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MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 14
Title: Evidence-Based Care of Individuals Born with Differences in Sex Development (DSD)/Intersex
Sponsor: Committee on Maternal and Perinatal Welfare
Sara Shields, MD, Chair

Report History: Original Sponsor: Committee on LGBTQ Matters
Referred to: Reference Committee A
Mary Beth Miotto, MD, MPH, Chair

Background
At I-18, the House of Delegates (HOD) referred LGBTQ Report I-18 A-2(b), Evidence-Based Care of Individuals Born with Differences in Sex Development (DSD)/Intersex, to the Board of Trustees (BOT) for report back with recommendations at I-19. The BOT referred this resolution to the Committee on Maternal and Perinatal Welfare in consultation with the Committee on LGBTQ Matters. The resolution/report states:

That the MMS supports delaying surgical interventions for infants with differences in sex development/intersex characteristics that are of a non-emergent status until the individual has the capacity to participate in the decision. (HP)

Fiscal Note: No Significant Impact

Reference Committee and HOD Testimony
At I-18, the reference committee recommended that this report be referred to the Board of Trustees for report back at I-19. The following is the reference committee’s rationale:

Your reference committee heard significant debate in person and online regarding the second recommendation. Many spoke in favor of adoption, and there was consensus that it is important to respect the autonomy of patients. However, many raised compelling medical concerns regarding how best to care for these patients, as evidenced by the differing positions of medical specialty societies. Your reference committee heard testimony noting that the NIH is currently working on a report on this issue. Given the need to evaluate more evidence in this area, the disagreement among clinicians regarding the evidence-based standard of care for these issues, and the complexity and heterogeneity of the medical conditions involved, your reference committee recommends referral.
HOD testimony heard several people speak against referral, noting the extensive research in the original report documenting the evidence of potential harms that come from performing nonessential gender reassignment surgery and underscoring support for a resolution that will improve the care of an underserved population. Testimony in support of adoption further noted the support of relevant medical and legal groups in support (e.g., American Academy of Family Physicians, the WHO, Physicians for Human Rights, Amnesty International, and the Gay and Lesbian Medical Association). Another person offered that additional research in the year after the resolution report is not likely to change the recommendation, and informed the HOD that the report had been made incorporating the recommendations from pediatric neurology and pediatric endocrinology.

Testimony in support of referral suggested that certain pediatric subspecialty groups have not supported this type of resolution at the AMA and that the AMA’s Counsel on Ethical and Judicial Affairs had considered the evidence and determined that there was not enough to support a similar resolution, and further that national urological societies and national endocrine societies were not in favor. Testimony explicitly requested further, updated research, including waiting on a report to be issued by an NIH working group.

Current MMS Policy
The MMS has the following policy on this item:

**CHILDREN AND YOUTH**

**Differences in Sex Development (DSD)/Intersex**

The MMS will promote the education of providers, parents, patients, and multidisciplinary teams based on the most current evidence concerning the care for individuals born with differences in sex development/intersex. (D)

Relevance to MMS Strategic Initiatives
MMS strategic priority — Patients/2/Critical: Assess vulnerable populations and determine where the MMS can have the strongest impact on access to appropriate care, including social determinants of health and health disparities.

Discussion
The Committee on Maternal and Perinatal Welfare discussed Report I-18 A-2(b), put forth by the MMS Committee on LGBTQ Matters. The current chair of the MMS Committee on LGBTQ Matters participated in the discussion to provide an overview of the research and background on the referred resolution.

A discussion ensued pertaining to the research and data referenced in the LGBTQ committee report. Committee members considered recommendations from the Gay and Lesbian Medical Association: Health Professionals Advancing LGBT Equality, the Word Health Organization, three former surgeon generals, the American Academy of Family Physicians, and Physicians for Human Rights. CMPW members also reviewed and considered testimony from the AMA, as well as research from the *Journal of Pediatric Urology*. CMPW members acknowledged that an NIH report was forthcoming, possibly in summer 2020, but came to understand the report was largely not expected to deviate from existing research and ultimately believed that the MMS should not wait for that report to act on the resolution. A CMPW member desired to wait on that report and inquired about the status of certain specialty societies — including pediatric, endocrinology, urology, and neonatology — and whether they’ve weighed in on the matter. Members of the committee
offered to follow up with relevant local specialty societies. It was noted that similar resolutions/recommendations are making their way through these bodies at the national level and are expected to be adopted, and that should not delay the MMS. Furthermore, it was noted that [per HOD testimony] when the original resolution was drafted the report had been made incorporating the recommendations from pediatric urology and pediatric endocrinology. Ultimately, given the evidence to date and the strong desire to support the right of self-determination to those born with DSD/intersex, the CMPW desired to move forward with a recommendation on this resolution.

A CMPW member and neonatologist weighed in that physicians in Massachusetts are presently acting largely in accordance with the policy outlined in the resolution such that gender assignment surgeries are rarely occurring at birth, and instead they are being delayed and a multidisciplinary approach is used with these cases. That same member communicated with the MCAAP and generally indicated they are supportive, despite not having adopted a policy statement at this time.

The chair presented language on the matter recommended, but not yet adopted, by the American Medical Association, which reads, “That our American Medical Association support optimal management of DSD through individualized, multidisciplinary care that: (1) seeks to foster the well-being of the child and the adult he or she will become; (2) respects the rights of the patient to participate in decisions and, except when life-threatening circumstances require emergency intervention, defers medical or surgical intervention until the child is able to participate in decision making; and (3) provides psychosocial support to promote patient and family well-being.” CMPW members discussed a preference for the AMA language, in particular noting that it was patient-centered and devoid of stigma.

Conclusion

Based on the research supporting the original LGBTQ resolution and the additional resources that were shared with the CMPW by the staff liaison prior to the meeting, the CMPW committed ultimately voted by a strong majority to adopt the AMA language in lieu of the original language in the resolution.

Recommendation:

That the Massachusetts Medical Society adopt in lieu of Resolution I-18 A-2(b) the following:

That the MMS supports optimal management of Differences in Sex Development/Intersex through individualized, multidisciplinary care that (1) seeks to foster the well-being of the child and the adult he or she will become; (2) respects the rights of the patient to participate in decisions and, except when life-threatening circumstances require emergency intervention, defers medical or surgical intervention until the child is able to participate in decision making; and (3) provides psychosocial support to promote patient and family well-being. (HP)

Fiscal Note: No Significant Impact

Estimated Staff Effort to Complete Directive(s): No Significant Impact
Whereas, An MMS strategic initiative is Patients/Critical: Assess vulnerable populations and determine where the MMS can have the strongest impact on access to appropriate care, including social determinants of health and health disparities; and

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

**TOBACCO/SMOKING**

**E-Cigarettes, Nicotine Liquids, and Personal Electronic Vaporizers** *(Please See Additional Policy under Liquid Nicotine Packaging)*

The MMS opposes the marketing, sales, and use of e-cigarettes and other nicotine delivery products among youths, particularly for persons under the age of twenty-one. *(HP)*

The MMS will continue to work with Massachusetts state lawmakers and officials to develop strategies to prevent marketing, sales, and use of e-cigarettes and other nicotine delivery products among youths, particularly for persons under the age of twenty-one. *(D)*

_MMS House of Delegates, 12/7/13 Amended (and Reaffirmed) by Implication MMS House of Delegates, 12/6/15_

The Massachusetts Medical Society will strongly advocate for statewide licensing to be required of all retail locations that sell any e-cigarettes, nicotine liquids, and personal electronic vaporizers, in a manner that allows local boards of health to impose additional regulation. *(D)*

_MMS House of Delegates, 5/4/19_

**Liquid Nicotine Packaging** *(Please See Additional Policy under Prescription and Non-prescription Drugs & Children and Youth)*

That the MMS advocate for state, local, and federal legislation and regulation to require child-resistant packaging and appropriate warning of the toxicity of this product for liquid nicotine refill products. *(D)*

_MMS House of Delegates, 5/2/15_
Whereas, There have been 18 reported deaths linked to use of e-cigarette products (defined as personal vaporizing devices and e-liquids) as of 10/01/2019;¹ and

Whereas, As many as 1,080 cases of e-cigarette-associated lung illness across 48 states have been documented as of 10/01/2019;¹ and

Whereas, The recent e-cigarette-associated lung illness cases serve as evidence contrary to the findings of past research studies suggesting that “e-cigarettes are less harmful than cigarettes when people who regularly smoke switch to them as a complete replacement”;²,³ and

Whereas, Aggressive advertising campaigns by e-cigarette product manufacturers touting the safety of e-cigarette product use have potentially spread misinformation about the safety of these products in the face of the recent cases of e-cigarette-associated lung illness;³ and

Whereas, Combustible cigarette warning labels conveying information about the health risks of smoking tobacco have historically been effective in educating consumers about the risks associated with combustible cigarette use;⁴ and

Whereas, There are currently no federal or Massachusetts state regulations mandating manufacturer or retail outlet issuance of consumer warning labels for non-nicotine e-cigarette products; and

Whereas, The Centers for Disease Control and Prevention are currently investigating a causal relationship between e-cigarette use and lethal lung illness;¹ and

Whereas, The American Lung Association issued a press release on 09/10/2019 stating that “E-cigarettes are not safe and can cause irreversible lung damage and lung disease”;⁵ therefore, be it

1. RESOLVED, That the MMS advocate for mandatory consumer warning labels on e-cigarette product packaging with the following proposed verbiage: “This product is currently the subject of research for a potential direct link to deadly lung disease” or some variant effectively conveying the same information; and, be it further (D)

2. RESOLVED. That the MMS advocate for continued research by the Centers for Disease Control and Prevention and American Lung Association investigating the health impact of e-cigarette products, especially as it pertains to the recent outbreak of severe pulmonary disease among e-cigarette product users (D).

Fiscal Note: No Significant Impact

Estimated Staff Effort

Estimated Expense of $3,000
Item #: 3
Code: Resolution I-19 A-102
Title: Informing Physicians, Health Care Providers, and the Public That Cooking with a Gas Stove Increases Household Air Pollution and the Risk of Childhood Asthma
Sponsors: T. Stephen Jones, MD
Regina LaRocque, MD
Brita Lundberg, MD

Referred to: Reference Committee A
Mary Beth Miotto, MD, MPH, Chair

Whereas, An MMS strategic initiative is Patients/Critical: Assess vulnerable populations and determine where the MMS can have the strongest impact on access to appropriate care, including social determinants of health and health disparities; and

Whereas, The MMS has the following relevant policies:

ENVIRONMENTAL HEALTH
Gas-Powered Leaf Blowers/Noise and Pollution
That the MMS adopt the following adapted from American Medical Association policies:

…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)

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

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. (D)

Whereas, Asthma is a public health problem in Massachusetts. In 2019, the Asthma and Allergy Foundation of America ranked the United States cities with the greatest asthma challenges. Three Massachusetts cities were in the top tier: Springfield (1st), Boston (8th), and Worcester (30th); and

Whereas, Asthma in Massachusetts disproportionately affects Black and Hispanic children and children from low-income families; and

Whereas, Household air pollution is a major health problem. Worldwide, it is responsible for more than three million deaths a year, and indoor air pollution is strongly linked to asthma;

Whereas, Household and outdoor air pollution are social determinants of health and associated with an increased risk of asthma; and air pollution contributes to health disparities in asthma;

Whereas, According to the United States Environmental Protection Agency (EPA), a growing body of scientific evidence indicates that, even in large cities, indoor air can be more polluted than the outdoor air; and

Whereas, Burning natural gas creates nitrogen dioxide (NO$_2$), particulate matter (PM$_{2.5}$), carbon monoxide (CO), and other byproducts that contribute to air pollution; and

Whereas, Nitrogen dioxide levels are significantly higher in homes with gas stoves than homes with electric stoves; and

Whereas, In a simulation of homes where gas cooking stoves are used without exhaust ventilation hoods, indoor NO$_2$ levels exceed outdoor air quality standards in 41%–70% of homes; and

Whereas, The burning of natural gas in stoves releases nitrogen oxides (NO$_X$) into indoor air and is an important source of household air pollution in the United States;

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Whereas, According to the EPA, "Breathing air with a high concentration of NO\textsubscript{2} can irritate airways in the human respiratory system. Such exposures over short periods can aggravate respiratory diseases, particularly asthma, leading to respiratory symptoms (such as coughing, wheezing or difficulty breathing), hospital admissions and visits to emergency rooms. Longer exposures to elevated concentrations of NO\textsubscript{2} may contribute to the development of asthma and potentially increase susceptibility to respiratory infections. People with asthma, as well as children and the elderly are generally at greater risk for the health effects of NO\textsubscript{2}";\(^{14}\) and

Whereas, The World Health Organization recognized the associations between cooking with gas stoves, indoor NO\textsubscript{2} levels, and asthma in their 2010 guidelines for indoor air quality;\(^{15}\) and

Whereas, Children living in a home with a gas cooking stove have a 42% increased risk of current asthma and a 24% increased lifetime risk of asthma according to a meta-analysis;\(^{16}\) and

Whereas, A year-long, prospective study of NO\textsubscript{2} exposure in 1,342 children with active asthma in Massachusetts and Connecticut found a dose-response relationship between the amount of NO\textsubscript{2} exposure and risk of asthma severity. Every five-fold increase in NO\textsubscript{2} exposure above 6 parts per billion (ppb) was associated with a dose-dependent increase in the risk of asthma severity, wheeze, and rescue medication use;\(^{17}\) and

Whereas, About one-third of households in the United States cook with gas stoves;\(^{18}\) and

Whereas, In homes with gas cooking stoves, children whose parents reported never using exhaust fans, or who did not have them available had lower lung function and higher adjusted odds of asthma 1.56 (1.03, 2.32), wheeze, 1.66 (1.16, 2.38), and bronchitis 1.66 (1.05–2.70) compared to children in homes where parents reported using exhaust fans;\(^{19}\) and

Whereas, In a randomized study comparing replacing gas stoves with electric stoves, using a free-standing high efficiency particulate air (HEPA) filters and installing above-stove hoods with exhaust fans were effective in reducing NO\textsubscript{2} levels;\(^{20}\) and


Whereas, in Massachusetts, informal questioning found that many parents, health professionals, local health departments, local boards of health, and others did not know about the association between cooking with gas stoves and increased risk of asthma; and

Whereas, Parents, public health staff, building inspectors, teachers, and many others should know about this association so that they can help protect children from household air pollution produced by gas stoves and reduce the risk of asthma; therefore, be it

1. RESOLVED, That the MMS reaffirms the United States Environmental Protection Agency findings that increased levels of nitrogen dioxide irritate the respiratory system, are associated with asthma aggravation, and, with longer exposure, may contribute to the development of asthma; and, be it further (HP)

2. RESOLVED, That the MMS recognizes the association between household air pollution produced by cooking with a gas stove and the increased risk of asthma and greater asthma severity among children living in such households; and, be it further (HP)

3. RESOLVED, That the MMS will inform its members and, to the extent possible, health care providers, the public, and relevant Massachusetts organizations that cooking with a gas stove increases household air pollution and the risk of childhood asthma and asthma severity; and, be it further (D)

4. RESOLVED, That the MMS will inform its members and, to the extent possible, health care providers, the public, and relevant Massachusetts organizations that the risks of household air pollution and asthma associated with gas cooking stoves can be mitigated by reducing the use of the gas cooking stove, using adequate ventilation, using a HEPA filter, or replacing the gas cooking stove with an electric stove. (D)

Fiscal Note: No Significant Impact

Estimated Staff Effort: One-Time Expense $2,000

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21 Personal communication from T. Stephen Jones and Andee Krasner April 4, 2019.
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 4
Code: Resolution I-19 A-103
Title: Expanding Access to Buprenorphine for Patients with Opioid Use Disorder
Sponsor: Nicolas Trad

Referred to: Reference Committee A
Mary Beth Miotto, MD, MPH, Chair

Whereas, An MMS strategic initiative is Patients/Critical: Improving access to health care for vulnerable populations and cutting regulations that unnecessarily hinder physicians' ability to care for patients; and

Whereas, The opioid epidemic is a public health crisis of historic proportions that has contributed to a decline in the US life expectancy and requires the coordinated efforts of Congress, health professionals, and health systems; and

Whereas, Buprenorphine is an evidence-based, lifesaving treatment for opioid use disorder, shown in the medical literature to reduce remission rates, medical complications, and overdose mortality rates tied to opioids; and

Whereas, Physicians must meet burdensome requirements in order to prescribe buprenorphine, as per the federal Drug Addiction Treatment Act of 2000 (DATA 2000), including an eight-hour training course, a waiver application, and a cap on the number of patients they are eligible to treat; and

Whereas, These restrictions have hampered our national response to the opioid crisis, with fewer than 8% of American physicians having obtained the DATA 2000 waiver and more than half of US counties lacking a buprenorphine prescriber; and

Whereas, Rapidly expanding access to office-based buprenorphine treatment has the potential to save tens of thousands of lives, as it did in France, which witnessed a 79% drop in opioid-related overdoses in the three years following the deregulation of buprenorphine in 1995;\textsuperscript{a} and

Whereas, Existing MMS policy calls for the “elimination by all Massachusetts health insurers of all prior authorization requirements or other special billing/administrative maneuvers that inhibit patient access to buprenorphine/naloxone” (Preauthorizations/Decision-Making, 12/01/18) but takes no position on federal buprenorphine prescribing restrictions; therefore, be it

RESOLVED, That the MMS supports the elimination of the buprenorphine waiver requirement and related restrictions, including the cap on the number of patients that physicians are eligible to treat with buprenorphine. (HP)

Fiscal Note: No Significant Impact

(out Estimated Expenses)

Estimated Staff Effort

to Complete Directive(s): No Significant Impact

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 5
Code: Resolution I-19 A-104
Title: Expanding Access to Methadone Treatment for Opioid Use Disorder in the Midst of the Opioid Crisis
Sponsor: Massachusetts Society of Addiction Medicine
Peter Friedmann, MD, MPH, President

Referred to: Reference Committee A
Mary Beth Miotto, MD, MPH, Chair

Whereas, Two current MMS strategic initiatives are to assess vulnerable populations and determine where the MMS can have the strongest impact on access to appropriate care, including social determinants of health and health disparities (Patients/2/Critical) and advocacy for technology and communication tools that improve health literacy, price transparency, and increase patient engagement (Patients/1/Intermediate); and

Whereas, The MMS has the following policy on reduction of illegal drug use:

PRESCRIPTION AND NON-PRESCRIPTION DRUGS

Reduction of Illegal Drug Use

The MMS supports enhanced medical and public health approaches as effective methods of reducing the illegal use of illegal drugs. (HP)

MMS House of Delegates, 11/17/01
Amended and Reaffirmed MMS House of Delegates, 5/9/08

; and

Whereas, The MMS has the following policy on substance use and misuse:

PRESCRIPTION AND NON-PRESCRIPTION DRUGS

Substance Use and Misuse

...The MMS will work to advance policy and programmatic efforts to address gaps in voluntary substance-use treatment services. (D)...

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

MMS House of Delegates, 4/28/18

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

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

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)

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)
MMS House of Delegates, 5/2/03
Reaffirmed and Item 3 Amended MMS House of Delegates 5/14/10
Amended MMS House of Delegates, 4/29/17

1; and
2
Whereas, Massachusetts is in the midst of an opioid crisis in which 1,981 citizens of the Commonwealth died of opioid-related overdoses in 2017;¹ and
3
Whereas, The three medications approved by the Food and Drug Administration for the treatment of opioid use disorder are methadone, buprenorphine, and naltrexone;²-⁸ and
4
Whereas, Methadone has been used since the early 1960s for long-term treatment of opioid use disorder;³,⁹-¹² and
5
Whereas, Methadone has been shown to be effective in the treatment of opioid use disorder (OUD),³,¹³-¹⁵ including reducing opioid use and overdose mortality;⁵,¹⁵-¹⁷ and
6
Whereas, Interim methadone, allowing prescribing clinicians in licensed opioid treatment programs to induce waitlist patients onto methadone without psychosocial counseling, has been shown to be safe, and has been shown to reduce opioid use, HIV risk behavior, less illegal income, and days incarcerated compared to waiting list participants;¹⁸-²⁰ and
7
Whereas, Medical maintenance, allowing office-based prescribing clinicians to manage stable patients referred from opioid treatment programs has been shown to be safe and effective at reducing treatment dropout, overdoses, mortality, HIV transmission, emergency department and hospital utilization, and cost of care;⁵,¹⁴,¹⁵,²¹,²² and
8
Whereas, Office-based methadone treatment for opioid use disorder, in collaboration with community pharmacists that can dispense and supervise methadone dosing, has been shown to be safe and improves retention in treatment for patients while reducing costs and increasing treatment capacity, especially in rural areas where access to specialty clinics may be limited;⁵,³³,³⁴ and
9
Whereas, Methadone prescribing for opioid use disorder treatment from emergency departments has been associated with reduced risk of fatal overdose and all-cause mortality, increased patient use of ambulatory care, reduced use of ED and inpatient care, and indicated no net increase in expenditures;²⁵,²⁶ and
10
Whereas, Methadone prescribing for opioid use disorder treatment from hospitals has been associated with improved retention in treatment, decreased readmission among patients with opioid use disorder, and reduced rates of serious infections requiring hospitalization;²⁷-²⁹ and
11
Whereas, Methadone prescribing for opioid use disorder treatment in jails and prisons has been associated with increased medication initiation on release, improved continuity and coordination of care, and less injection drug use six months after release;¹⁷,³⁰-³³ and
12
Whereas, Many patients with opioid use disorder prefer methadone over buprenorphine and/or naltrexone;⁶,³⁴-³⁶ and
13
Whereas, Current federal and state regulations are highly restrictive of the use of methadone for the indication of opioid use disorder;¹⁶,¹⁸,²¹,³⁷-⁴² and
Whereas, Many parts of the Commonwealth, particularly rural areas, have been described as “Methadone Deserts”, because of poor access to this lifesaving treatment;\textsuperscript{43,44} and

Whereas, Methadone cannot be prescribed by licensed physicians or advanced practitioners for treatment of OUD except in a clinic that meets all of the current regulations;\textsuperscript{3,16,21,38-40,42} and

Whereas, Physicians can prescribe methadone in an office setting for the treatment of opioid use disorder in many Western developed countries, including Canada since 1996;\textsuperscript{3,21,34,39,45-47} and

Whereas, Increased access to providing methadone for OUD treatment in Massachusetts would substantially increase the availability of evidence-based OUD treatment, and decrease opioid overdose deaths and other medical and social problems associated with opioid use disorders in Massachusetts;\textsuperscript{4,15,16,18,31,39,41,47-49} therefore, be it

1. RESOLVED, That the MMS states that current federal and state regulations are overly restrictive and limit the clinically indicated use of methadone to treat opioid use disorder in the midst of the opioid crisis; and, be it further (HP)

2. RESOLVED, That the MMS will advocate for amendment of federal and state laws to reduce current restrictions on the use of methadone for the treatment of opioid use disorder; and, be it further (D)

3. RESOLVED, That the MMS will advocate for implementation of effective models drawn from the experience of other nations and research evidence to expand access to methadone for the treatment of opioid use disorder. These models will include interim methadone in opioid treatment programs, office-based prescribing in collaboration with community pharmacists to dispense and supervise dosing; and prescribing and dispensing in emergency departments, hospitals, detoxification programs, skilled nursing facilities, home care settings, and other controlled environments (e.g., jails and prisons). (D)

Fiscal Note: No Significant Impact

Estimated Staff Effort to Complete Directive(s): Ongoing Expense of $3,000
References


43. Robert Bohler MD, Constance Horgan. *Addressing the Opioid Crisis in Small and Rural Communities in Western Massachusetts.* Massachusetts Health Policy Forum; 2019.


MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 6
Code: Resolution I-19 A-105
Title: An MMS-Sponsored Educational Session to Explore the Impact of Decriminalizing the Use of Illegal Drugs and Their Possession in Amounts Consistent with Personal Use Only

Sponsor: Ronald Newman, MD

Referred to: Reference Committee A
Mary Beth Miotto, MD, MPH, Chair

Whereas, An MMS strategic initiative is MMS/Immediate: To expand advocacy efforts in collaboration with key stakeholders on issues deemed critical to physicians and patients; and

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

PRESCRIPTION AND NON-PRESCRIPTION DRUGS
Substance Use and Misuse

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

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)

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

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)

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)

MMS House of Delegates, 5/2/03
Reaffirmed and Item 3 Amended MMS House of Delegates 5/14/10
Amended MMS House of Delegates 4/29/17
The MMS will work with the Department of Public Health, the legislature, and other appropriate state agencies to advocate for the state wide expansion of pre-booking jail diversion programs that redirect criminally-involved, eligible, non-violent individuals with substance use disorders to treatment programs. (D)

(Approved MMS Board of Trustees, 3/8/17)
Accepted MMS House of Delegates, 4/29/17

The MMS supports the state-wide implementation of accessible jail diversion programs for individuals with substance-use disorders. (HP)

The MMS will work with the legislature, the Department of Public Health, and other appropriate agencies to advocate for expanded government funding to substance-use disorder treatment programs with the intention of expanding capacity. (D)

MMS House of Delegates, 5/7/16

The MMS recognizes substance use disorder as a chronic relapsing disease frequently accompanied by psychiatric comorbidities and genetic susceptibility. The MMS supports legislative and policy efforts that reduce conviction and incarceration solely for personal possession and illicit use of drugs and supports increased access to harm reduction services and all forms of treatment. Furthermore, the MMS is opposed to penalizing or incarcerating people with substance use disorders on the basis of relapse, and/or failure to meet the conditions established by courts and other related entities that conflict with principles of evidence-based care of substance use disorders. (HP)

MMS House of Delegates, 5/4/19

Whereas, The United States has been waging a war on illegal drugs for over one hundred years;¹ and

Whereas, This war on drugs has been largely focused on punishing those who produce, import, sell, and use these drugs;² and

Whereas, Many consider this war on drugs to have been largely unsuccessful when one considers the ongoing and worsening morbidity and mortality associated with drug use and the impact illegal drug use has had on the social and financial health of the American people;³,⁴ and

Whereas, It is only logical that the assumptions and philosophies on which an approach deemed by many to be unsuccessful is based and by which it is being executed should be reassessed and alternatives explored; and

Whereas, Some other countries wage war on illegal drugs based on assumptions and philosophies that are different from those used by the United States; and

Whereas, Some of these countries have had success in decreasing both the morbidity and mortality related to drug use and the impact illegal drugs have had on the social and financial health of their people by decriminalizing the use of illegal drugs and the possession of small amounts consistent with personal use only; and

Whereas, Learning about these alternative assumptions and philosophies will allow physicians and others to consider different approaches to the problem of illegal drug use which could improve the health of our patients and of the Commonwealth; therefore, be it

RESOLVED, That the Massachusetts Medical Society will sponsor an educational session that will explore decriminalizing the use of illegal drugs and their possession in amounts consistent with personal use only and consider the impact that this approach could have on the Commonwealth of Massachusetts. Health care providers, legislators, health care administrators, and law enforcement officials should be among those invited to take part in the session. (D)

Fiscal Note: One-Time Expense of $8,000

Estimated Staff Effort to Complete Directive(s): One-Time Expense of $4,500

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MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 7
Code: CGM Report I-19 A-3
Title: Support for Adoption of the National POLST Form and Process in Massachusetts
Sponsor: Committee on Geriatric Medicine
Asif Merchant, MD, Chair
Referred to: Reference Committee A
Mary Beth Miotto, MD, MPH, Chair

Background
In 2017, members of the Committee on Geriatric Medicine (CGM) held a dedicated hour-long conversation with the executive director of the National POLST Paradigm (NPP) (https://polst.org) and learned that the national organization was working with leaders in every state to create a uniform document. Information included news that the Massachusetts Department of Public Health (MDPH) had appointed a MOLST Subcommittee Advisory Group, dedicated to improving the MOLST form to comply with the National POLST Paradigm. This subcommittee is part of the MDPH Palliative Care and Quality of Life Interdisciplinary Advisory Council.1

Furthermore, the Massachusetts Medical Society is a member of the Massachusetts Coalition for Serious Illness Care (http://maseriouscare.org) and has participated regularly in that organization since its inception in 2016.

By February 2019, several drafts of the proposed NPP form had been edited by the MOLST subcommittee. CGM leadership was invited to review and comment on the final national draft.

Current MMS Policy
ADVANCE CARE PLANNING/END-OF-LIFE CARE
Advance Care Planning
The MMS will continue to support the use of Medical Orders for Life Sustaining Treatment (MOLST) in Massachusetts, including providing education to Massachusetts providers regarding MOLST forms. (D)

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

The MMS will work with the AMA and relevant stakeholders to encourage adoption and use of a national database for advance directives, and to ensure its adequate funding.

MMS House of Delegates, 4/28/18

In order to support physicians in their efforts to help patients and their families to plan for serious illness and end-of-life care in advance, the Massachusetts Medical Society encourages its members to routinely discuss health care proxies “MOLST Form” and other advance directives. (HP)

The MMS will sponsor the promotion and dissemination of educational information to assist its members with having the difficult conversations concerning serious illness and end-of-life care with patients and their families. (D)

MMS House of Delegates, 5/18/07

Item 1: Amended and Reaffirmed MMS House of Delegates, 5/17/14

Item 2: Reaffirmed MMS House of Delegates, 5/17/14

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

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

MMS House of Delegates, 5/21/11

Amended and Reaffirmed MMS House of Delegates, 4/28/18

Reaffirmed MMS House of Delegates, 5/4/19

Current AMA Policy

Our AMA will: work with state medical associations to advocate with appropriate legislative and regulatory bodies to recognize POLST forms completed in one state as a valid expression of a patient’s directions for care: and (2) draft model state legislation and guidelines that will allow for reciprocity and/or recognition of POLST and other patient decision-making forms.

AMA Policy D-85.992

Relevance to MMS Strategic Initiatives

Three MMS strategic priorities include the following:

- Patients/1/Intermediate: Advocate for technology and communication tools that improve health literacy, price transparency, and increase patient engagement.
- Patients/2/Critical: Assess vulnerable populations and determine where the MMS can have the strongest impact on access to appropriate care, including social determinants of health and health disparities.
• Patients/5/Intermediate: Enhance collaboration with patients; health care and
  technology organizations; community resources; and state, federal, and other
  stakeholders; with a focus on our patient-centered objectives.

Discussion
The Committee on Geriatric Medicine has had ongoing discussions with the executive
director of the National POLST Paradigm and a member of the Palliative Care and
Quality of Life Interdisciplinary Advisory Council Committee/Chair of the MOLST Advisory
Committee.

Additionally, in 2018, the AMA notified all state and national medical specialty societies
of its willingness to work with them to advocate with appropriate legislative and
regulatory bodies to recognize POLST forms completed in one state as a valid
expression of a patient’s direction for care. The AMA also drafted model state
legislation allowing for reciprocity and/or recognition of POLST and other patient
decision-making forms.

The final version of the national POLST form was released in September 2019.

In October 2019, the 28-person MOLST Advisory Committee voted to recommend to the
Massachusetts Department of Public Health that it adopt the national POLST form, to be
accompanied by a Massachusetts Implementation Guide that reflects an improved
governing structure and key implementation components.  

Adopting the national POLST form would bring Massachusetts into compliance with the
national standard and builds in a standardized, evidence-based process and form. Every
individual, their health care agent, and their guardian can engage in planning
discussions with clinicians to receive quality care from first diagnosis of a serious illness,
through managing treatment, to end-of-life care. Use of the POLST form would align the
policies and procedures of all major stakeholders for better care transitions.

Free multilingual documents and downloadable tools for consumers and care providers
are available on the NPP website, as well as key implementation components such as
online professional education, consumer education, and quality monitoring. The
Massachusetts Medical Society’s original goal of achieving reciprocity across states
would be partially realized. Twenty-four states have adopted the POLST form, including
New Hampshire, New York, and Maine, and 21 states are developing a POLST
program.

Conclusion
It follows that the MMS should urge the Massachusetts Department of Public Health to
adopt the national POLST form. This is in keeping with our policy.

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2 Ibid.
3 A Game Changer for Living Well with Serious Illness. Honoring Choices Massachusetts
  website. www.honoringchoicesmass.com/a-game-changer-for-ma-serious-illness-care/. Published
It is important that in addition to the NPP documents and tools, a Massachusetts-specific guide be developed. This would include education for physicians, the patient, the surrogate (if the patient lacks capacity), as well as physician assistants, nurse practitioners, advance practice registered nurses, advanced practice nurse practitioners, and emergency medical services.

The Massachusetts Medical Society should be the leading voice in educating physicians on the newly revised national POLST form for Massachusetts. This will include information on the proper use of the form for community-dwelling patients with serious illness, as well as use of the form throughout health care facility transition. The Society will have a strong impact on access to appropriate care for patients with serious illness, and the new national POLST form, Implementation Guide, and physician trainings will serve to “enhance collaboration with patients, health care and technology; community resources; and state, federal, and other stakeholders; with a focus on our patient-centered objectives.”

Recommendations:

1. That the MMS advocate to the Massachusetts Department of Public Health that the national POLST form be adopted for use in Massachusetts. (D)

2. That the MMS lead the physician education component of the Massachusetts Implementation Guide, which will reflect the improved governing structure and key implementation components of the national POLST form. (D)

3. That the MMS conduct an online webinar on the use of the Massachusetts version of the national POLST form. (D)

4. That the MMS support the statewide implementation of the Massachusetts version of the national POLST form. (D)

Fiscal Note: One-Time Expense of $10,000

Estimated Staff Effort to Complete Directive(s): One-Time Expense of $2,500

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