area. Your reference committee discussed these varied points in detail and concluded that the weight of the points made by those testifying, the potential risk of the specificity of the language contained in this proposed resolution and how that may impair current MMS legislative activities, and the potential impact to standing MMS policy, all argued in favor of not adopting this resolution. Your reference committee therefore recommends that this resolution be not adopted.
Item #: 4
Code: Resolution A-17 B-204
Title: Health Insurance in which Copayments Vary with Clinical Utility, a Value-Based Insurance Design
Sponsors: Joel Rubenstein, MD
Charles River District Medical Society
Mawya Shocair, MD, President
Referred to: Reference Committee B
Aimie Zale, MD, Chair

Recommendation:

Mister speaker, your reference committee recommends that Resolution A-17 B-204 be referred to the Board of Trustees for decision.

RESOLVED, That the Massachusetts Medical Society seeks partnerships and dialogue with relevant stakeholders, including academic health policy departments, health insurance companies, self-insured companies, physicians, consumer advocacy groups, and specialty societies, that have developed appropriate use criteria to explore the concept and feasibility of a model of value-based insurance design coupled with medical savings accounts in which consumer’s copayment for specific services would vary inversely with clinical utility. (D)

Fiscal Note: One-Time Expense of $30,000 (Out-of-Pocket Expenses)

FTE: Existing Staff (Staff Effort to Complete Project)

Your reference committee received testimony regarding this resolution both in person and online. Testimony reflected general consensus on two points: first, that demand for services (and the concomitant provision of those services) is one of the major driver of health care costs; and second, that high-deductibles, and high copayments cause patients to avoid all care, not just unnecessary or ineffective care. This resolution attempts to address these two facts by increasing the cost to patients of care with low clinical utility, but decreasing it for care of proven utility. Testimony, however, reflected a belief that this is a national issue, and is, in fact, one on which the AMA is currently working. Some stated that a study of this issue would cost millions of dollars, that a large body of research is already available on the topic, and that perhaps a meta-analysis of current knowledge and available data would be more useful. Another testifier raised the issue of how to measure the value or clinical utility of a given procedure or service to a specific patient at a particular moment. Your reference committee also noted online testimony that highlighted the recently implemented mental health parity law, but indicated concern that this resolution could result in greatly increased copayments for mental health services, given that there is such great difficulty in defining and measuring successful outcomes for mental health treatment. The sponsor recognized the complexity of this issue and indicated support for referral based on the testimony presented. Because of all these complex issues, your reference committee recommends that this resolution be referred to the Board of Trustees for decision.

House Vote: _______________________________
Item #: 5
Code: Resolution A-17 B-205
Title: Nursing Facilities’ Doctors and Other Prescribers Should Be Exempt from Consulting MassPAT
Sponsor: Robert Lebow, MD
Referred to: Reference Committee B
Aimie Zale, MD, Chair
Recommendation:

Mister speaker, your reference committee recommends that Resolution A-17 B-205 be referred to the Board of Trustees for decision.

RESOLVED, That the Massachusetts Medical Society will advocate for law, regulation, or guidance providing that doctors and other providers in nursing homes and skilled nursing facilities are exempt from consulting the prescription monitoring program or MassPAT. (D)

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

Your committee heard overwhelming support for this resolution but also heard some important concerns voiced about the facilities to which this MassPAT exemption should apply. In discussing these concerns there was overwhelming support for exemptions in nursing homes and there was a general consensus with regard to the fact that Short Term stays in Skilled Nursing Facilities should not be exempt. Your reference committee reviewed and discussed two proposed amendments, one submitted by the sponsor initially and then another submitted later and supported by the sponsor.

The challenge your reference committee faced was how to exactly structure the language to accomplish the specific exemptions in an appropriate manner. It was felt that the term Long Term Care may actually include other facilities that do not align with the intent of the exemption. Your reference committee discussed how the term “Long Term Care” covers nursing homes, assisted living facilities, skilled nursing facilities, etc. and the reference committee felt this term was too broad to accomplish the intended goals. Your committee acknowledges the importance of and the need for exemption to MassPAT in this general area, and desires to preserve the intent of the resolution and the will of those testifying. The reference committee feels that there is an important need for clarified language. As such, your reference committee recommends referral to the BOT for decision.

House Vote: _______________________________
1. RESOLVED, That the MMS advocate for new legislation to restore repealed legislation that allows the recycling of nursing home drugs that are unused, sealed, and dated; and, be it further (D)

2. RESOLVED, That the MMS advocate for legislation to enact prescription drug donation that allows unused, sealed, and dated medications to be directed by physician offices and clinics to patients in need who are uninsured or underinsured; and, be it further (D)

3. RESOLVED, That the MMS advocate for legislation specific to cancer programs and clinics to accept and recycle cancer-specific drugs to patients in need who are uninsured or underinsured. (D)

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

FTE: Existing Staff
(Staff Effort to Complete Project)

Your reference committee heard unanimous testimony in support of this resolution. Testimony presented the fact that exorbitant prescription drug prices coupled with an abundant supply of unused and individually packaged drugs has created an opportunity to implement a prescription donation program on behalf of underinsured and uninsured patients, who may not be able to afford treatment with these drugs otherwise. Testimony supported the need for a safe program that would include physician led redistribution of unused, sealed and dated medications in order to ensure accuracy of dosing and efficacy of treatment for patients. Testimony also supported physicians and clinics leading this process. Further, there was strong support to extend this legislative initiative to cancer programs and clinics. Based on the testimony, your reference committee recommends adopting this resolution.

House Vote: _______________________________
Mister speaker, your reference committee recommends that Resolution A-17 B-207 be adopted.

RESOLVED, 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

FTE: Existing Staff

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.

House Vote: ___________________________
Mister speaker, your reference committee recommends that Resolution A-17 B-208 be adopted.

1. RESOLVED, That the MMS work with the Mass Serious Illness Coalition and the State Legislature to find ways to encourage completion of health care proxies, (for example, by providing a Health Care Proxy form as part of driver licensure and renewal); and, be it further (D)

2. RESOLVED, That the MMS work with the Mass Serious Illness Coalition and the State legislature to create a Health Care Proxy registry, available to physicians, other providers, and appropriate entities, with 24/7 secure access. (D)

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

FTE: Existing Staff (Staff Effort to Complete Project)

Your reference committee heard unanimous support for this resolution, both in-person and online, reiterating the importance of completing a health care proxy form. Based on the overwhelming support, your reference committee recommends adopting this resolution.

House Vote: ________________________________
Mister speaker, your reference committee recommends that the recommendation contained in COL Report A-17 B-1 [A-16 A-102] be adopted and the remainder of the report be filed.

That the Massachusetts Medical Society not adopt Resolution A-16 A-102, which reads as follows:

1. That the MMS advocate for laws that would make a Living Will legal in the state of Massachusetts. The Living Will would serve as an alternative to the Health Care Proxy, allowing a person to choose either one, but not both. (D)

2. That the MMS advocate for appropriate education of the public regarding the use of the Living Will once it becomes legal in the state of Massachusetts. (D)

Fiscal Note: No Significant Impact

(Out-of-Pocket Expenses)

FTE: Existing Staff

(Staff Effort to Complete Project)

Your reference committee heard unanimous support for this report. Those testifying indicated support for the points made in the report, and largely supported the Committee on Legislation’s report’s recommendation to not adopt Resolution A-16 A-102. Your reference committee therefore recommends adopting this report, COL Report A-17 B-1.

House Vote: ________________________
Mr. Speaker, your reference committee recommends that Resolution A-17 B-209 be adopted.

RESOLVED, That the MMS advocate to relevant review websites that they develop a method to verify a physician-patient relationship before allowing public comments about physicians to be posted on their website. *(D)*

Fiscal Note: No Significant Impact

FTE: Existing Staff

Your reference committee heard testimony in universal support of this resolution. Testimony noted that false website reviews can cause harm to an individual’s reputation which in turn could impact a practice’s operations. Testimony also noted that some physicians are reviewed for services they don’t provide at all, and that concerns with regard to HIPAA make it difficult for physicians to respond to or defend themselves on review sites the way a hotel or other travel provider can defend itself on customer review websites. The Committee for the Sustainability of Private Practice raised the concern that the process of having websites verify that a physician-patient relationship exists prior to a review being posted would be difficult, but should not prevent the Society from advocating for such verification. Your reference committee therefore recommends that this resolution be adopted.

House Vote: ________________________________
Mister speaker, your reference committee recommends that Resolution A-17 B-210 be referred to the Board of Trustees for report back at A-18.

RESOLVED, That the MMS advocate in legislative forums where allied health professionals seek to provide the same or similar services as a physician with no, limited, or reduced oversight structures, that said individuals be subject to the same statutory and regulatory mandates with regard to the provision of those services, including but not limited to residency requirements, professional liability insurance requirements, continuing education mandates, and adjudicatory and discipline standards. (D)

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

FTE: Existing Staff
(Staff Effort to Complete Project)

Your reference committee heard substantial testimony with various opinions regarding this resolution. Testimony in favor of this resolution stated that requiring nurse practitioners and physician assistants, who wish to perform the same or similar services as a physician, to be subjected to the same statutory and regulatory mandates as a physician, would improve the quality of medicine. Additionally, one delegate testifying indicated that expanding the language to include holding licensed health professionals to the same standard would also be important and proposed an amendment.

Testimony in opposition stated that making allied health professionals meet the same parameters as physicians is tantamount to saying that they are capable of providing the same quality of care as physicians. There was an overall sentiment expressed that indicated the need to concentrate on physician requirements and not creating requirements for people in other professions. Furthermore, some felt that this resolution was moving in the wrong direction and was a bit too late because of the current environmental focus on team-based care as a mechanism to improve access to health care. Due to the complexity and controversy of this issue, your reference committee recommends referral to the Board for report back at A-18.

House Vote: _______________________________
Item #: 12
Code: COL/CQMP Report A-17 B-2 [I-16 B-3]
Title: Reimbursement for Physician Oversight in Incident to Billing

Sponsors: Committee on Legislation
Hugh Taylor, MD, Chair
Committee on the Quality of Medical Practice
Barbara Spivak, MD, Chair

Report History: CSPP Report I-16 B-3
Original Sponsor: Committee on the Sustainability of Private Practice

Referred to: Reference Committee B
Aimie Zale, MD, Chair

Recommendation:

Mister speaker, your reference committee recommends that the recommendation contained in COL/CQMP Report A-17 B-2 [I-16 B-3] be adopted as amended by addition and deletion to read as follows and the remainder of the report be filed.

That the Massachusetts Medical Society adopt as amended CSPP Report I-16 B3 to read as follows:

1. That the Massachusetts Medical Society will introduce and support legislation requiring that MassHealth will recognize the value of physician supervision of advanced practice nurses (APNs) and physician assistants (PAs), within a physician-led team-based practice, by continuing to reimburse for services, and supervision, of provided by APNs and PAs who are actively supervised, at to equal 100% of the physician’s reimbursement rate. (D)

2. That the Massachusetts Medical Society encourage all payers to recognize the value of physician supervision of advanced practice nurses (APNs) and physician assistants (PAs), within a physician-led team-based practice, by continuing to reimburse for services, and supervision, of provided by APNs and PAs to equal who are actively supervised, at 100% of the physician’s reimbursement rate. (D)

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

FTE: Existing Staff
(Staff Effort to Complete Project)

Your reference committee heard substantial testimony with regard to the recommendations contained in the COL and CQMP report titled Reimbursement for Physician Oversight in Incident to Billing. Those testifying from the COL and CQMP indicated that the intent of this report was to address the need for continued recognition
by payers for the time and effort of physicians with regard to supervision of APNs and
PAs. Additionally, a member of the Committee for Sustainability of Private Practice
spoke to the importance of this report to those in private practice and mentioned the
need for reimbursement for time and effort around physician-led team care. Your
reference committee also heard testimony delivered by delegates who were very
concerned about “paying APNs like physicians”, overall scope of practice, and concerns
with regard to quality of care delivered by the APNs and PAs.

Your reference committee heard overall support for this report but also heard loud
opposition by those few who testified in opposition. Your reference committee discussed
in detail all points including those online and noted that there appeared to be confusion
about the intent of the recommendations, which was to preserve existing payments for
the supervision of APNs and PAs and thus suggested amending the language to
enhance specificity. Your reference committee felt that some modification to the
language would be beneficial to clarify the intent, which was to preserve payments, not
to expand or increase payments to APNs or PAs. Your reference committee felt that
some modification to the language would clarify that intent and as such, we recommend
adopting as amended.

House Vote: _______________________________
Mister speaker, your reference committee recommends that the recommendations contained in OMSS Report A-17 B-3 be adopted and the remainder of the report be filed.

1. That the MMS advocate for a transparent process, including opportunity for an appeal, within alternative payment models and Medicare Advantage to protect physicians from punitive consequences for patient referrals out of network when those referrals are made in order to provide optimal and timely care for patients. (D)

2. That MMS supports protecting the patient’s freedom to choose a physician and a health care delivery system, in order to preserve the patient-physician relationship. (HP)

Your reference committee heard testimony universally in support of the recommendations contained in this report. Testimony reflected the idea that the underlying issue is one of network adequacy and that, when a physician is a member of a narrow network, out-of-network referral to ensure patients receive adequate, timely, and appropriate care should not be penalized. Your committee therefore recommends adopting this report.

House Vote: _______________________________
Mister speaker, your reference committee recommends that the recommendation contained in OMSS Report A-17 B-4 be adopted and the remainder of the report be filed.

That the Massachusetts Medical Society adopt the following adapted from American Medical Association policy:

1. That the MMS continue its advocacy to expedite interoperability of electronic health record (EHR) systems, standardize key EHR elements, and engage the vendor community to promote improvements in EHR usability. (D)

2. That the MMS support evidence-based discharge criteria and principles regarding discharge planning, teamwork, communication, responsibility/accountability among attending physicians and continuing care providers, as well as the transfer of pertinent patient information and the discharge summary. (HP)

3. That the MMS advocate for timely and consistent communication between physicians in inpatient and outpatient care settings to decrease gaps in care coordination and improve quality and patient safety, and to explore new mechanisms to facilitate and incentivize this communication. (D)

4. That the MMS encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization. (HP)

5. That the MMS supports the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician’s narrative and recommendations for ongoing care. (HP)

6. That the MMS supports hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
   a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient’s needs, goals of care and treatment preferences.
   b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during
discharge planning. Particular attention is paid to the abilities and
limitations of patients and their families/caregivers.

c. Specific discharge instructions are provided to patients and families
or others responsible for providing continuing care both verbally
and in writing. Instructions are provided to patients in layman’s
terms, and whenever possible, using the patient’s preferred
language.

d. Key discharge instructions are highlighted for patients to maximize
compliance with the most critical orders.

e. Understanding of discharge instructions and post-discharge care,
including warning signs and symptoms to look for and when to seek
follow-up care, is confirmed with patients and their
families/caregiver(s) prior to discharge from the hospital.

(HP)

7. That the MMS supports making hospital discharge instructions available to
patients in both printed and electronic form, and specifically via online
portals accessible to patients and their designated caregivers. (HP)

8. That the MMS supports implementation of medication reconciliation as part
of the hospital discharge process. The following strategies are suggested
to optimize medication reconciliation and help ensure that patients take
medications correctly after they are discharged:
   a. All discharge medications, including prescribed and over-the-
      counter medications, should be reconciled with medications taken
      pre-hospitalization.
   b. An accurate list of medications, including those to be discontinued
      as well as medications to be taken after hospital discharge, and the
dosage and duration of each drug should be communicated to
patients.
   c. Medication instructions should be communicated to patients and
      their families/caregivers verbally and in writing.
   d. For patients with complex medication schedules, the involvement of
      physician-led multidisciplinary teams in medication reconciliation
      including, where feasible, pharmacists should be encouraged.

(HP)

9. That the MMS encourages patient follow-up in the early time period after
discharge as part of the hospital discharge process, particularly for
medically complex patients who are at high-risk of re-hospitalization. (HP)

10. That the MMS encourages hospitals to review early readmissions and
modify their discharge processes accordingly. (HP)

11. That the MMS work with the AMA to develop model guidelines for
physicians to improve communications to other physicians, hospital staff,
and patients; incorporate these guidelines into the MMS Model Medical
Staff Bylaws; and promote these guidelines to payers, hospitals, and
patients. (D)

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

(Staff Effort to Complete Project)

Your reference committee heard unanimous testimony in favor of the recommendations put forth in this report, which were adapted from the American Medical Association's policy and expanded. In addition, your reference committee heard testimony suggesting creation of a task force to develop a standardized uniform discharge summary. Your reference committee believed this would be best addressed by a separate resolution focused on the creation of a multi-stakeholder collaborative group. In light of the positive testimony, your reference committee recommends adopting this report.

House Vote: ________________________________
Mister speaker, your reference committee recommends that Resolution A-17 B-211 be referred to the Board of Trustees for report back at I-17.

1. RESOLVED, That the Massachusetts Medical Society coordinate and collaborate with the Massachusetts Chapter of the American College of Surgeons to promote the curriculum and continuing education/certification in the Stop the Bleed Program, developed by the American College of Surgeons to promote widespread population awareness and first-responder training for disaster and trauma events, throughout the Commonwealth of Massachusetts; and, be it further (D)

2. RESOLVED, That the Massachusetts Medical Society coordinate and collaborate with the Massachusetts Chapter of the American College of Surgeons, and other appropriate local and national partners to advocate to state and local government bodies, agencies, and departments for financial support (or to develop funding mechanisms) to provide training and dissemination/deployment of the necessary equipment for the Stop the Bleed Program (including bleeding kits/tourniquets/hemostatic gauze and dressings) to all pre-hospital providers and EMS systems/rigs, and hospital and health care systems and facilities, including funding to provide tourniquets and hemostatic gauze to those receiving instructor and basic provider training in the Commonwealth; and, be it further (D)

3. RESOLVED, That the Massachusetts Medical Society advocate to appropriate government agencies and departments to develop mechanisms to ensure and verify that existing sites with Emergency Medical Equipment (AED devices) are also equipped with bleeding kits/tourniquets/hemostatic gauze and dressings; and, be it further (D)

4. RESOLVED, That the Massachusetts Medical Society advocate to appropriate government agencies and departments to assess needs and to expand deployment of Emergency Medical Equipment (including AED and bleeding kits/tourniquets, hemostatic gauze and dressings) to additional sites and venues experiencing sustained or periodic high-concentrated populations (including but not limited to schools and colleges/universities, government and civic venues, sporting and entertainment complexes and events, large commercial and industrial centers, transportation hubs, etc.). (D)

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

FTE: Existing Staff
(Staff Effort to Complete Project)
Your reference committee received in-person and online testimony regarding this resolution, which seeks to have the MMS support and help to implement a bleeding control program in collaboration with the American College of Surgeons. Testimony generally favored disseminating information and providing training on how to treat bleeding trauma emergently, but there was some question regarding whether the Society should endorse or implement the ACS’s program. Although your reference committee agrees that training physicians and others to treat bleeding trauma is appropriate, it is not clear whether “Stop the Bleed,” “Bleeding Control,” or “Stop the Bleeding,” all of which are trademarks and service marks of different entities, would be the appropriate program—or whether there might be another program that is better. Your reference committee therefore recommends that this resolution be referred to the Board of Trustees for report back at I-17 so that greater clarity and direction can be provided.

House Vote: _________________________________
Mister speaker, your reference committee recommends that the recommendation contained in COL Report A-17 B-5 [A-16 B-203] be adopted and the remainder of the report be filed.

That the Massachusetts Medical Society adopt as amended Resolution A-16 B-203 to read as follows:

1. RESOLVED, That the MMS advocate for legislative and regulatory efforts to expand access to care for patients of Massachusetts licensed physicians, who wish to use telemedicine where appropriate to minimize the barriers to care for their patients and that can be delivered to the patient at home or wherever the patient may need care. (D)

2. RESOLVED, That the MMS advocate for continuing efforts to evaluate the efficacy, safety, and applicability of telemedicine. (D)

3. RESOLVED, that the MMS continue to advocate for parity in payment for telemedicine services that are equivalent to in-person services, when they are medically appropriate. (D)

Fiscal Note: No Significant Impact

Your reference committee heard mixed testimony, both online and in person, on the recommendations contained in this report back from the Committee on Legislation. There was general consensus that telemedicine could increase access to care, provide adequate care for some populations in some circumstances, and that it is time to make telemedicine a real possibility in the Commonwealth. Some testimony noted that some private payers already reimburse for telemedicine, but that the Commonwealth lags behind other jurisdictions because of overall lack of reimbursement. One testifier suggested that this report should acknowledge that medical care is best when provided at in-person, face-to-face interactions. After considering all testimony, your reference committee recommends that the recommendations contained in this report be adopted.
Mister speaker, your reference committee recommends that the recommendation contained in OMSS Report A-17 B-6 be adopted and the remainder of the report be filed.

That the Massachusetts Medical Society adopt the following adapted from American Medical Association policy.

1. That the MMS support whistleblower protections for physicians — particularly employed physicians — who raise questions of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity. *(HP)*

2. That the MMS advocate for whistleblower protections in medical staff bylaws and incorporate these protections in the MMS Model Medical Staff Bylaws. *(D)*

3. That the MMS advocate for medical staff bylaws to include a provision for the development of a “medical staff forum” with open meetings on at least a quarterly basis, so medical staff members can meet with the hospital or health system administration to discuss issues of quality, safety, and the efficacy of health care within their organization. *(D)*

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

(Out-of-Pocket Expenses)

FTE: Existing Staff

(Staff Effort to Complete Project)

Your reference committee heard unanimous testimony in support of this report. Testimony indicated that this is an important topic to address particularly for employed physicians who need support from the MMS through inclusion of language specific to employment contracts in the MMS’ Model Medical Staff Bylaws. Your reference committee considered the strong support of those testifying and recommends adopting this report.

House Vote: _______________________________
Mister speaker, your reference committee recommends that BOT Informational Report A-17-02 be filed.

Your reference committee heard limited testimony with regard to this item. The informational report was extracted from the consent calendar for the purpose of adding an amendment. However, the underlying report resulted from a referral at A-16 to the Board of Trustees for decision. The proposed amendment modifies the decision of the Board. Your reference committee heard limited testimony in favor of the additional amendment. In reviewing and discussing the proposed amendment, your reference committee felt that there was not enough testimony to justify this amendment. Therefore your reference committee recommends filing this informational report as written.
Mister speaker, your reference committee recommends that Late CQMP Informational Report A-17-31 be filed.

Your reference committee heard limited testimony in favor of the proposed recommendations created from the conclusions of the High Deductible Health Plan informational report. Some of the limited testimony indicated that the lengthy and last minute nature of the late file unfortunately did not allow for substantial review and discussion. The reference committee discussed the nature of the report and its importance and felt that there unfortunately was not enough of a compelling argument and not enough awareness or understanding about the extraction of the report to justify supporting the proposed recommendations. Therefore, your reference committee recommends filing this informational report as written.
Mister speaker, this concludes the report of Reference Committee B. My thanks to reference committee members Helen Cajigas, MD, Christopher Garofalo, MD, Steve Kasparian, MD, Mary Beth Miotto, MD, Mr. Maximilian Pany, and Renee Snow, MD; staff coordinators Kerry Ann Hayon, MHA, Yael Miller, MBA, Jillian Pedrotty, MHA, and Lisa Smith; legal counsel Liz Rover Bailey, Esq.; and all those who testified before the committee.

For the reference committee,

Aimie Zale, MD, Chair
### REFERENCE COMMITTEE C: MMS Administration

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**Adopted, HOD First Session, Speakers’ Consent Calendar**

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Item #: 1
Code: CSP Report A-17 C-1
Title: MMS Annual and Three-Year Strategic Plans
Sponsor: Committee on Strategic Planning
Henry Dorkin, MD, Chair

Referred to: Reference Committee C
Kathryn Hughes, MD, Chair

Recommendation:

Mister speaker, your reference committee recommends that the recommendations contained in CSP Report A-17 C-1 be adopted and the remainder of the report be filed.

1. That the Massachusetts Medical Society’s strategic priorities for Fiscal Year 2017–2018 are the following: a focus on physician and patient advocacy, membership value and engagement, governance, and communication. In order to advance the Society’s mission and prepare for the future needs of the physician community and their patients, the goals of our one-year strategic plan will be the following:

   - **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.

   - **Membership Value and Engagement:**
     - Ensure that the Society is positioned to meet the changing needs of its members.
     - Support members in developing the skills and knowledge they need to continue to be successful practitioners, leaders, and patient advocates in a changing health care environment.

     - Create opportunities to grow, diversify, and engage membership across all physician demographic segments and practice settings.

     - Enhance member engagement through innovative education, support, mentoring, and networking opportunities.

   - **Governance:**
     - Ensure that the Society stays relevant and is structured to maximize membership growth, diversity, and engagement.
Look for ways to create meaningful local and remote participation and promote physician engagement and leadership opportunities.

Communication:
- Ensure two-way communication that fulfills the needs of our physician members, promotes the Society’s efforts and achievements, and positions the Society as a leadership voice in health care, working on behalf of all physicians and patients.
- Enhance engagement through social media, online channels, marketing, collaboration, support, mentoring, and networking.

2. The Massachusetts Medical Society’s strategic priorities for Fiscal Years 2017–2020 are rooted in the long-term objective of quality improvement and the effective control of health care costs, with a focus on sustainable health care delivery, practice viability, and preservation of professionalism. In order to advance the mission of the Society and prepare for the future needs of the physician community and their patients, the three-year strategic priorities are as follows:

- **Sustainable Health Care Delivery:** Play a leadership role in developing a sustainable model of health care delivery by promoting the integration of public health, behavioral health, and the social determinants of health across physician practices; engage physicians and patients in end-of-life and aging patient care issues; develop resources and tools on marijuana and opioid use, misuse, dependence, and abuse; and promote physician-led care teams in support of improved patient care and outcomes.

- **Practice Viability:** Advocate for practice viability and physician professionalism, including the fair practice of clinical and economic integration, appropriately funded mandates, professional liability reform, a sustainable physician workforce, and an optimal practice environment, which, among other things, combats physician burnout.

- **Preservation of Professionalism:** Advocate for health care settings that foster a culture of professionalism to ensure patient-centered, physician-led care teams; promote a sense of community, professional satisfaction, and meaning through physician wellness, education, training, support, mentoring, and networking opportunities.

(HP)

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

FTE: Existing Staff (Staff Effort to Complete Project)

Your reference committee recommends adoption of this report. Testimony in support of the report noted that the report is a result of extensive consideration by committees of the medical society and its officers.

House Vote: _______________________________
Mister speaker, your reference committee recommends that the recommendation contained in OFFICER Report A-17 C-2 (SECTION A) be adopted and the remainder of the report be filed.

A. That the MMS reaffirm for seven (7) years the following policies eligible for sunsetting:

ALLIED HEALTH PROFESSIONS AND SERVICES

1a. OB/GYNs and Certified Nurse-Midwives
The Massachusetts Medical Society (MMS) adopts the following statement regarding relationships between obstetrician-gynecologists and certified nurse-midwives*:

The MMS recognizes that in those circumstances in which obstetrician-gynecologists and certified nurse-midwives work together in the care of women, the quality of those practices is enhanced by a working relationship characterized by mutual respect and trust as well as professional responsibility and accountability. When obstetrician-gynecologists and certified nurse-midwives work together, they should concur on a clear mechanism for consultation, management, and referral based on the individual needs of each patient.

Recognizing the high level of responsibility that obstetrician-gynecologists and certified nurse-midwives assume when providing care to women, the MMS supports and encourages communication and collegial relationships between physicians and certified nurse-midwives. (HP)

*Certified nurse-midwives are registered nurses who have graduated from a midwifery education program accredited by the American College of Nurse Midwives (ACNM) Division of Accreditation and have passed a national certification examination administered by the ACNM Certification Council, Inc.

MMS House of Delegates, 11/8/03
Reaffirmed MMS House of Delegates, 5/15/10

2a. Scope of Practice
The MMS only supports an entity’s attempt to increase its scope of practice if: (1) the entity has proven a clear and distinctly identifiable public purpose and benefit, and; (2) has proposed legislation that addresses appropriate supervision, meaningful educational requirements, public protections, and practice standards. (HP)

MMS House of Delegates, 5/14/10
CHILDREN AND YOUTH
3a. Special Health Care Needs
The Massachusetts Medical Society (MMS) agrees with the definition of a medical home as care that is accessible, comprehensive, continuous, coordinated, family-centered, compassionate, culturally-competent, and in which the primary care physician shares responsibility for the patient’s health and well-being with other participants involved in providing care. (HP)

The MMS supports the concept that children with special health care needs should receive care that is accessible, comprehensive, continuous, coordinated, family-centered, compassionate, culturally-competent, and in which the primary care physician shares responsibility. (HP)

The MMS encourage both primary and specialty care physicians involved in caring for children with special health care needs to become familiar with the medical home concept and to work within their practices and their specialty societies to incorporate this concept. (HP)

MMS House of Delegates, 11/8/03
Reaffirmed and Items 1 and 2 Amended MMS House of Delegates, 5/14/10

COMMUNICATION
4a. Health Insurance Companies
That the Massachusetts Medical Society file legislation prohibiting representatives of health insurance companies from initiating communications with patients and their families regarding treatment options and code status. (D)

MMS House of Delegates, 5/14/10

DRUGS AND PRESCRIPTIONS
5a. Biosimilar Medications
The MMS endorses the following AMA policies:

D-125.989 Substitution of Biosimilar Medicines and Related Medical Products.

Our AMA will: (1) monitor legislative and regulatory proposals to establish a pathway to approve follow-on biological products and analyze these proposals to ensure that physicians retain the authority to select the specific products their patients will receive; and (2) work with the U.S. Food and Drug Administration and other scientific and clinical organizations to ensure that any legislation that establishes an approval pathway for follow-on biological products prohibits the automatic substitution of biosimilar medicines without the consent of the patient’s treating physician. (Res. 918, I-08)

(HP)

H-125.980 FOLLOW-ON BIOLOGIC MEDICATIONS.
AMA policy is that pharmaceutical companies should be allowed to make follow-on biologic medications available to physicians and their patients in a reasonable period of time with a reasonably predictable pathway to bring them to market, and our AMA will advocate for enactment of federal law that would establish a pathway for follow-on biologic medications to be allowed on the market, with two guiding principles: 1) a reasonable time frame for US Food and Drug Administration exclusivity and patent expiration with a straightforward regulatory process for
follow-on biologic competitors to be brought to market, and 2) the protection of patient safety in both the original branded products and all follow-on products that are brought to market. (Res. 220, A-09) (HP)

The MMS and AMA will work with the FDA and any other relevant regulatory bodies that are responsible for assessing variance in bioequivalency and bioavailability of generic products and branded products so that the MMS and AMA are able to provide policy recommendations. (D)

MMS House of Delegates, 12/5/10

6a. Prescription Prices
The Massachusetts Medical Society supports legislation to create a voluntary negotiated price reduction program with pharmaceutical companies that lowers prescription drug prices in order to make them affordable for the citizens of the Commonwealth of Massachusetts.

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

ENVIROMENTAL HEALTH

7a. Air Quality
The Massachusetts Medical Society supports minimization of brush burning adjacent to smoke sensitive sites such as schools, hospitals and long-term care facilities.

The Massachusetts Medical Society encourages consumer awareness of nonburning alternatives for the disposal of residential brush and green waste.

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

8a. Chemical/Environmental Exposures
The MMS recommends that physicians, as part of routine clinical practice, take an environmental history of patients to understand whether they may be exposed to potential toxic exposures in the home, workplace, or environment. (HP)

The MMS finds that there is currently insufficient science about the causes of — or treatments for — the constellation of symptoms referred to as “chemical sensitivity” (also known as “multiple chemical sensitivity” or “idiopathic environmental illness”) to support any treatment modalities for these symptoms. (HP)

That, if and when there is a body of peer-reviewed, evidence-based, scientific literature, that more clearly defines the syndrome known as multiple chemical sensitivity, the sequelae of acute exposures, and other related phenomena, that subsequent continuing medical education that the MMS may sponsor be based on scientific investigation and confirmation. (HP)

MMS House of Delegates, 5/14/10

ETHICS

9a. Medical Ethics
The Massachusetts Medical Society supports the embodiment of the Massachusetts Medical Society Code of Ethics, as amended from time to time, within the Medical Staff Bylaws of all Massachusetts hospitals, clinics, and other health care facilities structured by such internal governance. (HP)
HEALTH CARE DELIVERY

10a. Accountable Care Organizations
The MMS will advocate that the Commonwealth of Massachusetts develop a plan with the MMS for Aliens with Special Status (legal aliens) to maintain their relationships with their current physicians. (D)  

MMS House of Delegates, 5/14/10

11a. Complementary and Alternative Medicine
The Massachusetts Medical Society (MMS) encourages physicians to become better informed regarding the practices and techniques of Complementary and Alternative Medicine (CAM) so they may be better able to discuss, when appropriate, the benefits and risks of such practices. This may include relevant patient safety issues related to possible interactions between CAM and traditional treatments, as well as matters of professional liability regarding informed consent, standards of care, and referrals to CAM providers.

The MMS recommends that courses on CAM offered by medical schools include a scientific analysis of the potential therapeutic utility, safety, and efficacy of these modalities.

The MMS endorses the AMA policies on CAM including support of the research efforts of the National Institutes of Health’s National Center for Complementary and Alternative Medicine.

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

HEALTH INSURANCE/MANAGED CARE PLANS

12a. Administrative Costs
The Massachusetts Medical Society believes that, unless otherwise required by law, physicians should be paid a reasonable fee for the preparation of reports, copying, and postage when asked to provide information to third parties.

Physicians shall continue to comply with the requirement to provide copies of medical records to the patient according to state law.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

13a. Financial Incentives
It shall be the policy of the MMS that health plans should not establish financial incentives or quotas that interfere with clinical judgment such as limiting diagnostic tests, services, referrals, or access to care.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

14a. Managed Care Resources & Education
The Massachusetts Medical Society will review existing state statutes, state regulations and policies concerning timely payment by third party payers, disseminate this
information to the membership and, where appropriate, file legislation to enhance timely payment of claims including the provision of penalties and interest.

**MMS House of Delegates, 5/3/96**

**Reaffirmed MMS House of Delegates, 5/2/03**

**Reaffirmed MMS House of Delegates, 5/14/10**

**HEALTH SYSTEM REFORM**

15a. Health Care Costs

The MMS adopts principles for spending of finite health care dollars that include, but are not limited to, the following:

1. Recommendations about how best to spend limited health care dollars should be made based on the best available evidence regarding cost-effective application of resources as reviewed by a committee of representative physicians, residents of Massachusetts, and others with the expertise necessary to make these recommendations.

2. The committee's recommendations should be free from any financial conflict of interest or political influence.

3. The plan for development of recommendations must include a robust feedback process that includes frequent review of all guidelines and a timely, individual grievance process.

4. All deliberations of the committee reviewing and developing the recommendations should be transparent and open to public scrutiny.

5. In order to promote physicians' adoption of guideline recommendations designed to minimize defensive medicine, maintain quality, and reduce health care costs, malpractice reform is necessary.

**MMS House of Delegates, 12/4/10**

16a. Universal Access

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)*

**HEALTH WORKFORCE**

17a. The Massachusetts Medical Society (MMS) will continue to monitor physician workforce issues through primary and secondary research, including working with health care leaders, as appropriate.

**MMS House of Delegates, 5/2/03**

**Reaffirmed MMS House of Delegates, 5/14/10**

*(Items 2 and 3 of Original: Sunset)*
18a. MMS will advocate, as soon as is fiscally prudent, for fully funding efforts aimed at encouraging the entry and retention of more primary care physicians in the Commonwealth, such as programs to address the high cost of living in Massachusetts and various other incentives for primary care physicians.

MMS House of Delegates, 5/14/10

HOSPITALS

19a. Hospitalists
The Massachusetts Medical Society endorses the following principles developed by the American Medical Association, American Hospital Association, the Joint Commission, the Centers for Medicare and Medicaid Services, and the Society of Hospital Medicine:

Principles for a Sustainable and Successful Hospitalist Program

Vision
1. Seek to involve and address the needs of all key stakeholders in designing and implementing a hospitalist program. These stakeholders include patients, the medical staff, other clinical professionals, hospital administration, and the hospitalists.

- Patients: A hospitalist program introduces a new “player” into the healthcare system. Patients expect to have their primary care physician (PCP) treating them when they are admitted to the hospital. As such, it is important that all parties (the PCP, the hospital, and the hospitalist) develop communication programs that explain the hospitalist model. Brochures and newsletters are tools that can be used to improve communications. Also, it is important to measure patient satisfaction. When evaluating patient satisfaction with hospitalists, recognize that there are factors that can negatively impact these ratings — specifically, the likelihood that the patients have been admitted through the emergency department and they are expecting care from their PCPs.

- Medical Staff: Hospitalist programs can provide a significant service to other physicians at the hospital. Specifically, 1) PCPs may not want to do emergency call at the hospital; 2) PCPs may decide that doing inpatient care is not cost effective and/or it disrupts their office-based practice; 3) surgeons and specialists may seek hospitalist support in handling more routine inpatient care and/or in co-managing their patients; and 4) emergency physicians and hospitalists have to work together to treat and admit patients. As such, it can be helpful to involve the medical staff in the design, implementation, and review of the hospitalist program. A “Hospitalist Advisory Committee” may be a useful vehicle for addressing these issues. A hospitalist program may want to implement satisfaction surveys, to determine how the hospitalists are perceived by other members of the medical staff. Also, hospitalists should be involved in medical staff activities and in its leadership.

- Other Clinical Professionals: The care and treatment of medical inpatients requires coordination among all of the clinical professionals in the hospital — nurses, case managers, social workers, physical therapists, etc. These professionals also can play a role in the development and implementation of a hospitalist program. If nurse turnover is an issue at the hospital, hospitalists may play a role in addressing nurse satisfaction.

- Hospital Administration: Hospital administrators often define the goals and provide the financial support for hospitalist programs. By definition, they will play a key role in designing and monitoring the hospitalist program.
• Hospitalists: Hospitalists need to be treated as professional colleagues and as equal, legitimate members of the medical staff, not as contractors hired to do the work that other physicians do not want to do. A successful hospitalist program will acknowledge the importance of physician satisfaction and the risks and dangers to the program of the potential burnout of hospitalists.

NOTE: In developing and implementing the goals of the hospitalist program, a balance must be sought among the interests of the various stakeholders. Issues may arise if it appears that the interests of one group of stakeholders (i.e., the hospital administrators, the medical staff, other clinical staff, the hospitalists) is overemphasized.

2. Promote a hospitalist model that focuses on team-based inpatient care. The delivery of inpatient medical care often suffers from coordination problems. During the hospital stay, patients and their family members may have to sort through information, diagnoses, and treatments from an attending physician, consulting specialists, nurses, residents, therapists, social workers, case managers and others. Effective inpatient care is a “team sport.” Since hospitalists spend virtually all of their time in the hospital, there is a unique opportunity for hospitalists and other clinical professionals to develop shared goals, mutual respect, and improved communication. A team-based model of inpatient care can result in superior coordination of care and patient outcomes.

3. Recognize the potential of hospitalists to help address vital strategic issues for the hospital. These concerns include financial pressures; staffing shortages and dissatisfaction; quality and patient safety; new technologies; employer and consumer demands for performance metrics; capacity constraints; and increased competition. Many physicians are no longer able or willing to serve on hospital committees or play a leadership role for the medical staff. Hospitalists have the potential to step in and help address these key issues for the following reasons:

• Hospitalists spend the majority of their time in the inpatient environment, making them familiar with hospital systems, policies, services, departments, and staff.

• Hospitalists are inpatient experts who possess clinical credibility when addressing key issues regarding the inpatient environment.

• Many hospitalists are hospital employees who can understand the tradeoffs involved in balancing the needs of the institution with those of the medical staff, the referral sources, and the patients. Even hospitalists who are not employed by the hospital have an intimate knowledge of the issues that the hospital is facing and are invested in finding solutions to these problems.

4. Anticipate the ongoing evolution in the scope of hospitalist practice. As hospitalist programs mature within their organizations, often the hospital leadership and medical staff seek to expand the role and responsibilities of hospitalists. All hospitalists should be prepared for an evolving set of responsibilities that may expand beyond the traditional scope of their training background. If hospitalists agree to assume broader responsibilities, they may need to acquire additional skills and expertise. That being said, the hospital leadership and medical staff should be careful not to overburden the hospitalists or mandate new responsibilities for the hospitalists.
balance must be sought that addresses a reasonable workload, the skills of the
hospitalists, and the needs of the institution.

Organization/Structure
5. Choose a hospitalist leader with the right skills and experience. Selecting the right
leader is fundamental to a successful hospitalist practice. These individuals are hard
to find. They must be excellent clinically and have superb communications skills.

6. Although they need to be assertive, they must also be good listeners. Political skills
are essential to navigate medical staff, departmental, and administrative issues. An
understanding of and appreciation for practice economics will help to ensure that
revenue is optimized and benefits to the financial supporters of the program are
tracked.

7. Build structure and incentives with the goal of creating an “ownership” mentality for
hospitalists in the practice. Hospitalists need to think of themselves as owners of
their practice, even if they are employees or contractors of a hospital or
multispecialty clinic. An employee or “shift” mentality may lead to hospitalists
unwilling to step in to help out other physicians (both hospitalists and non-
hospitalists) or to stay until the work is done. They may feel like it is someone else’s
problem to address the financial status of the hospitalist program. There are many
ways that a hospitalist program can create this sense of ownership, but perhaps the
most effective is to implement a compensation system that rewards performance,
including productivity and clinical quality. The goal of the compensation model and
incentives should be to connect physician incomes with the economic health and/or
clinical quality of the practice. Ongoing training and education with regular audits for
proper documentation, billing, and coding are essential to maximizing reimbursement
for the work that has been done and to maintaining fiscal viability of any program.
Physicians who are in a hospital employee or “guaranteed salary” practice model
may be particularly vulnerable to neglecting proper billing and coding since this
might not affect their individual income, but this has tremendous impact on the
financial health of both the program and the hospital.

8. Assure that the hospitalist practice has the necessary tools and support to achieve
their objectives: Like any physician practice, a hospitalist program needs adequate
administrative support to help with billing, performance reporting, tracking patient
census and volumes, information exchange with PCPs, etc. The practice may want to
consider purchasing one of the hospitalist software products available in the
marketplace. Also, hospital administration should assure that the hospitalists have
access to other hospital departments such as information systems, finance, and
utilization reporting. Finally, the medical director of the hospitalist program needs
sufficient non-clinical time to address administrative and leadership issues.

Relationships/Communications
9. Use of hospitalist program should be optional for referring physicians and should
never be mandated, especially not by hospital administration or by third party payers.
Success of a hospitalist program requires the support and “buy-in” of all of the
stakeholders involved in its use, particularly the referring physicians and the patients.
Under no circumstances should a PCP be required to refer patients to a hospitalist
program in lieu of caring for that patient him/herself. Likewise, no third-party payors
should require patients be followed by a hospitalist rather than their PCPs they have
chosen, unless the PCP is not contracted with the payor or the facility. PCPs may
choose to forgo rounding on their own hospitalized patients and this, in turn, may
require those patients to see a different physician, but those patients could usually
then choose a different physician that still makes rounds if this is their preference.

10. Develop a process for identifying, addressing, and resolving issues between
hospitalists and the medical staff. Whenever a hospitalist program is introduced at a
hospital, a range of new “practice” issues arise with the medical staff. Examples
include: 1) the roles of the hospitalist and the emergency physician; 2) the role of the
hospitalist in providing emergency department call; 3) the responsibilities of the
hospitalist and the surgeon when co-managing a patient; 4) the responsibilities of the
hospitalist and the medical specialist when co-managing a patient; 5) the availability
of specialists for consultations; 6) the hospitalist’s choice of consultants; and 7) the
timeliness of hospitalist communications to PCPs; etc. Physician leadership at the
hospital (e.g., a Chief Medical Officer or Vice President – Medical Affairs) can play a
vital role in identifying and resolving these issues. Some hospitals have used a
“Hospitalist Advisory Committee” to address the issues.

11. Assure hospitalists and community physicians share accountability for the patient
and the exchange of patient information in a timely manner. Community physicians
(typically PCPs) refer their patients to hospitalists for inpatient care. This creates a
discontinuity of care and both parties must assume a level of accountability. At
admission, the PCP must be sure that the hospitalist receives all information need to
treat the patient. At discharge, the hospitalist must dictate discharge notes which
should be transcribed and transmitted to the referring doctor on a “stat” basis. It is at
these “transitions of care” that there are risks to the patient. Both parties must be
diligent to assure that key information (medications, test results, follow up
requirements, etc.) is transmitted and acted upon in a clear and timely fashion. During
the hospitalization, the hospitalist needs to communicate to the PCP if there are
significant changes in the patient’s condition; the PCP should be accessible if any
new issues arise that may require further input or information.

12. Establish regular communication and dialog between the hospital leadership and the
hospitalist program. Hospital leadership needs to review the performance of the
hospitalist program to assure that the objectives are being met. The hospitalists need
access to hospital administrators and medical staff leaders to address obstacles or
barriers to their performance. In successful hospitalist programs, there are periodic
meetings between the two parties at which these topics are discussed and action
plans are developed for moving forward.

Operations/Management

13. Design a flexible schedule for the hospitalists that recognizes competing priorities
and demands. A hospitalist’s schedule should take into account the following
variables:
• Patient-hospitalist continuity over the course of the hospital stay. Ideally, a patient
should see the same hospitalist throughout his or her hospital stay. This is likely
to improve patient satisfaction, reduce errors, and increase hospitalist efficiency.
• The bimodal distribution in work over the course of the day. A typical day for a
hospitalist practice follows this pattern: 1) it is very busy with rounds on existing
patients from early in the morning until sometime in the early afternoon; 2) then it
is relatively quiet in the early afternoon; 3) finally it gets busy again with
admissions from late afternoon until about 10 p.m. to midnight.
• Sustainable physician lifestyle. Is the group’s schedule one that a doctor could
work for many years? Or do problems arise such as regular night work leading to
sleep deprivation or working too few days annually so that each worked day
requires a very high patient load? Does the schedule protect extended “block time
off” but trade this for working too many days consecutively so that physicians are
exhausted by the end of the “long stretch?”
• Reasonable provision for night work. Once a hospitalist group is admitting six to
eight patients per day, the program should consider a separate night shift staffed
by a doctor who has no daytime responsibility the day before or after. Ideally, the
practice should have one or more dedicated “nocturnists” who work only at night,
while the remaining doctors in the group work only during the daytime.
• Adaptability and scalability. Every group should think about how their schedule
might change if/when patient volume grows and one or more doctors are added.
Growth will often require changing the schedule significantly, rather than just
adding new doctors into the existing scheduling rotation.

14. Staff the hospitalist program in a way that recognizes the potential for growth, the
daily variations in patient volume, and the hospitalists’ responsibilities: A significant
problem encountered by many hospitalist programs is patient volume growth that
occurs more quickly than anticipated. Recruiting lead times for hospitalists are long
and physician turnover is common. A frequent cause of hospitalist practice crisis or
failure is an overwhelmed hospitalist team. A hospitalist program should staff in a
way that appropriately anticipates growth in patient volume.

From day-to-day, there are significant variations in the volume of patients
demanding care from hospitalists. Hospitalist staffing needs to recognize this
variation. A cap on patient volume for individual hospitalists in the practice can be a
useful tactic. Specifically, when one doctor reaches the cap in patients, other
hospitalists help out. Finally, as previously described, hospitalists often have broad
non-patient care responsibilities within the hospital — leading projects, staffing
committees, etc. The hospitalist staffing model must provide sufficient “protected
time” for these activities.

15. Track and report hospitalist performance measures against goals: In conjunction with
the hospital and the medical staff, the hospitalist practice should establish
performance goals and metrics. By tracking performance against these measures,
variations can be picked up earlier in the process and corrective actions introduced.
The program should generate periodic performance reports on parameters such as
clinical quality, resource utilization, practice economics, physician productivity, and
satisfaction (of patients, referring physicians, nurses, and hospitalists). These
performance reports should be shared with the hospitalists in the practice and other stakeholders (e.g. hospital quality program) as appropriate.

16. Focus on effective revenue cycle management for the hospitalist program through systems, training, and reporting. Unless patient encounters are coded properly, billed accurately and promptly, and collected fully, the hospitalist practice will experience significant deficits and/or require excessive levels of subsidization. Hospital billing departments may not be familiar with the role of hospitalists. In those situations, seek out a vendor that has experience in the hospitalist field and check its references.

17. Make sure it has integrated a compliance program into the coding and billing process and has the ability to provide complete activity and trend reports.

Poor coding, especially under-coding, is a common problem among hospitalist programs. This is especially true for programs that have not implemented production based incentives. Educating the doctors in coding and undertaking regular audits of their performance is worth the effort and expense. It can lead to significant additional revenue to the hospitalist practice, potentially reducing the amount of financial support required from the hospital or medical group.

(HP)

MMS House of Delegates, 5/14/10

20a. Uniform Standards for Non-Profits and For-Profits

The Massachusetts Medical Society supports the concept that all for-profit hospitals or health care delivery systems be held to the same standards as not-for-profit hospitals or health care delivery systems in providing free care, support for medical education and research, and commitment to the needs of their respective communities.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

LEGAL MEDICINE

21a. Due Process

The Massachusetts Medical Society will frame and support legislation to prohibit insurance companies from making material changes in existing signed agreements with physicians, particularly those changes that are deleterious to patients’ interests, without giving prior written notification and a reasonable opportunity for ‘meaningful’ negotiations with individual physicians or their designees.

The Massachusetts Medical Society will frame and support legislation to require insurance companies to submit any disputes with physicians over material changes in existing provider contracts, particularly those changes that are deleterious to patients interests, to binding arbitration, if challenged.

The Massachusetts Medical Society encourages insurance and managed-care companies to negotiate contracts with physicians in fairness and good faith, without open-ended clauses and unilateral rights to amend.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
22a. Conflicts of Interest Policy
The Massachusetts Medical Society (MMS) Policy Statement on Conflicts of Interest states:

**POLICY STATEMENT ON CONFLICTS OF INTEREST**

MMS delegates, trustees, officers, committee members, and agents assume a fiduciary duty to act in the best interests of MMS, as well as in accordance with applicable state and federal laws and regulations. A conflict of interest occurs when a delegate, trustee, officer, committee member, or agent has a material financial or beneficial interest which is likely to affect decisions made by or on behalf of MMS, or participates in other activities which significantly may impair the objectivity of or inappropriately influence the delegate’s, trustee’s, officer’s, committee member’s, or agent’s decisions or actions on MMS matters.

It shall be the policy of MMS that its delegates, trustees, officers, committee members, and agents shall either abstain from participation in such MMS decisions or activities or shall make full disclosure of conflicts or potential conflicts of interest. Such disclosure shall be to the Board of Trustees in accordance with procedures which the Board shall from time to time adopt.

MMS Officers, during their term of office and for two years thereafter, shall not assume any administrative position with an organization for which MMS appoints, elects, or nominates officers and/or directors without the approval of the Board of Trustees.

The Board of Trustees procedures pertaining to conflicts of interest shall be implemented in a manner which is intended to be legally enforceable. Questions regarding application of this policy and the Board’s procedures shall be resolved by the Committee on Administration and Management.

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

23a. House of Delegates
The Finance Committee of the Massachusetts Medical Society will review all regularly submitted and late resolutions that have a fiscal note of $5,000 or greater and make a recommendation as to the fiscal impact of each resolution to the House of Delegates.

MMS House of Delegates, 11/8/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

24a. That whenever possible, fiscal notes will be amended to reflect the recommendations of a reference committee in its report to the House of Delegates.

MMS House of Delegates, 11/8/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

25a. Physician Health Services
The House of Delegates votes to increase the Board of Trustees’ role as sole voting member with respect to Physician Health Services, Inc.

The House of Delegates votes to delegate to the Board of Trustees the authority to act for and on behalf of the Massachusetts Medical Society in its capacity as sole voting member of Physician Health Services, Inc., in all matters which, by law, the Articles of
Organization of Physician Health Services, Inc., or the bylaws thereof require action by
the sole voting member, including, but not limited to amendment of the said Articles or
bylaws, except that such delegation of authority shall not be construed as extending any
power which the House of Delegates is prohibited from delegating and provided that the
actions of the Board of Trustees in this capacity as sole voting member shall be reported
to the House of Delegates.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

26a. Sections
The Massachusetts Medical Society will reimburse medical student and resident
members a reasonable amount for travel that pertains to official Massachusetts Medical
Society business, particularly for travel to and from committee meetings (and the like) of
which the student or resident is a member.
The medical student and resident reimbursement for travel be an appropriate amount for
miles traveled, tolls, and (reasonable) parking fees.
Medical student and resident reimbursement for travel not imply indemnification for
motor vehicle accidents.
The Board of Trustees shall be charged with the establishment of criteria for medical
student and resident reimbursement of travel.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

27a. Strategic Direction
The MMS approves the Framework for Strategic Planning as presented in Chart 2:
Massachusetts Medical Society
Framework for MMS Strategic Planning

MMS Planning Process – Every 3 Years

1. Review MMS Mission and Values
2. Articulate 3 Year Strategic Direction for MMS
3. Submit MMS Strategic Direction to HOD

Annual Strategic Planning Process

1. Committee:
   a. Assess External/Internal Environmental Forces
   b. Assess Member & key constituent concerns
   c. Assess effectiveness of programs/services
2. Prepare Update of MMS Annual Strategic Objectives/Priorities: Present to Board of Trustees
3. Report Annual Strategic Objectives/Priorities to HOD at Annual Meeting
4. Committee assists with prioritization

MMS House of Delegates, 5/31/02
Framework Amended MMS House of Delegates, 5/2/03
(Chart 1 of Original: Sunset)
Amended MMS House of Delegates, 5/14/10
28a. Unfunded/Partially-Funded Resolutions/Reports

The MMS Board of Trustees or its designated agents will develop an informational report that would be presented at each House of Delegates meeting that:

a. Those reports and resolutions that thus far are not funded or partially so
b. Stands alone as a report with an appropriate title, which is not to be contained within a more lengthy report (e.g., the budget)
c. Updates prior such nonfunded or partially funded reports and resolutions
d. Supplies the links or hyperlinks to the entire verbiage of above-mentioned reports or resolutions to ensure the responsibility of the House of Delegates to restudy the appropriateness and support of these decisions
e. Includes the reasoning (financial, legislative, etc.) for this status and decision. (D)

MMS House of Delegates, 5/14/10

MEDICAID

29a. MassHealth Program

The Massachusetts Medical Society will work with the Massachusetts Division of Medical Assistance (MassHealth) to revisit the MassHealth drug list and prior authorization process so that patient well-being is not compromised. (D)

MMS House of Delegates, 11/8/03

MMS House of Delegates, 5/14/10

MEDICAL EDUCATION

30a. State-Funded Medical School

The Massachusetts Medical Society (MMS) recognizes the importance of having a state-funded medical school in Massachusetts to provide a high-quality, but lower-cost option for residents of the Commonwealth to obtain a medical education.

The MMS will express to the Governor and the Massachusetts Legislature the advantages of having a publicly-funded medical school to benefit the residents of the Commonwealth of Massachusetts.

The MMS strongly urges the Governor and the Massachusetts Legislature to maintain the University of Massachusetts Medical School’s status as a public institution supported in part by state funding.

MMS House of Delegates, 5/2/03

MMS House of Delegates, 5/14/10

PHYSICIAN PAYMENT

31a. Third-Party Insurers

The Massachusetts Medical Society (MMS) will advocate for laws, regulations, or directives for all insurance carriers, including Medicaid and Medicare, to pay for mandated services required by law or regulation. (D)

MMS House of Delegates, 11/8/03

Reaffirmed MMS House of Delegates, 5/14/10

PREAUTHORIZATIONS

32a. Office Practice Expenses

The MMS will sponsor legislation requiring insurance companies doing business in Massachusetts to reimburse reasonable physician office practice expenses related to physician processing of prior authorizations for medications and procedures which
require a medical decision/review by a physician or other licensed health professionals
under his/her supervision and/or liability coverage. (D)

MMS House of Delegates, 5/14/10

33a. Preauthorizations/Decision-Making
The MMS takes the position that decision-making regarding preauthorization of payment
for medically necessary services and treatment is the defacto practice of medicine, and
those involved in those reviews should be held liable for bad outcomes and in
malpractice actions stemming from delay and/or denial of care. (HP)

MMS House of Delegates, 12/4/10

PROFESSIONAL LIABILITY
34a. Tort Reform
The Massachusetts Medical Society will work diligently to assure that significant
changes in state payment methodology are associated with significant and meaningful
professional liability reforms. (D)

MMS House of Delegates, 5/14/10

PUBLIC HEALTH
35a. Gambling
The Massachusetts Medical Society will advocate and educate regarding the adverse
public health effects of gambling as a service to our legislators and other parties
interested in objective and factual data. (D)

MMS House of Delegates, 12/4/10

That if casino gambling were to move forward, then the MMS shall advocate for
dedicated revenues, at adequate funding levels, for the treatment of public health
problems (e.g., alcohol, substance abuse and gambling addictions) which may be
aggravated by the presence of casino gambling. (D)

MMS House of Delegates, 12/4/10

QUALITY OF CARE
36a. Sleep Medicine
The MMS supports continued delivery of high-quality care for patients with sleep
disorders in Massachusetts. (HP)
The MMS supports incorporation of new diagnostic tools and therapies to treat sleep
disorders utilizing evidence-based clinical guidelines and accreditation standards. (HP)
The MMS support the principle that management of chronic sleep disorders requires
programs that incorporate comprehensive sleep evaluations, access to appropriate
testing, evidence-based treatment protocols, and collaboration between primary care
providers and sleep specialists. (HP)

MMS House of Delegates, 12/4/10

REGULATION AND LICENSURE
37a. Board of Registration in Medicine
The Massachusetts Medical Society will work with the Board of Registration in Medicine
to establish limitations for accessing physicians’ medical and/or mental health treatment
records when they are irrelevant to the matter under investigation.
The Massachusetts Medical Society will encourage the Board of Registration in Medicine, when it is inquiring into the medical or mental health status of a licensee, to accept a treatment summary provided by the treating physician in lieu of accessing the licensee's medical or mental health records.

If negotiations with the Board of Registration in Medicine do not result in a satisfactory response, the Massachusetts Medical Society's Committee on Legislation will seek to secure a statutory privilege protecting physicians’ medical and/or mental health treatment records from access by the Board of Registration in Medicine, except and to the degree that the Board can establish a compelling need to access those portions relevant to a current investigation.

MMS House of Delegates, 11/8/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

SURGERY
38a. Ambulatory Surgery Centers
The Massachusetts Medical Society (MMS) supports the development and utilization of accredited freestanding ambulatory surgery centers as part of a multiplicity of patient care delivery options, including physician office practices and outpatient hospital care for the provision of ambulatory surgery services as a mechanism to control health care costs, ensure access to care, and provide quality patient care in the Commonwealth. (HP)

MMS House of Delegates, 11/8/03
Reaffirmed MMS House of Delegates, 5/14/10

39a. Outpatient Surgery
The Massachusetts Medical Society (MMS) will continue to collaborate with the Massachusetts Board of Registration in Medicine (BRM) regarding the endorsement of the MMS Office-Based Surgery Guidelines for surgery and anesthesia in the office-based setting.

The MMS reaffirms its existing policy adopted at I-01 that these practice guidelines are not intended to be unique or exclusive indicators of appropriate care. Any physician should be able to demonstrate that the care rendered is safe and appropriate, even if it may vary from the guidelines in some respects.

The MMS believes that surgical and anesthesia care, regardless of where performed or by whom, should be provided in accordance with accepted standards of practice and in a manner that insures the safety of the patient during the performance of surgery, administration of and recovery from anesthesia, and at the time of discharge from the facility.
The MMS will work to refine the guidelines for surgery and anesthesia in the office-based setting on an ongoing basis as needed and forward the revisions to the BRM for incorporation.

MMS House of Delegates, 5/31/02
(Items 2, 5, 7, and 8 of Original: Sunset)
Reaffirmed and Item 1 Amended MMS House of Delegates, 5/14/10

TOBACCO
40a. Point-of-Sale Tobacco Advertising
The MMS will work collaboratively with other organizations of similar interests to advocate for legislation in the Commonwealth to require tobacco vendors to remove tobacco products and all tobacco advertising from public view at cash registers and counters in all retail establishments, excluding shops that exclusively sell tobacco products. (D)

MMS House of Delegates, 12/4/10

41a. Smoking/Tobacco Policies
The Massachusetts Medical Society shall not undertake joint business ventures with tobacco companies or the tobacco industry or with business entities which provide significant professional representation or services to tobacco companies or the tobacco industry.

MMS House of Delegates, 5/3/96
Reaffirmed, MMS House of Delegates, 5/2/03
Reaffirmed, MMS House of Delegates, 5/14/10

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

FTE: Existing Staff
(Staff Effort to Complete Project)

Your reference committee heard testimony only in support of the report; therefore, adoption is recommended.

House Vote: ____________________________
Recommendation:

Mister speaker, your reference committee recommends that the recommendation contained in OFFICER Report A-17 C-2 (SECTON B) be adopted and the remainder of the report be filed.

B. That the MMS amend and reaffirm the following policies eligible for sunsetting (added text shown as “text” and deleted text shown as “text”):

ACCIDENT PREVENTION
1b. Safety Belts
The Massachusetts Medical Society shall advocate for functioning seat belts in all passenger seats in taxicabs and ride sharing services.

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

HEALTH CARE DELIVERY
2b. Telemedicine
The Massachusetts Medical Society, with other interested parties, including the American Medical Association, continue to encourage the Centers for Medicare and Medicaid Services of the Department of Health and Human Services and all other payors to reimburse physicians for telemedicine services beyond the rural and underserved areas.

MMS House of Delegates, 5/2/03
Amended MMS House of Delegates, 5/14/10

HEALTH SYSTEM REFORM
3b. Health Care Costs
The Massachusetts Medical Society (MMS) acknowledges the unsustainable escalation of health care costs. (HP)

The MMS will partner with other stakeholders to address system-wide mechanisms to control the forces responsible for the escalation in health care costs. These include among others:

a. improving the market structure for medical services through transparency of price and outcomes
b. encouraging the development of guidelines in diagnosis and treatment of conditions where evidence-based approaches are not yet available
c. suggesting insurance reform mechanisms to reduce consumer purchase of marginally-useful service, likely through higher copayment for such services

The MMS encourages a pluralistic compensation system to include fee-for-service, salary, capitation, and limited pilot studies that utilize global payments system. (D)

The MMS acknowledges that the fee-for-service system has positive value in the payment for medical services. (HP)

The MMS will continue its strong support for medical liability reform, and implementation of early resolution programs, to reduce the waste resulting from over utilization resulting from defensive medicine. (HP)

MMS House of Delegates, 5/14/10

4b. Ideal Payer System

The Massachusetts Medical Society (MMS) defines an ideal payer system and the definition encompasses goals that include:

- universal coverage of population;
- coverage of preexisting conditions;
- accessibility to everyone regardless of location or background;
- portability for all medically necessary services; and

The MMS definition of an ideal payer system encompasses comprehensive services that include:

- acute and chronic illness care;
- prevention of disease and disability by risk assessment and education to change behaviors that may lead to disease or injury, early disease detection and treatment: to prevent, diminish, compress, and delay its disablesments;
- rehabilitation of disabled persons: to improve their function for work and living;
- immunization;
- counseling and other behavior health support;
- unimpeded access to appropriate specialty and subspecialty care; and

The MMS definition of an ideal payer system encompasses qualities, that include:

- efficiency/cost-effectiveness;
- equity/fairness, convenience and satisfying;
- maximal patient and physician involvement and engagement, including, choice, mutual decision-making, and respect;
- use of appropriate technologies, scientifically assessed for the needs of patients;
- continuous improvement efforts for better health care;
- outcomes through: practitioner education, at the undergraduate, graduate, and continuing medical education levels;
- research;
- reorganization of processes of care;
- professional self-management, internal to the practice;
- voluntary participation of physicians and patients;
• maintain freedom of physicians to contract directly with their patients;
• individuals retain right to establish medical saving accounts and to
purchase catastrophic health insurance from insurer’s of their choice
• maintain freedom of entry into the health insurance market and attention
given and care delivery changes made based on outcome measurement
and patient and physician experience surveys; and

The MMS definition of an ideal payer system encompasses characteristics for
payment of services and insurance, that include:
• simplicity
  uniform administrative criteria for eligibility and billing,
  single forms,
  single open formulary;
• accountability;
• consistency in benefit coverage limitations related to scientific evidence
  and expert opinion;
• timeliness;
• responsiveness: correction of defects; and
• appropriate funding

MMS House of Delegates, 5/2/03

HOSPITALS
5b. Hospital/Organized Medical Staff
The Massachusetts Medical Society will establish supports policy stating that an
existing medical staff should have the right to reorganize and redefine its own
governance structure as appropriate. (HP)

The MMS will advocate for all properly licensed and hospital credentialed
physicians involved in patient care to be eligible for voice and vote in organized
medical staff self-governance. (D)

The MMS will establish supports policy that affirms that the medical staff, as a
principle of self-governance, should be a representative democracy where the
members personally participate with voice and vote in the decision-making and
election of their representatives. (HP)

MMS House of Delegates, 5/14/10

6b. The Massachusetts Medical Society will continue to work to bring about a
better understanding in and collaboration between hospitals and physicians.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Amended MMS House of Delegates, 5/14/10

MASSACHUSETTS MEDICAL SOCIETY ADMINISTRATION AND MANAGEMENT
7b. House of Delegates
The Massachusetts Medical Society will reimburse delegates attending a meeting
of the House of Delegates for the cost of their overnight accommodations for one
two nights, if needed.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
PUBLIC HEALTH

8b. Emergency Preparedness
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.
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.

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.

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

9b. Hand Washing
The Massachusetts Medical Society advocates hand washing as a simple, safe, effective method to prevent infectious disease for the general population, and in particular prior to eating and preparing food, and after using the bathroom.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

TOBACCO

10b. Anti-Smoking Poster Contest
The Massachusetts Medical Society and the Massachusetts Medical Society Alliance will establish sponsor an annual, statewide elementary school anti-smoking poster contest.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
(Item 2 of Original: Sunset)

VIOLENCE

11b. Evaluation and Prevention
The Massachusetts Medical Society (MMS) will continue to encourage all physicians to include routine and targeted inquiry across the lifespan screening for violence as part of their normal evaluation and prevention activities with patients.

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
(Items 2 and 3 of Original: Sunset)
Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

Your reference committee heard testimony only in support of the report; therefore, adoption is recommended.

House Vote: _______________________________
Mister speaker, your reference committee recommends that the recommendation contained in OFFICER Report A-17 C-2 (SECTION C) be adopted and the remainder of the report be filed.

C. That the MMS reaffirm for one year pending new policy recommendation the following policies eligible for sunsetting:

ADDITION

1c. Drug Addiction
The MMS will work with other appropriate public and private entities to increase access to services for opiate treatment.

The MMS will work with physicians, including those specializing in addictions, to develop ways to increase access to opiate treatment.

The MMS supports efforts to educate physicians about newly available treatment options for addicted patients in primary care and other settings and, in particular, encourage further education around the pharmacologic potential for improved treatment.

MMS House of Delegates, 5/2/03
Reaffirmed and Item 3 Amended MMS House of Delegates 5/14/10

CHILDREN AND YOUTH

2c. Bullying
The MMS will develop and offer cultural competency training for health care providers particularly directed toward those caring for adolescents and young adults in pediatric and family practices and university health care settings. Such training should provide tools to identify and assist at-risk adolescents and young adults with the aim of preventing self harm, suicide, and disability resulting from bullying. *(D)*

The MMS will work to foster more collaboration between health care providers and their local schools to assist educators in protecting their students from bullying by improving their physical and psychological wellness, self esteem, and respect for others. *(D)*
The MMS recognizes that bullying is a particular concern for lesbian, gay, bisexual, transgender youth, and those who are questioning their sexual orientation, and develop education and training for physicians and patients that particularly address the special health care needs of these patients. *(HP)*

* MMS House of Delegates, 12/4/10

**DRUGS AND PRESCRIPTIONS**

3c. Prescription Marketing
The Massachusetts Medical Society disapproves of the direct product specific advertising of prescription drugs to the public.

* MMS House of Delegates, 11/8/96
  Reaffirmed, MMS House of Delegates, 5/2/03
  Reaffirmed, MMS House of Delegates, 5/14/10

**ETHICS**

4c. Ethics and Managed Care
The Massachusetts Medical Society Policy Statement on Ethics and Managed Care states:

**Ethics and Managed Care**

*Preamble:*

The medical profession has long subscribed to a body of ethical standards. Initially developed for the benefit of the patient, ethical principles must also serve to guide the physician in his or her relationship with colleagues as well as other entities in the health care arena. Several relevant principles adopted by the American Medical Association and the Massachusetts Medical Society remain constant:

- A physician shall be dedicated to providing competent medical services with compassion and respect for human dignity, in a cost effective manner.
- A physician shall deal honestly with patients and colleagues.
- A physician shall respect the law and also recognize a responsibility to seek changes in those requirements that are contrary to the best interests of the patient.
- A physician shall make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- A physician shall, in the provision of appropriate patient care, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

Changes in the practice environment now require physicians to examine their professional relationships even more closely. The following principles are offered to reaffirm the primacy of the traditional physician-patient relationship and the standards of conduct between and among colleagues. They also seek to clarify appropriate conduct between physicians and health care organizations that challenge traditional models of medical practice.

**PHYSICIAN TO PATIENT RELATIONSHIP**

(1) Patient Advocacy Is Fundamental
The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interest of their patients first. (AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(2) Advocacy for Patient Benefit
Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for care they believe will materially benefit their patients. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care).

(3) Primacy of Patient Welfare over Physicians' Financial Interests
While physicians should be conscious of costs and not provide or prescribe unnecessary services, concern for the quality of care the patient receives should be the physician's first concern. Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity: Reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician's financial benefit is unethical. Similarly, to limit appropriate diagnostic tests, referrals, hospitalization, or treatment, for the physician's financial benefit is unethical. If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit. (Adapted from AMA CEJA Opinion 8.03 Conflicts of Interest: Guidelines, Adapted from AMA CEJA Opinion 2.09 Costs)

(4) Physician Participation in Allocation Process
Practicing physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create organizational structures that allow practicing physicians to have meaningful input into the plan's development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis, be evidence based whenever feasible, and updated to reflect advances in medical knowledge and changes in relative costs. (Adapted from AMA Policy 285.982: Ethical Issues in Managed Care; AMA CEJA Opinion 8.13 Managed Care Guidelines)

(5) Appeals from Denials of Care
Adequate and timely appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise...
when a health plan has an allocation guideline that is generally unfair in its 
operation. In such cases, the physician’s duty as patient advocate requires 
not only a challenge to any 
derials of treatment from the guideline but also advocacy at the health 
plan’s policy-making level to seek an elimination or modification of the 
guideline. (Adapted from AMA CEJA Opinion 8.13 Managed Care 
Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

A physician should be able to assist patients who wish to seek additional, 
appropriate care outside the plan when the physician believes the care is in 
the patient’s best interests. (Adapted from AMA CEJA Opinion 8.13 
Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed 
Care)

Disclosure of Financial Incentives to Patients by Plan and by Physician

Health Plans must disclose any financial inducements or contractual agreements 
that may tend to limit the diagnostic and therapeutic alternatives that are offered 
to patients or restrict referral or treatment options. Physicians must clearly and 
adequately respond to inquiries by patients regarding any financial incentives. 
The health plans must make adequate disclosure to patients enrolled in the plan 
at enrollment and annually thereafter. Physicians must also inform their patients 
of medically appropriate treatment options regardless of their cost or the extent of 
their coverage. (Adapted from MA Policy 285.998: Managed Care #4, Financial 
Incentives)

PHYSICIAN TO PHYSICIAN

(1) Negotiating Contracts between Physicians

Negotiating contracts between physicians in a health plan is ethical and 
appropriate only if the standard of care is the same for all patients and 
there is disclosure to the patients of the financial arrangements that may 
affect their care.

(2) Referrals to Specialists

Patients are entitled to all the benefits outlined in their insurance plan.
Therefore, it is unethical for a referring physician to restrict the referral 
options of patients who have chosen a plan that provides for access to an 
unlimited or broad selection of specialist physicians. It is also unethical to 
base the referral of these patients on a discount for the capitated patients 
in a primary care physician’s practice. Physicians should not be restricted 
from informing their patients of out-of-plan specialists, when their 
expertise may offer important advantages to the patient. (Adapted from 
AMA CEJA Opinion 8.052 Negotiating Discounts for Specialty Care; MMS 
Policy)

(3) Financial Inducements

Payment by or to a physician solely for the referral of a patient is fee 
splitting and is unethical. (AMA CEJA Opinion 6.02 Fee Splitting)

A physician may not accept payment of any kind, in any form, from any 
source, such as a pharmaceutical company or pharmacist, an optical 
company or the manufacturer of medical appliances and devices, for
prescribing or referring a patient to said source. (AMA CEJA Opinion 6.02
Fee Splitting)
These payments violate the requirement to deal honestly with patients and
colleagues. The patient relies upon the advice of the physician on matters
of referral. All referrals and prescriptions must be based on the skill and
quality of the physician to whom the patient has been referred or the
quality and efficacy of the drug or product prescribed. (Adapted from AMA
CEJA Opinion 6.02 Fee Splitting)

PHYSICIAN TO HEALTH CARE ORGANIZATION
(1) Non-participation in Unprofessional Care
Physicians should not participate in any organization that encourages or
requires care at below minimum professional standards, unless actively
involved in trying to change and improve the deficient standards. (Adapted
from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy
285.982: Ethical Issues in Managed Care)

Physicians who have administrative and/or executive responsibilities in
health care organizations should be knowledgeable about medical ethics
and should encourage the health care organization to make ethically
appropriate medical decisions. (Task Force on Ethical Standards in
Managed Care, MMS 1996)

(2) Incentives to Limit Care
Health plans should not establish financial incentives or quotas that
interfere with appropriate clinical management such as limiting diagnostic
tests, services, referrals, or access to care. (MMS Policy)

When physicians are employed or reimbursed by managed care plans that
offer financial incentives to limit care, serious potential conflicts are
created between the physicians’ personal financial interests and the needs
of their patients. Efforts to contain health care costs should not place
patient welfare at risk. Thus, financial incentives are permissible only if
they promote the cost-effective delivery of health care and not the
withholding of medically necessary care. (AMA Policy 285.982: Ethical
Issues in Managed Care; AMA CEJA Opinion 8.13 Managed Care
Guidelines)

Physician payments that provide an incentive to limit the utilization of
services should not link financial rewards with individual treatment
decisions over periods of time insufficient to identify patterns of care or
expose the physician to excessive financial risk for services provided by
physicians or institutions to whom he or she refers patients for diagnosis
or treatment. When risk sharing arrangements are relied upon to deter
excess utilization, physician incentive payments should be based on
performance of groups of physicians rather than individual physicians, and
should not be based on performance over short periods of time. (AMA
Policy 285.982: Ethical Issues in Managed Care; Adapted from AMA CEJA
Opinion 8.054 Financial Incentives and the Practice of Medicine)
The magnitude of fee withholds, bonuses and other financial incentives should not affect provision of appropriate care. (Adapted from AMA Policy 285.982: Ethical Issues in Managed Care; AMA CEJA Opinion 8.13 Managed Care Guidelines)

(3) Allocation Guidelines and Policy Making
Any broad allocation guidelines that restrict care and choices, which go beyond the cost/benefit judgments made by physicians as part of their normal professional responsibilities, should be established at a policy-making level so that individual physicians are not asked to engage in ad hoc bedside rationing. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for care they believe will materially benefit their patients. (Adapted from AMA CEJA Opinions 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(4) Physician Participation in Allocation Process
Practicing physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create organizational structures that allow practicing physicians to have meaningful input into the plan’s development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(5) Appeals from Denials of Care
Adequate and timely appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in denial of care that, in the physician’s judgment, would materially benefit the patient. In such cases, the physician’s duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise in which a health plan has an allocation guideline that is generally unfair in its operation. In such cases, the physician’s duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan’s policy-making level to seek an elimination or modification of the guideline. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

A physician should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient’s best interests. (AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)
Informed Consent and Plan Disclosure

Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that managed care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan and on annual re-enrollment. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

Full Disclosure to Patients

Physicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician’s obligation to disclose treatment alternatives to patients is not altered by a limitation in the coverage provided by the patient’s managed care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the managed care plan. Patients may then determine whether an appeal is appropriate, or whether they wish to seek care outside the plan for treatment alternatives that are not covered. (AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

Disclosure of Incentives to Patients, by Plan and by Physician

Health plans must disclose any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or restrict referral or treatment options. Physicians must clearly and adequately respond to inquiries by patients regarding any financial incentives. Health plans must make adequate disclosure to patients enrolled in the plan at enrollment and annually thereafter. Physicians must also inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage. (Adapted from AMA Policy 285.998: Managed Care)

Medical Judgments and Plan Administration

Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. In the operation of such plans, physicians should not be subjected to lay interference in professional medical matters and their primary responsibility should be to the patients they serve. Assuming a title or position that removes the physician from direct patient-physician relationships, such as the title of Medical Director, does not override professional ethical obligations. (AMA CEJA Opinion 8.05 Contractual Relationships, AMA CEJA Opinion 8.021 Ethical Obligations of Medical Directors.)

Physician Contracts and Plan Administration

Physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary, but should be aware of the potential for some types of systems to create conflicts of interest because of financial incentives to withhold medically indicated services. Physicians must not allow such financial incentives to
influence their judgment of appropriate therapeutic alternatives or deny their patient’s access to appropriate services based on such inducements.

(Adapted from AMA Policy 285.998: Managed Care)

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

PHYSICIANS

5c. Physician Call

1. The Massachusetts Medical Society adopts the following principles:

MMS On-Call Principles:
The MMS On-Call Principles apply to all physicians. These principles are separate and distinct from the formal regulations governing resident work hours that must be followed by hospitals for residency program accreditation by the Accreditation Council for Graduate Medical Education (ACGME).

1. The MMS opposes government regulation of physician work hours.
2. The MMS opposes uniform limits or any other consecutive time constraints, as these can compromise patient care and limit flexibility of scheduling within individual physician practices. Furthermore, the broad diversity of specialty practices indicates that a uniform or standardized approach to regulation of physician work hours would not be appropriate.
3. Physicians have an ethical duty to their patients and profession to provide safe, compassionate, quality medical care. These duties depend on a safe and healthy working environment for all physicians. To this end, clinical responsibilities must be organized in such a way as to prevent excessive patient care responsibilities, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation.
4. The individual physician can most appropriately determine whether the clinical schedule allows the physician to meet her/his ethical obligations to the patient.
5. There should be adequate backup if sudden, unexpected patient care needs create fatigue sufficient to jeopardize patient care during or following the on-call period. Institutions and other practice organizations should ensure that such backup is available if required. No institution or call system should require a physician to provide clinical care when the physician believes that she/he will not be able to meet her/his ethical obligations to the patient.
6. Health care delivery systems must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment.
7. As there are different duties defined by each specialty, guidelines for work-hour responsibilities should be made in consultation with each physician, given that responsibilities vary by setting, region, and...
specialty. In addition, what constitutes excessive fatigue and sleep deprivation will vary by physician.

8. Each specialty department should determine who among its members are required to serve on-call for the emergency department, subject to appropriate compensation to be determined at the local level. In making the determination for who is required to serve on-call, the specialty department may exempt from call service members above a certain age, or with a certain number of years service to the medical staff, or those serving in medical staff leadership positions. Other individual exemptions, for hardship, temporary disability, or other reasons may be granted by the chair on a case-by-case basis.

9. Physicians and hospitals should work collaboratively to develop solutions to on-call needs for emergency departments; adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage; the organization and function of on-call services should be determined through hospital policy and medical staff by-laws; and include methods for monitoring and assuring appropriate on-call performance.

10. It is in the best interests of patients when physicians practice in a fair, equitable, safe, healthy, and supportive environment.

(HP)

2. The MMS will explore working with the Massachusetts Hospital Association (MHA) to develop systems for on-call coverage. (D)

3. The MMS will explore other solutions to on-call coverage, including the development of a “surgicalist” or “acute care surgery” specialty, locum tenens, and assistance from larger medical centers for smaller hospitals. (D)

4. The MMS will advocate for malpractice reform to specifically address increased liability associated with emergency call coverage. (D)

MMS House of Delegates, 5/14/10

6c. Principles on Medical Professional Review of Physicians

The Massachusetts Medical Society adopts the following amended Principles #2, #10, and #27 policy and principles on Medical Professional Review of Physicians within Health Insurance Companies and Medical Professional Review of Physicians within Health Care Facilities.

These principles are separate from the model principles that apply to medical peer review of physicians for health care facilities. The following principles include an independent appeal and review process for disputed peer review outcomes by a health insurance company.

Massachusetts Medical Society Policy on Medical Professional Review of Physicians within Health Insurance Companies
Introduction:
Activities conducted by health insurance companies to evaluate the performance of physicians may or may not constitute “peer review” or “professional review activity” under Massachusetts or federal law, depending on whether or not such activities fall within the requisite statutory definitions. The MMS believes that all such activities, however, should follow a fair, evidence-based, ethical, and coherent process, and has therefore adopted the following Model Principles for Professional Review of Physicians within Health Insurance Companies as guidance for such activities as may be applicable to their setting.

The following recommendations are made based on the above considerations in order to enhance:

• Quality improvement
• Credibility in the process of medical professional/peer review of physicians
• Fairness and due process
• Patient access — by not inappropriately terminating, removing or sanctioning physicians
• System approaches to patient safety and quality of care.

Model Principles for Medical Professional Review of Physicians within Health Insurance Companies

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event should include not only prevent factors, but also the contributory effects of the health care system.
3. All the relevant information should be obtained promptly from the subject physician on a confidential basis. In addition, relevant information from other sources should be obtained and made available to the subject physician to the fullest extent legally permissible followed by early discussion with the subject physician to evaluate the “incident” and explore alternate courses of action, all on a confidential basis.
4. The process should be mindful of, and attuned to, prevention; and the outcome should include recommendations, if appropriate, for individual remediation.
5. Triggers that initiate a medical professional review within a health plan should be valid, transparent and available to all credentialed, participating provider or contracted physicians and should be uniformly applied, with objective and evidence-based pre-screening, to all cases and physicians.
6. Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process. Such cases should be referred to Physician Health Services, Inc., or another appropriate physician health or wellness program.
7. At a minimum, the standards set by the Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity for “professional review bodies” should be followed if a disciplinary process is engaged during medical professional review. These standards are the most
elementary safeguards of due process for medical professional review activities.

Section 11112 Standards for professional review actions

"a. In general...professional review action must be taken–

(1) in the reasonable belief that the action was in the furtherance of quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)."

“Adequate notice and hearing–A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action
   The physician has been given notice stating –
   (A) (i) that a professional review action has been proposed to be taken against a physician
       (ii) reasons for the proposed action
   (B) (i) that the physician has the right to request a hearing on the proposed action
       (ii) any time limit (of not less than 30 days) within which to request such a hearing, and
   (C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing–If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating –
   (A) the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice, and
   (B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice–If a hearing is requested on a timely basis under paragraph (1)(B) –
   (A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) –
       (i) before an arbitrator mutually acceptable to the physician and the health care entity,
       (ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or
       (iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;
   (B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;
   (C) in the hearing the physician involved has the right –
       (i) to representation by an attorney or other person of the physician’s choice,
(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
(iii) to call, examine, and cross-examine witnesses,
(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right—

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.”

In addition, the notice of hearing should contain a summary of the allegations and of the episodes of care under evaluation.

8. Summary termination of credentials or of participating provider contract or status (or, if applicable, suspension or restriction of clinical privileges) should only be used to prevent “imminent danger to the health of any individual.” Such summary actions should be followed by adequate notice and hearing procedures prior to becoming final.

9. All parties involved in the medical professional review process must preserve the confidentiality of all records, information and proceedings. However, all of the facts obtained for and in the medical professional review process should be available to the subject physician to the fullest extent legally permissible.

10. A medical professional review panel or peer review committee, engaged in a formal medical professional/peer review, corrective action or disciplinary proceeding, should not include direct economic competitors of the subject physician or those for whom there may be bias or lack or objectivity vis-à-vis the subject physician, and should, whenever feasible, include a fair representation of specialists/subspecialists from the subject physician’s specialty/subspecialty from among credentialed, participating provider or contracted physicians within the health plan. The subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to the commencement of the proceedings. Such challenge would be part of the procedure specified in the health insurance company bylaws outside of peer review protections and not a part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

11. Health plans should employ mechanisms to rotate service on their medical professional review panels or peer review committees among their credentialed, participating provider or contracted physicians.

12. Membership on the medical professional panel or peer review committee should be open to all credentialed, participating provider or contracted physicians in the health plan and not be restricted to one or more groups such as employed or salaried physicians only. The committee should
include more than just medical directors, medical officers or other
administrative officers of the health plan.

13. Only physicians are peers of the subject physician, and only physicians
should be voting members of committees conducting medical professional
review of physicians.

14. Whenever a medical professional review panel or peer review committee
adequately representing the specialty/subspecialty of the subject physician
cannot effectively be constituted with physicians from within the health
plan while excluding direct economic competitors, or at the request of the
subject physician, qualified external consultants or an external peer review
panel through another appropriate institution (e.g., medical specialty
society) authorized to conduct peer review of physicians should be
appointed in accordance with the health plan’s bylaws if such actions fall
within statutory medical professional/peer review protections.

15. Physicians serving on the medical professional review panel or peer review
committee should receive information and, where available, training, in the
elements and essentials of medical professional/peer review.

16. The health plan should ensure that the physicians serving on any medical
professional review panel or peer review committee are provided with
appropriate indemnification and insurance for medical professional/peer
review acts taken in good faith. The health plan should also provide
assistance to the panel or committee in abiding by the requirements of
HCQIA to be eligible for federal immunity if applicable.

17. The medical professional review panel or peer review committee of a health
plan should be guided by generally accepted clinical guidelines and
established standards and practices, when available, in making their
determination on matters of quality care or professional competency. When
the matter before the medical professional review panel or peer review
committee involves professional conduct, such as an allegation of
disruptive behavior, the medical professional review panel or peer review
committee should be guided by applicable professional ethical principles
(e.g., MMS Code of Ethics, AMA Principles of Medical Ethics, relevant
specialty society ethical codes). Those guidelines, standards, practices
and principles should be made available in a timely manner to the subject
physician before any hearing on the matter.

18. Clinical guidelines, standards and practices used for evaluation of quality
of care should be transparent and available to the extent feasible.

19. Wherever feasible, structured assessment instruments and, if available,
multiple reviewers should be used to increase reliability.

20. Where feasible, statistical analysis to compare with peers’ performance
should be used with appropriate case mix adjustment.

21. Adequate notice (no less than 30 days) should be given to the subject
physician for any formal hearing or appeal.

22. All the pertinent information obtained by the medical professional review
panel or peer review committee regarding the subject matter should be
made available to the subject physician to the fullest extent legally
permissible in a timely manner before the hearing.
23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.

24. Any conclusion reached or action recommended or taken should be based upon the information presented to the medical professional review panel or peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a “reasonably prudent person” standard.

25. If the conclusion reached is that improvement is necessary, any action recommended by a health plan should include, as an important focus, steps for remediation, as needed, for the subject physician.

26. The findings, recommendations and actions of the medical professional review panel or peer review committee of a health plan should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician’s act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it should address what specific remediation, if any, is recommended for the physician (whenever feasible, in terms that permit measurement and validation of remediation, when completed).

27. A process should be available to appeal any disciplinary finding of a health plan following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An appeals process before a disinterested third party, not connected to the health plan, should be made available to the subject physician within statutory medical professional/peer review protections. If the original action was part of a peer-review protected process, the appeal should be part of the peer-review protected process as well.

28. In all instances of medical professional review activities conducted within health insurance companies, the applicable processes and procedures should be clearly stated, with specific detail, in health plan provider manuals or written policies, of uniform application, made available in advance to the subject physician. Such processes and procedures should contain the particular due process, hearing and appeals rights available to the subject physician, and, to the extent that medical professional review or peer review privilege, confidentiality and immunity legal protections are available to such medical professional review activities, such processes and procedures should conform to the requirements of federal and state law. In conformity with Principle No. 12, to avoid or at least mitigate conflicts of interest, or the perception thereof, the medical professional review panels or peer review committees of health insurance companies should include as members with full participation and voting rights physicians who are not employees or contractors (other than contracting as a participating provider) of the health insurer.

29. The Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on
the basis of cost containment. *(MMS Council, 5/17/91; Reaffirmed, House of
Delegates, May 7, 1999)*

30. These Model Principles for Medical Professional Review of Physicians
within Health Insurance Companies are intended to apply to all medical
professional review activities conducted by health insurance companies of
their credentialed, participating provider or contracted physicians, however
designated: e.g., professional review, peer review, credentialing appeals,
corrective actions or otherwise.

*(HP)*

*(MMS House of Delegates, 5/08/09)*

1. The Massachusetts Medical Society amends its existing Model Principles
for Incident-Based Peer Review for Health Care Facilities to include an
independent appeal and review process for disputed peer review outcomes
by a hospital and to update the principles to account for changes in
regulations and standards developed since the principles were created in
2003 as to read as follows:

**Massachusetts Medical Society Policy**
**Model Principles for Medical Peer Review of Physicians for Health Care Facilities**

2. The following recommendations are made based on the above
considerations in order to enhance:
   • Quality improvement
   • Credibility in the process of medical peer review of physicians for health
care facilities
   • Fairness and due process
   • Patient access — by not inappropriately removing or sanctioning
     physicians
   • System approaches to patient safety and quality of care

That the Massachusetts Medical Society Model Principles for Medical Peer Review
of Physicians for Health Care Facilities are as follows:

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event in a health care
   facility must not only include prevent factors, but also the contributory
   effects of the health care system.
3. All the relevant information should be obtained promptly from the subject
   physician. In addition, relevant information from other sources should be
   obtained and made available to the subject physician to the fullest extent
   legally permissible followed by early discussion with the subject physician
to evaluate the “incident” and explore alternate course of action.
4. The process must be mindful and attuned to prevention and recommend
   appropriate individual and system changes for remediation.
5. Triggers that initiate a medical peer review within a health care facility
   should be valid, transparent and available to all member physicians and
   should be uniformly applied, with objective and evidence-based pre-
screening, to all cases and physicians.
6. Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process.

7. At a minimum, the standards set by Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity must be followed if a disciplinary process is engaged during professional review. These standards are the most elementary safeguards of due process in a health care facility.

Section 1112 Standards for professional review actions

“a. In general…professional review action must be taken—

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).”

“Adequate notice and hearing—A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating—

(A) (i) that a professional review action has been proposed to be taken against a physician

(ii) reasons for the proposed action

(B) (i) that the physician has the right to request a hearing on the proposed action

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing—If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating—

(A) the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice—If a hearing is requested on a timely basis under paragraph (1)(B)—

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)—

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;
(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;
(C) in the hearing the physician involved has the right –
   (i) to representation by an attorney or other person of the physician’s choice,
   (ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
   (iii) to call, examine, and cross-examine witnesses,
   (iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
   (v) to submit a written statement at the close of the hearing; and
(D) upon completion of the hearing, the physician involved has the right
   (i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
   (ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.”

In addition, the notice of hearing should contain a summary of the allegations and the episodes of care under evaluation.

8. Summary suspension or restriction of clinical privileges may only be used to prevent “imminent danger to the health of any individual.” Such summary actions must be followed by adequate notice and hearing procedures prior to becoming final.

9. All parties involved in the peer review process must preserve the confidentiality of all records, information and proceedings. However, all of the facts obtained for and in the peer review process shall be available to the subject physician to the fullest extent legally permissible.

10. A peer review committee, engaged in a formal peer review or disciplinary proceeding, may not include direct economic competitors of the subject physician or those for whom there may be bias or lack of objectivity vis-à-vis the subject physician and should include a fair representation of specialists/subspecialists from the subject physician’s specialty/subspecialty whenever feasible. The subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to commencement of the proceedings. Such challenge would be a part of the procedures specified in the health care facility bylaws, outside of peer review protections and not part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

11. Physicians should rotate service on the peer review committee (round robin).

12. Membership on the peer review committee must be open to all physicians on the medical staff and not be restricted to one or more groups such as those practicing exclusively at a given institution, salaried physicians only or faculty physicians only.

13. Only physicians should be voting members of committees conducting medical peer review of physicians.
14. Whenever a peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the institution while excluding direct economic competitors or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution authorized to conduct peer review of physicians should be appointed in accordance with the medical staff bylaws and medical peer review protection statutes.

15. Physicians serving on the peer review committee should receive information and where available, training, in the elements and essentials of medical peer review.

16. The hospital or the organization on whose behalf the peer review is done must ensure that the physicians serving on any peer review committee are provided with appropriate indemnification and insurance for peer review acts taken in good faith. The organization must also provide assistance to the committee in abiding by the requirements of HCQIA to be eligible for federal immunity.

17. The peer review committee of a health care facility should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination. When the matter before the peer review committee involves professional conduct such as an allegation of disruptive behavior, the peer review committee should be guided by applicable professional ethical principles (e.g., the MMS Code of Ethics, the AMA Principles of Medical Ethics, relevant specialty society ethical codes). Those guidelines, standards and practices must be made available in a timely manner to the subject physician before any hearing on the matter.

18. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.

19. Wherever feasible, structured assessment instruments and multiple reviewers should be used to increase reliability.

20. Where feasible, statistical analysis to compare with peers’ performance must be used with appropriate case mix adjustment.

21. Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.

22. All the pertinent information obtained by the peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.

23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.

24. Any conclusion reached or action recommended or taken should be based upon the information presented to the peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a “reasonably prudent person” standard.

25. If the conclusion reached is that improvement is necessary, any action recommended by a health care facility should include, as an important
26. The findings, recommendations and actions of the peer review committee of a health care facility should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician’s act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it must address what specific remediation, if any, is recommended for the physician and what, if any, for the system (whenever feasible, in terms that permit measurement and validation of remediation, when completed).

27. A process should be available to appeal any disciplinary finding of a health care facility following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An appeals process before a disinterested third party, not connected to the medical staff or the hospital, should be made available to the subject physician within statutory peer review protections. If the original action was part of a peer-review protected process, the appeal should be part of the peer-review protected process as well.

(MMS House of Delegates, November 8, 2003; Amended, 5/14/10)

28. The Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on the basis of cost containment. (MMS Council, 5/17/91; reaffirmed House of Delegates, May 7, 1999)

(HP)

Physician Payment

7c. Third Party Insurers

The Massachusetts Medical Society (MMS) will continue to communicate to the health plans that a uniform minimum time allowance for the submission and resubmission of nonfederal claims would enhance physicians’ ability to meet administrative requirements. (D)

The MMS will advocate for a uniform minimum time allowance for nonfederal claims of at least 90 days for:

(a) the initial submission of claims;
(b) the resubmission or initial submission of claims to another health plan, in which 90 days would be calculated from the date of the first insurer’s remittance advice;
(c) the submission of additional information, in which 90 days would be calculated from the date the physician receives a communication from the health plan requesting additional information; and
(d) the submission of a claim to a new insurer after retroactive notification of loss of eligibility due to insurer change. (D)
The MMS will monitor health plans’ adherence to their filing-limit policies and communicate noncompliance to the appropriate parties. (D)

The MMS will continue to utilize administrative and legislative activities to promote the establishment of equitable physician recoupment policies at health plans. (D)

MMS House of Delegates, 11/9/02
Amended MMS House of Delegates, 11/8/03
Reaffirmed and Item 1 Amended MMS House of Delegates, 5/14/10

QUALITY OF CARE
8c. Patient Safety
The Massachusetts Medical Society accepts the Institute of Medicine’s (IOM) recommendations on Identifying Priority Areas for Quality Improvement, IOM Report Priority Areas for National Action, Transforming Health Care Quality (2003):

1. That the priority areas collectively:
   - Represent the U.S. population’s health care needs across the lifespan, in multiple health care settings involving many types of health care professionals.
   - Extend across the full spectrum of health care, from keeping people well and maximizing overall health; to providing treatment to cure people of disease and health problems as often as possible; to assisting people who become chronically ill to live longer, more productive, and comfortable lives; to providing dignified care at the end of life that is respectful of the values and preferences of individuals and their families.

2. Use of the following criteria for identifying priority areas:
   - Impact – the extent of the burden – disability, mortality, and economic costs – imposed by a condition, including effects on patients, families, communities, and societies.
   - Improvability – the extent of the gap between current practice and evidence-based best practice and the likelihood that the gap can be closed through change in an area; and the opportunity to achieve dramatic improvements in the six national quality aims identified in the Quality Chasm report (safety, effectiveness, patient-centeredness, timeliness, efficiency and equity).
   - Inclusiveness – the relevance of an area to a broad range of individuals with regard to age, gender, socioeconomic status, and ethnicity/race (equity); the generalizability of associated quality improvement strategies to many types of conditions and illnesses across the spectrum of health care (representativeness); and the breadth of change effected through such strategies across a range of health care settings and providers (reach).

3. That DHHS, along with other public and private entities, focus on the following areas for transforming health care:
Care coordination (cross-cutting)
Self-management/health literacy (cross-cutting)
Asthma – appropriate treatment for persons with mild/moderate persistent asthma
Cancer screening that is evidence-based – focus on colorectal and cervical cancer
Children with special health care needs
Diabetes – focus on appropriate management of early disease
End of life with advanced organ system failure – focus on congestive heart failure and chronic obstructive pulmonary disease
Frailty associated with old age – preventing falls and pressure ulcers, maximizing functions, and developing advanced care plans
Hypertension – focus on appropriate management of early disease
Immunization – children and adults
Ischemic heart disease – prevention, reduction of recurring events, and optimization of functional capacity
Major depression – screening and treatment
Medication management – preventing medication errors and overuse of antibiotics
Nosocomial infections – prevention and surveillance
Pain control in advanced cancer
Pregnancy and childbirth – appropriate prenatal and intrapartum care
Severe and persistent mental illness – focus on treatment in the public sector
Stroke – early intervention and rehabilitation
Tobacco dependence treatment in adults
Obesity (emerging area)

4. That the Agency for Healthcare Research and Quality (AHRQ), in collaboration with other private and public organizations, be responsible for continuous assessment of progress and updating of the list of priority areas. These responsibilities should include:

- Developing and improving data collection and measurement systems for assessing the effectiveness of quality improvement efforts.
- Supporting the development and dissemination of valid, standardized measures of quality.
- Measuring key attributes and outcomes and making this information available to the public.
- Revising the selection criteria and the list of priority areas.
- Reviewing the evidence base and results, and deciding on updated priorities every 3 to 5 years.
- Assessing changes in the attributes of society that affect health and health care and could alter the priority of various areas.
- Disseminating the results of strategies for quality improvement in the priority areas.

5. That data collection in the priority areas:

- Go beyond the usual reliance on disease – and procedure-based information – to include data on the health and functioning of the U.S. population.
• Cover relevant demographic and regional groups, as well as the population as a whole, with particular emphasis on identifying disparities in care.
• Be consistent within and across categories to ensure accurate assessment and comparison of quality enhancement efforts.

6. That the Congress and the Administration provide the necessary support for ongoing process of monitoring progress in the priority areas and updating the list of areas. This support should encompass:
• The administrative costs borne by the AHRQ.
• The costs of developing and implementing data collection mechanisms and improving the capacity to measure results.
• The costs of investing strategically in research aimed at developing new evidence on interventions that improve the quality of care and at creating additional, accurate, valid, and reliable measures of quality. Such research is especially critical in areas of high importance in which either the scientific evidence for effective interventions is lacking or current measures of quality are inadequate.

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

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

Your reference committee heard testimony only in support of the report; therefore, adoption is recommended.

House Vote: _______________________________
Mister speaker, your reference committee recommends that the recommendation contained in COV Report A-17 C-3 be adopted as amended by deletion to read as follows and the remainder of the report be filed:

That the MMS adopt in lieu of the bullying policy adopted at I-10 the following:

The Massachusetts Medical Society will develop and make available training for health care providers about bullying, cyberbullying, and other forms of harassment directed at vulnerable populations across the lifespan. Topics will include the spectrum of bullying behaviors, definitions, risk factors, health effects, techniques for inquiry and identification, intervention and response, and empowerment of those victimized to seek help from a trusted person or organization. All training will emphasize the employment of a trauma-informed and culturally responsive approach, paying particular attention to the needs of individuals who belong to vulnerable and marginalized groups, including but not limited to ethnic and racial minorities, religious minorities, as well as lesbian, gay, bisexual, transgender, questioning persons, and other gender and sexual minorities. (D)

Fiscal Note: One-Time Expense of $2,000 (Out-of-Pocket Expenses)

FTE: Existing Staff (Staff Effort to Complete Project)

Your reference committee heard testimony only in support of the report. The amendment to the recommendation is proposed to reflect testimony that all populations may be subject to bullying/harassment. It was noted that specific vulnerable populations are identified elsewhere in the recommendation.
Mister speaker, your reference committee recommends that the recommendations contained in TFOTP Report A-17 C-4 be adopted and the remainder of the report be filed.

That the MMS adopt as amended its opioids and substance use disorder policy amended and reaffirmed at A-10 to read as follows:

1. The MMS recognizes that addiction, equivalent to a severe substance use disorder, is a chronic, relapsing brain disease. (HP)

2. The MMS supports efforts to educate physicians and physicians-in-training about pain management, principles for safe opioid prescribing, prevention of substance use disorder, identification of substance use disorder, treatment of substance use disorder, and referring patients to appropriate treatment. (HP/D)

3. The MMS will work with appropriate public and private entities to increase access to services for individuals with substance use disorder. (D)

4. The MMS will work with physicians, including those specializing in substance use disorder, to develop ways to increase access to treatment for individuals with substance use disorder. (D)

5. The MMS supports efforts to educate physicians and physicians-in-training about treatment options for patients with substance use disorder in primary care and other settings and encourage further education around medication-assisted treatment and other forms of treatment. (HP/D)

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

FTE: Existing Staff
(Staff Effort to Complete Project)

Your reference committee heard unanimous testimony in support of the report. This report updates existing MMS policy originally adopted in 2003 and reaffirmed in 2010.
Item #: 5
Code: CPH Report A-17 C-5 [A-16 C-6c]
Title: Impaired Drivers Policy
(Policy Sunset Process: Reaffirmed One Year at A-16 Pending Review)
Sponsor: Committee on Public Health
Steven Ringer, MD, Chair
Report History: CSP Report A-16 C-6c
Original Sponsor: Committee on Strategic Planning
Referred to: Reference Committee C
Kathryn Hughes, MD, Chair

Recommendation:
Mister speaker, your reference committee recommends that the recommendations contained in CPH Report A-17 C-5 [A-16 C-6c] be adopted and the remainder of the report be filed.

That the Massachusetts Medical Society adopt as amended the policy on impaired drivers reaffirmed at A-09, to read as follows:

1. The Massachusetts Medical Society supports initiatives that improve driving safety, such as periodic re-testing of drivers in increased-risk categories, promotion of alternative modes of transportation, and improved patient education about driving responsibly. (HP)

2. The Massachusetts Medical Society promotes education on the dangers of impaired and distracted driving in all its forms. (HP)

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

Your reference committee heard testimony only in support of the report. This report updates existing MMS policy originally adopted in 2002 and reaffirmed in 2009 and 2016 for one year.

House Vote: _______________________________
Mister speaker, your reference committee recommends that the recommendation contained in CGM/CPH Report A-17 C-6 [A-16 C-6c] be adopted and the remainder of the report be filed.

That the Massachusetts Medical Society adopt as amended the advance directives policy amended and reaffirmed at A-09 to reads as follows:

1. The Massachusetts Medical Society will continue to work with hospitals, medical schools, and other interested organizations to develop and promote educational materials to improve physician and patient knowledge of and implementation of health care proxies beginning at age 18 and continuing throughout the life span. (D)

2. The Massachusetts Medical Society will continue to work with hospitals, medical schools, and other interested organizations to develop public education materials and programs to improve understanding of and increase utilization of advance directives, health care proxies and other appropriate health care documents, palliative care, and policies and procedures that uphold the individuals’ choice, goals, and values throughout life. (D)

Fiscal Note: No Significant Impact

FTE: Existing Staff

Your reference committee received online testimony in support of the report. This report updates existing MMS policy originally adopted in 1995 and subsequently reaffirmed.
Mister speaker, your reference committee recommends that the recommendations contained in CQMP/TFPCC Report A-17 C-7 [A-16 C-6] be adopted and the remainder of the report be filed.

1. That the Massachusetts Medical Society adopt as amended the physician call policy (4c) adopted at I-09, to read as follows:

   The Massachusetts Medical Society will modify its model Medical Staff Bylaws, as necessary, to address emergency department call coverage policies. (D)

   The MMS will explore ways in which to address the safety and equitability of specialty emergency department on call coverage by all institutions, with a special emphasis on underserved communities. (D)

2. That the Massachusetts Medical Society adopt in lieu of the physician call policy (5c) adopted at A-09 the following:

   The MMS will advocate for a balance between necessitating physician on-call services and meeting the needs of the patient population. (D)

   The MMS recognize that on-call services:
   • Vary by setting, region, and specialty, and therefore, cannot be so specific that they would explicitly dictate a physician’s practice.
   • Should provide the physician with the flexibility to determine the direction of his or her career.
   • Should accommodate and balance appropriate time off in determining physician responsibility.

(HP)

(Items 1–3 adapted from AMA policy)
ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges or state licensure. (HP)

The Massachusetts Medical Society support the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans’ enrollees. (HP)

The Massachusetts Medical Society advocate that physician on-call coverage for emergency departments be guided by the following principles:

a. The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients.

b. Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients.

c. The organization and function of on-call services should be determined through hospital policy and medical staff bylaws, and include methods for monitoring and assuring appropriate on-call performance.

d. Hospital medical staff bylaws and emergency department policies regarding on-call physician’s responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.

e. Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.

f. Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care.

g. Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained.

h. The decision to operate or close an emergency department should be made jointly by the hospital and medical staff.

i. Emergency on-call compensation agreements should be transparent to all medical staff members.

j. Compensation for emergency call can be an effective tool to ensure adequate participation on hospital staffs and on emergency call.

(HP)

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

FTE: Existing Staff (Staff Effort to Complete Project)

Your reference committee heard testimony unanimously in favor of the report. The report incorporates AMA policies into the MMS policy adopted in 2009. Testimony recognized that physician call policy is an issue that needs to be addressed. The Committee on Finance testified that the fiscal note may increase depending upon the scope of work required to update model bylaws.

House Vote: _____________________________
Mister speaker, your reference committee recommends that the recommendations contained in CQMP Report A-17 C-8 [A-16 C-6] be adopted and the remainder of the report be filed.

1. That the Massachusetts Medical Society adopt as amended the capitation policy (2c) adopted at I-09 to reads as follows:

**PHYSICIAN PAYMENT**

The Massachusetts Medical Society (MMS) supports physicians’ right to contract directly with payers and/or employers to obtain payment for services. *(HP)*

The MMS opposes the imposition of capitation and/or bundled payments on physicians and groups that state they are not ready to do so. The MMS insists that the decision to accept capitation and/or bundled payments be voluntary and self-determined by said physicians and groups based on their financial assessments and clinical integration competencies. *(HP)*

The MMS strongly recommends that organizations that take downside risk arrangements, including capitation, must also purchase appropriate stop-loss insurance and other appropriate tools to mitigate substantial risk. *(HP)*

The MMS opposes any activity on the part of government or insurance companies that decreases payments to physicians or increases cost sharing to patients as incentives to accept capitation and/or bundled payments. *(HP)*

The MMS will use its resources to oppose elimination of fee-for-service medicine. *(D)*

The MMS will publicly promote the high quality of medical care in Massachusetts and educate the public and out public officials that many of the benefits of high quality health care measures, such as prevention, screening, chronic disease management, electronic health records and wellness programs, improve care and produce value. *(D)*
The MMS opposes price and growth caps on physicians and physician organizations and instead supports the many alternative reform options to limit growth in health care spending, including establishing a statewide cost growth goal, development of health and cost outcomes scorecards (such as the Comprehensive Health Impact Assessments (CHIA) and the Health Policy Commission reports), growth in alternative payment models that are adequately funded, improved price transparency, integration of behavioral health and primary care, expansion of tele-health, decreasing unnecessary emergency room use and avoidable readmissions, and using the American Board of Internal Medicine’s Choosing Wisely® program as an opportunity for improvement. (HP)

2. That the Massachusetts Medical Society sunset the capitation policy (3c) adopted at I-09, which reads as follows:

The MMS will oppose the implementation of a statewide universal compensation system of global payment. (D)

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

FTE: Existing Staff (Staff Effort to Complete Project)

Your reference committee heard testimony only in support of the report. The sponsor noted that the amendments to the original policy adopted in 2009 were made to address the current healthcare landscape which includes bundled payments.

House Vote: _______________________________
Item #: 9
Code: Resolution A-17 C-301
Title: The Boston Medical Library is the Library of the Massachusetts Medical Society
Sponsors: MMS Presidential Officers:
    James Gessner, MD
    Henry Dorkin, MD
    Alain Chaoui, MD
    Grant Rodkey, MD
    S. Jay Jayasankar, MD
    Edith Jolin, MD
    Richard Pieters, MD
    Peter Schneider, MD

Referred to: Reference Committee C
Kathryn Hughes, MD, Chair
Recommendation:

Mister speaker, your reference committee recommends that Resolution A-17 C-301 be adopted.

RESOLVED, That the MMS amend its bylaws to designate the Boston Medical Library as the library of the Massachusetts Medical Society. (D)

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

FTE: Existing Staff (Staff Effort to Complete Project)

Your reference committee heard testimony in strong support of this resolution noting that the resolution will codify the longstanding relationship that already exists between the entities. A concern was raised that MMS members do not have full access to Boston Medical Library resources. Testimony noted that the scope of services and access offered to MMS members by the BML are currently under review by the Medical Society.

House Vote: _______________________________
Recommendation:

Mister speaker, your reference committee recommends that the recommendations contained in CWM Report A-17 C-9 be adopted and the remainder of the report be filed.

1. That the Massachusetts Medical Society (MMS) evaluate the voucher program for its designated intent to waive fees for MMS-sponsored programs in addition to educational offerings provided by the New England Journal of Medicine, for those members who volunteer their time and services to the MMS with regard to the program’s value, member opportunities for use, equity in calculation of voucher values and limit, and operational efficiencies. (D)

2. That the findings and recommendations of the voucher program evaluation be reported back to the HOD at I-17. (D)

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

FTE: Existing Staff (Staff Effort to Complete Project)

Your reference committee heard testimony both in-person and online unanimously in support of this report. Testimony noted a need for transparency, equity, and operational efficiency in the voucher program.

House Vote: _______________________________
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<tr>
<th>Item #</th>
<th>11</th>
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<tbody>
<tr>
<td>Code:</td>
<td>Report A-17 C-10 [CWM Report I-16 C-3]</td>
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<tr>
<td>Title:</td>
<td>MMS Leadership Promotion and Governance</td>
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<tr>
<td>Sponsor:</td>
<td>MMS Presidential Officers:</td>
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<tr>
<td>Alain Chaoui, MD</td>
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<td>Henry Dorkin, MD</td>
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<td>James Gessner, MD</td>
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<td>Report History:</td>
<td>CWM Report I-16 C-3 Committee on Women in Medicine</td>
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<tr>
<td>Referred to:</td>
<td>Reference Committee C Kathryn Hughes, MD, Chair</td>
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<tr>
<td>Recommendation:</td>
<td>Mister speaker, your reference committee recommends that the recommendation contained in Report A-17 C-10 [CWM Report I-16 C-3] be adopted and the remainder of the report be filed.</td>
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<tr>
<td>That the Massachusetts Medical Society adopt as amended CWM Report I-16 C-3 to read as follows:</td>
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1. That the Massachusetts Medical Society facilitate increased leadership opportunities on its special committees by limiting a special committee member’s service as chair to three consecutive years (not sum total). A committee member who has served as chair for three consecutive years may be re-elected as chair after not serving as chair for at least two presidential years. Years served as chair shall not include time served filling a vacancy in the position of chair. (D)

2. That a Massachusetts Medical Society member’s leadership service as chair be limited to not more than one special committee concurrently. (D)

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

FTE: Existing Staff (Staff Effort to Complete Project)

Limited testimony expressed concern about restricting the report to special committees and that the proposed language may have changed the intent of the original report proposed by the Committee on Women in Medicine at I-16. However, the testimony was generally in favor of this report.

House Vote: _______________________________
Mister speaker, your reference committee recommends that the recommendations contained in COB Report A-17 C-11 be adopted and the remainder of the report be filed.

THE REPORT

The Committee on Bylaws recommends that the House of Delegates approve the following amendments to the Bylaws (except as otherwise noted, added text is shown as “text” and deleted text is shown as “text”):

TFTL Report: I-16 C-1 [I-15 C-3] Ensure Representative Diversity in MMS Leadership Pathways

CHAPTER 5 • Sections

5.01 Categories of Sections
There shall be a Medical Student Section, a Resident and Fellow Section, an Organized Medical Staff Section, an Academic Physician Section, an International Medical Graduate Section, and a Minority Affairs Section.

5.07 Minority Affairs Section
The Minority Affairs Section is composed of Massachusetts Medical Society members who represent the interests of underrepresented groups and communities across the membership.

5.071 House of Delegates Representation
The Minority Affairs Section is entitled to one delegate in the House of Delegates. Such delegate shall be elected annually by the Minority Affairs Section.

CHAPTER 6 • The House of Delegates

...
6.02 Composition
The House of Delegates is composed of delegates elected by the district societies as provided in 3.15 and in addition:
(1) One delegate from each designated medical specialty society as provided in 4.03.
(2) Two delegates duly authorized from the student membership in each medical school in the Commonwealth of Massachusetts and the Medical Student Section trustee and alternate as provided in 5.021.
(3) Eight delegates from the Resident and Fellow Section as provided in 5.031.
(4) One delegate from the Organized Medical Staff Section of the Society as provided in 5.041, one delegate from the Academic Physician Section of the Society as provided in 5.051, and one delegate from the International Medical Graduate Section as provided in 5.061 and one delegate from the Minority Affairs Section as provided in 5.071.
(5) The President, President-elect, Vice President, Secretary-Treasurer, Assistant Secretary-Treasurer, Speaker and Vice Speaker.
(6) The president and secretary of each district medical society.
(7) Chairs of all standing committees of the Society.
(8) Past Presidents of the Society.
(9) Delegates-at-large, as recommended by the Board of Trustees, may be elected by the House of Delegates. Delegates-at-large must be members of the Massachusetts Medical Society, must be elected individually, and will have the right to vote.
(10) The President of the Massachusetts Medical Society Alliance.
(11) Trustees and alternates from each district medical society as provided in 3.17.
(12) The President of the Boston Medical Library provided that he or she must be a member of the Society.

ITEM B:

CHAPTER 5 • Sections

5.07 5.08 Delegate Vacancies
A vacancy that occurs in the office of delegate shall be filled for the unexpired term by the President of the Massachusetts Medical Society after consultation with the representatives of the sections.

5.08 5.09 Limitations
Sections of the Massachusetts Medical Society may not speak for or on behalf of the Massachusetts Medical Society.

(D)

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

FTE:  Existing Staff
(Staff Effort to Complete Project)
Your reference committee heard testimony only in support of this report. The amendments to the bylaws codify the vote of the House to establish a minority affairs section and make housekeeping amendments to clarify Chapter 5 of the bylaws.

House Vote: _______________________________
Mister speaker, this concludes the report of Reference Committee C. My thanks to reference committee members Nick Argy, MD, JD, Mr. Emal Lesha, Mr. Patrick Lowe, Mawya Shocair, MD, Mr. Steven Young, and Ms. Marguerite Youngren; staff coordinators Brett Bauer, Colleen Hennessey, and David Wasserman; legal counsel Paul Auffermann, Esq.; and all those who testified before the committee.

For the reference committee,

Kathryn Hughes, MD, Chair