FINAL HOUSE VOTES:
REFERENCE COMMITTEE A: Public Health

Item #	Title	Code	Action	Referred to	Page
1	Physician-Involvement in Extreme Risk Protection Orders	Resolution A-18 A-101	Adopted as Amended	Legislation	xx
2	Opposition to "Concealed Carry Reciprocity"	Resolution A-18 A-102	Adopted	Legislation (Item 1) MA AMA Delegation *(Expedited by MMS Officers for June AMA Meeting)* (Item 2)	xx
3	Opposition to the Criminalization of Self-Induced Abortion	Resolution A-18 A-103	Adopted as Amended	Legislation (Item 1) MA AMA Delegation (Item 2)	xx
4	Limiting the Scope of Involuntary Civil Commitment of Persons for Reasons Related to Substance-Use Disorder	Resolution A-18 A-104	Adopted as Amended	Task Force on Opioid Therapy and Physician Communication (Items 1, 3) Legislation (Items 2, 5) MA AMA Delegation (Items 4, 6)	xx
5	Section 35 Reform: Ensuring Acceptable Standards for the Treatment of Persons Involuntarily Civilly Committed for Substance-Use Disorders	Resolution A-18 A-105	Adopted as Amended	Legislation	xx
6	Opioid Crisis May Be Ameliorated by Decriminalization, But Legalization Would Be More Effective at Reducing Deaths	Resolution A-18 A-106	Referred to the BOT for Report Back at A-19	Legislation (in consultation with) Task Force on Opioid Therapy and Physician Communication	xx
7	Capital Punishment Policy	EGPS Report A-18 A-1	Adopted	(MMS *Policy Compendium*)	xx

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8	Addressing the Human Health Impacts of Neonicotinoids	Resolution A-18 A-107	Adopted as Amended	(MMS *Policy Compendium*)	xx
9	Gaming Addiction Now a Mental Health Disorder	Resolution A-18 A-108	Not Adopted	NA	xx
10	Child Abuse in the Fashion Industry	Resolution A-18 A-109	Not Adopted	NA	xx
11	Fetal and Infant Mortality Review in Massachusetts	CMPW Report A-18 A-2	Adopted as Amended	MMS *Policy Compendium* (Item 1) Legislation Maternal and Perinatal Welfare (Item 2)	xx
12	Ensuring Oral Health as a Component of Accountable Care Organizations	COOH Report A-18 A-3	Adopted as Amended	(MMS *Policy Compendium*) (Item 1) Legislation The Quality of Medical Practice (Item 2) The Quality of Medical Practice (Item 3)	xx
13	Food Insecurity Screening	CNPA Report A-18 A-4	Adopted as Amended	(MMS *Policy Compendium*) (Items 1, 2) Nutrition and Physical Activity (Item 3)	xx
14(a)	Streamlining Human Immunodeficiency Virus Testing of Source Patients following an Occupational Exposure	CPH/COL/MA AMA/OMSS Report A-18 A-5 [A-17 A-103]	(Divided): Item 14(a) Adopted as Amended	MMS Presidential Officers	xx
14(b)	Streamlining Human Immunodeficiency Virus Testing of Source Patients following an Occupational Exposure	CPH/COL/MA AMA/OMSS Report A-18 A-5 [A-17 A-103]	(Divided): Item 14(b) Referred to the BOT for Report Back at I-18	Legislation (in consultation with) Public Health	xx

ADOPTED AS AMENDED

Item #:	1
Code:	Resolution A-18 A-101
Title:	Physician-Involvement in Extreme Risk Protection Orders
Sponsors:	Dr. Tedi Begaj, MD Dr. Michael Hirsh, MD Mr. Alexander Pomerantz Mr. Matthew Townsend Mr. Suhas Gondi Mr. Nishu Uppal Mr. Patrick Lowe
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**Committee on Legislation**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

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

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

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

ADOPTED

Item #:	2
Code:	Resolution A-18 A-102
Title:	Opposition to "Concealed Carry Reciprocity"
Sponsors:	Carole Allen, MD, MBA, FAAP Committee on Violence Intervention and Prevention Wendy Macias-Konstantopoulos, MD, MPH, Chair Massachusetts Chapter of the American Academy of Pediatrics DeWayne Pursley MD, MPH, FAAP, President
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

HOUSE VOTE:	**Adopted**
Referred to:	**(Item 1) Committee on Legislation** **(Item 2) MA AMA Delegation *(Expedited by MMS Officers for June AMA Meeting)***
Informational Report:	**I-18**
Strategic Priority:	**Physician and Patient Advocacy**

1. **That the MMS oppose all forms of "concealed carry reciprocity" federal legislation that would require all states to recognize concealed carry permits granted by other states and allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws. *(D)***

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

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

ADOPTED AS AMENDED

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

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(Item 1) Committee on Legislation** **(Item 2) MA AMA Delegation**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

1. **That the MMS will advocate against any legislative efforts or laws in Massachusetts or federally to criminalize self-induced abortion. *(D)***

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

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

ADOPTED AS AMENDED

Item #:	4
Code:	Resolution A-18 A-104
Title:	Limiting the Scope of Involuntary Civil Commitment of Persons for Reasons Related to Substance-Use Disorder
Sponsor:	Michael Sinha, MD, JD, MPH
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(Items 1, 3) Task Force on Opioid Therapy and Physician Communication** **(Items 2, 5) Committee on Legislation** **(Items 4, 6) MA AMA Delegation**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

1. **That the MMS advocate for and advance research into any harms, benefits, and/or efficacy of any involuntary commitment solely related to substance-use disorder. *(D)***

2. **That the MMS oppose involuntary civil commitment of persons for reasons solely related to substance-use disorder without judicial involvement. *(D)***

3. **That the MMS work to advance policy and programmatic efforts to address gaps in voluntary substance-use treatment services. *(D)***

4. **That the MMS advocate that the American Medical Association oppose further expansions of authority to involuntary civil commitment of persons for reasons solely related to substance-use disorder without judicial involvement in Massachusetts and nationally. *(D)***

5. **That the MMS advocate to limit the practice of involuntary civil-commitment for reasons solely related to substance-use disorder in Massachusetts in furtherance of health, ethical, and patients' rights imperatives. *(D)***

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

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

ADOPTED AS AMENDED

Item #:	5
Code:	Resolution A-18 A-105
Title:	Section 35 Reform: Ensuring Acceptable Standards for the Treatment of Persons Involuntarily Civilly Committed for Reasons Related to Substance-Use Disorders
Sponsor:	Dylan Heckscher
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**Committee on Legislation**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

1. **That the MMS advocate that all persons involuntarily civilly committed in Massachusetts for reasons related to substance-use disorder be confined only in facilities monitored and approved of by the Department of Public Health or Department of Mental Health, and be subject only to treatment consistent with accepted medical guidelines. *(D)***

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

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

REFERRED TO THE BOT FOR REPORT BACK AT A-19

Item #:	6
Code:	Resolution A-18 A-106
Title:	Opioid Crisis May Be Ameliorated by Decriminalization, But Legalization Would Be More Effective at Reducing Deaths
Sponsor:	William R. Cohen, MD
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

HOUSE VOTE:	**Referred to the BOT for Report Back at A-19**
Referred to:	**Committee on Legislation (in consultation with) Task Force on Opioid Therapy and Physician Communication**
Report for Action: (Recommendation to HOD on whether to Adopt, Amend, Not Adopt)	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

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

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

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

ADOPTED

Item #:	7
Code:	EGPS Report A-18 A-1
Title:	Capital Punishment Policy
Sponsor:	Committee on Ethics, Grievances, and Professional Standards Ronald Arky, MD, Chair
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

HOUSE VOTE:	**Adopted**
Referred to:	**(MMS *Policy Compendium*)**
Informational Report:	**NA**
Strategic Priority:	**Physician and Patient Advocacy**

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

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

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

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

These actions include, but are not limited to:
(d) determining a prisoner's competence to be executed. A physician's medical opinion should be merely one aspect of the information taken into account by a legal decision maker, such as a judge or hearing officer;
(e) treating a condemned prisoner who has been declared incompetent to be executed for the purpose of restoring competence, unless a commutation order is issued before treatment begins. The task of re-evaluating the prisoner should be performed by an independent medical examiner;

(f) prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure;
(g) monitoring vital signs on site or remotely (including monitoring electrocardiograms);
(h) attending or observing an execution as a physician;
(i) rendering of technical advice regarding execution.
And, when the method of execution is lethal injection:
(j) selecting injection sites;
(k) starting intravenous lines as a port for a lethal injection device;
(l) prescribing, preparing, administering, or supervising injection drugs or their doses or types;
(m) inspecting, testing, or maintaining lethal injection devices; and
(n) consulting with or supervising lethal injection personnel.

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

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

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

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

ADOPTED AS AMENDED

Item #:	8
Code:	Resolution A-18 A-107
Title:	Addressing the Human Health Impacts of Neonicotinoids
Sponsors:	Prithwijit Roychowdhury Regina LaRocque, MD Brita E. Lundberg, MD
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(MMS *Policy Compendium)***
Informational Report:	**NA**
Strategic Priority:	**Professional Knowledge**

1. **That the MMS is concerned about harmful effects of neonicotinoids on public health. *(HP)***

2. **That the MMS advocates for research and development of less hazardous alternatives to neonicotinoids. *(HP)***

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

NOT ADOPTED

Item #:	9
Code:	Resolution A-18 A-108
Title:	Gaming Addiction Now a Mental Health Disorder
Sponsor:	Ihor Bilyk, MD
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

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

2. **RESOLVED, That the MMS encourage physicians to advise their patients and parents of their patients of the addictive potential of gaming; and, be it further *(D)***

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

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

NOT ADOPTED

Item #:	10
Code:	Resolution A-18 A-109
Title:	Child Abuse in the Fashion Industry
Sponsor:	Ihor Bilyk, MD
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

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

2. **RESOLVED, That the MMS discuss with legislators about how to further study and possibly prevent the potential for child sexual exploitation and abuse within the fashion industry, as published in recent news outlets. In particular, issues that may be addressed with legislators may include the possibility of providing legal protections and reform of the youth-obsessed fashion industry to include basic safeguards such as private dressing rooms, if not currently available (so models don't have to get naked in public); to require the presence of a parent/guardian and an additional non–industry-related adult on the set at all photo shoots, if not currently available (to prevent having the underage model alone in the room with a photographer or other industry professional); and to require having a work contract, if not currently available, to include a parent/guardian and the underage model that details exactly what type of photo shoot would be done and whether any nudity would be involved. *(D)***

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

ADOPTED AS AMENDED

Item #:	11
Code:	CMPW Report A-18 A-2
Title:	Fetal and Infant Mortality Review in Massachusetts
Sponsor:	Committee on Maternal and Perinatal Welfare Elizabeth Monaco, MD, Chair
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(Item 1) MMS *Policy Compendium*** **(Item 2) Committee on Legislation and Committee on Maternal and Perinatal Welfare**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

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

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

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

ADOPTED AS AMENDED

Item #:	12
Code:	COOH Report A-18 A-3
Title:	Ensuring Oral Health as a Component of Accountable Care Organizations
Sponsors:	Committee on Oral Health Hugh Silk, MD, Chair Michelle Dalal, MD
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(Item 1) (MMS *Policy Compendium*)** **(Item 2) Committee on Legislation and The Committee on the Quality of Medical Practice** **(Item 3) The Committee on the Quality of Medical Practice**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

1. **That the MMS recognizes oral health is an integral part of health and wellness. *(HP)***

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

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

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

ADOPTED AS AMENDED

Item #:	13
Code:	CNPA Report A-18 A-4
Title:	Food Insecurity Screening
Sponsor:	Committee on Nutrition and Physical Activity Scott Butsch, MD, MSc, Chair
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(Items 1, 2) (MMS *Policy Compendium*)** **(Item 3) Committee on Nutrition and Physical Activity**
Informational Report:	**(Item 3) A-19**
Strategic Priority:	**Physician and Patient Advocacy**

1. **The MMS encourages routine food insecurity screening by health care providers, their organizations, and schools, with validated food insecurity screening tools or larger screening sets for social determinants of health that incorporate screening for food insecurity. *(HP)***

2. **The MMS encourages health practices to adopt as policy screening all patients for food insecurity as a critical component of clinical care, especially in underserved communities. *(HP)***

3. **The MMS will share with its members and relevant healthcare organizations resources for food insecurity screening and referrals to food and nutrition assistance. *(D)***

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

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<u>(14(a) ADOPTED AS AMENDED</u>
(14(b) next page:

Item #:	14(a)
Code:	CPH/COL/MA AMA/OMSS Report A-18 A-5 [A-17 A-103]
Title:	Streamlining Human Immunodeficiency Virus Testing of Source Patients following an Occupational Exposure
Sponsors:	Committee on Public Health Steven Ringer, MD, Chair Committee on Legislation Theodore Calianos, MD, Chair MA AMA Delegation Alain Chaoui, MD, FAAFP, Chair Organized Medical Staff Section Frank Carbone Jr., MD, Chair
Report History:	Resolution: A-17 A-103 Original Sponsors: Brandon Wojcik, MD, Jennifer Singleton, MD, and Resident and Fellow Section
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

HOUSE VOTE:	**(14a) Adopted as Amended**
Referred to:	**MMS Presidential Officers**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

That the MMS work with appropriate organizations to promote adoption by hospitals and other healthcare organizations of admission and procedural consent documents that inform the patient that testing for HIV and other blood-borne pathogens, such as hepatitis B and hepatitis C, will be performed in the event of an occupational exposure of a healthcare worker to the patient's blood or body fluids. This would best be accomplished by addition of a separate provision to the "blanket" informed consent forms signed by patients on admission to hospitals or outpatient facilities, which will stipulate that the results of such testing will be released to the patient and that appropriate counseling will be provided by a qualified physician, in the event of a positive result.
The form also will inform the patient that the results will be released to the exposed healthcare worker for the sake of providing appropriate preventive measures. This separate provision must clearly state that refusal to grant permission for testing will not in any way jeopardize the care provided to the patient by the healthcare organization or any of its staff or professional employees. *(D)*

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

REFERRED TO THE BOT FOR REPORT BACK AT I-18

Item #:	14(b)
Code:	CPH/COL/MA AMA/OMSS Report A-18 A-5 [A-17 A-103]
Title:	Streamlining Human Immunodeficiency Virus Testing of Source Patients following an Occupational Exposure
Sponsors:	Committee on Public Health Steven Ringer, MD, Chair Committee on Legislation Theodore Calianos, MD, Chair MA AMA Delegation Alain Chaoui, MD, FAAFP, Chair Organized Medical Staff Section Frank Carbone Jr., MD, Chair
Report History:	Resolution: A-17 A-103 Original Sponsors: Brandon Wojcik, MD, Jennifer Singleton, MD, and Resident and Fellow Section
Referred to:	Reference Committee A Marian Craighill, MD, MPH, Chair

HOUSE VOTE:	**(14b) Referred to the BOT for Report Back at I-18**
Referred to:	**Committee on Legislation (in consultation with) Committee on Public Health**
Report for Action: (Recommendation to the HOD on whether to adopt, amend, not adopt)	**I-18**
Strategic Priority:	**Physician and Patient Advocacy**

That the MMS work with appropriate organizations to advocate removal of mandated informed written consent in the performance of HIV testing, and to utilize HIPAA-appropriate patient notification and counseling in result interpretation. *(D)*

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

FINAL HOUSE VOTES:
REFERENCE COMMITTEE B: Health Care Delivery

Item #	Title	Code	Action	Referred to:	Page
1	Massachusetts Should Look toward Ending Its Determination of Need (DON) Laws	Resolution A-18 B-201	Referred to BOT for Report Back at A-19	Legislation	zz
2	Ensuring Prescription Drug Price Transparency from Retail Pharmacies	Resolution A-18 B-202	Adopted as Amended	Legislation (Item 1) MA AMA Delegation and Legislation (Item 2) MA AMA Delegation (Item 3)	zz
3	Patient-Reported Outcome Measures: Current State and Proposed MMS Principles	CQMP Report A-18 B-1	Adopted as Amended	(MMS *Policy Compendium*) The Quality of Medical Practice (#13) (and *MMS Policy Compendium*)	zz
4	Current State of OpenNotes Medical Records	CQMP Report A-18 B-2	Adopted as Amended	(MMS *Policy Compendium*) (Item 1) The Quality of Medical Practice (Item 2) (and MMS *Policy Compendium*)	zz
5	Impact of the High Capital Cost of Hospital EMRs on the Medical Staff	OMSS Report A-18 B-3	Adopted as Amended	Organized Medical Staff (in consultation with) InformationTechnology	zz
6	Billing and Collections Practice Policy	EGPS Report A-18 B-4	Adopted	(MMS *Policy Compendium*)	zz
7	No-Cost Volunteer License to Practice Medicine	Resolution A-18 B-203	Adopted	Legislation	zz
8	Provision of Access to Third-Party Payer Medical Directors to Treating Providers	Resolution A-18 B-204	Adopted as Amended	The Quality of Medical Practice	zz

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	to Facilitate Patient Care				
9	One Reimbursement Fee Schedule for All Medicaid ACOs	Resolution A-18 B-205	Referred to BOT for Report Back at A-19	Legislation (in consultation with) The Quality of Medical Practice	zz
10	Equality in Reimbursement for Patient-Related Care	Resolution A-18 B-206	Adopted	The Quality of Medical Practice	zz
11	Hospital Disaster Plans and Medical Staffs	OMSS Report A-18 B-5	Adopted	Organized Medical Staff Section (in consultation with) Preparedness	zz
12	Transforming the Medical Liability Environment	CPL Report A-18 B-6	Adopted	Finance	zz
13	Health Care Is a Basic Human Right	OFFICERS Report A-18 B-7 [A-17 B-202]	Adopted as Amended	MMS Presidential Officers (in consultation with) Ethics, Grievances, and Professional Standards	zz
14	Maximizing Function and Minimizing Disability	CPH/CME Report A-18 B-8 [A-17 A-111]	Adopted as Amended	(MMS *Policy Compendium*) (Item 1) Medical Education (in consultation with) Environmental and Occupational Health (Item 2)	zz
15	Recognition of Out-of-State DNR/Physician Orders for Life Sustaining Treatment (POLST) Forms in Massachusetts	CGM Report A-18 B-9 [A-17 B-207]	Adopted as Amended	Geriatric Medicine (Items 1-2) Geriatric Medicine and MA AMA Delegation (Item 3)	zz
16	Protecting the Patient-Physician Relationship: MassHealth ACO	COSPP Report A-18 B-10	Adopted as Amended	(MMS *Policy Compendium*) (Item 1) Legislation (Items 2-4)	zz

REFERRED TO THE BOT FOR REPORT BACK AT A-19

Item #:	1
Code:	Resolution A-18 B-201
Title:	Massachusetts Should Look toward Ending Its Determination of Need (DON) Laws
Sponsors:	Raj Devarajan, MD Massachusetts Gastroenterology Association Jaya Agrawal, MD, President
Referred to:	Reference Committee B Nicolas Argy, MD, JD, Chair

HOUSE VOTE:	**Referred to the BOT for Report Back at A-19**
Referred to:	**Committee on Legislation**
Report for Action: (Recommendation to HOD on Whether to Adopt, Amend, Not Adopt)	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

1. **That the MMS favors repeal of the Determination of Need (DON) law in Massachusetts in order to further the goals of health care reform. *(HP)***

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

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

ADOPTED AS AMENDED

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

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(Item 1) Committee on Legislation** **(Item 2) MA AMA Delegation and Committee on Legislation** **(Item 3) MA AMA Delegation**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

1. **That the MMS include retail pharmacies, electronic pharmacy networks, and health plans in advocacy efforts supporting drug price transparency for health care providers and patients. *(D)***

2. **That the MMS work with the AMA and any other relevant organizations to advocate for state and federal legislation requiring transparency of medication price and out-of-pocket costs for prescription medications at retail pharmacies. *(D)***

3. **That the MMS encourage the AMA to work with insurance companies, retail pharmacies, state and federal governments, and any other relevant organizations, to create a national database accessible to health care providers and patients that lists medication price and after-insurance out-of-pocket costs for prescription medications. *(D)***

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

ADOPTED AS AMENDED

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

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(MMS *Policy Compendium*)** **(#13) The Committee on the Quality of Medical Practice (and *MMS Policy Compendium*)**
Informational Report:	**(#13) A-19**
Strategic Priority:	**Physician and Patient Advocacy**

That the MMS adopt the following:

MMS Principles on Patient-Reported Outcome Measures (PROMs)

1. **Quality improvement activities are an integral part of health care delivery today.**
2. **PROMs are expected to play a more prominent role in improving and assessing performance by including the patient's assessment of the comparative effectiveness of different treatments, in part because of the growing emphasis on patient-centered care and value-based payment designs.**
3. **In the era of patient-centered care and motivation toward high-quality care, active implementation of patient-reported outcome tools (Internet, automated phone systems, phone app, etc.) is a logical next step toward achieving these goals, as long as those tools are accessible to those less comfortable with technology and account for the cost of implementation.**
4. **Implemented correctly, PROMs have the potential to improve patient-physician communication, increase symptom management and control, and increase patient and physician satisfaction.**
5. **When selecting a PRO to measure, the PROM should be short, relevant to clinical care, validated, industry-standard, and may be covered by PROMIS (Patient-Reported Outcomes Measurement Information System) domain.**
6. **Routinization of this type of two-way communication between the provider and the patient, through use of the electronic tools mentioned above, may serve to improve care in ways that advance the Triple Aim's design to (i) improve patient experience, (ii) enhance the health of populations, and (iii) reduce per capita cost of health care.**

7. **Health plans, payers, and other health care improvement organizations should reimburse for quality improvement implementation activities, especially PROMs, as these measures require technology support, workflow adjustments, and continuous improvement.**
8. **However, PROMs should not be used to benchmark the performance of providers in different practices, specialties, or geographic locations against one another, potentially influencing payers to link reimbursement to evidence of the effectiveness of their treatment. Instead, these quality improvement tools should be used to advance quality of care within a specific practice or medical center, improve provider-patient communication, and enhance understanding of expectations. Because PROMs are in their infancy, more research needs to be done to understand how to risk-adjust these measures and how to account for realistic and unrealistic patient and provider expectations.**
9. **In addition to the need for added research on risk adjustment and patient expectations, PROMs performance results should not be linked to reimbursement due to many other factors, including patients' compliance, demographic, and social factors, which influence outcomes and create bias. Because PROMs results are not completely attributable to the physician's performance alone, providers find it hard to reconcile reimbursement and the often-imprecise nature of PROMs results. Rather, PROMs should be used to complement quality improvement activities.**
10. **The need for demographic (age, sex, etc.) risk adjustment to make PROMs more valuable should be emphasized both at the clinical level for providers to be able to use PROMs appropriately but even more so at the health plan level if PROMs are to be used for any type of provider comparison or payment.**
11. **Although the goal of medicine is to improve health outcomes for patients, using PROMs results for physician accountability and reimbursement requires additional research and validation of measures and outcomes.**
12. **The MMS strongly advocates for monitoring national dialogue surrounding PROMs, including a focus on their validity and usefulness in clinical practice.**
13. **The MMS will keep the membership informed of identified issues with relevant implemented patient-reported outcome measures and advocate strongly, by whatever means appropriate, for the growth and maturation of PROMs as a quality improvement tool and against implementation of inappropriate or inadequate PROMs, and against the use of PROMs results for quality incentive payments.**

(HP)

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

ADOPTED AS AMENDED

Item #:	4
Code:	CQMP Report A-18 B-2
Title:	Current State of OpenNotes Medical Records
Sponsor:	Committee on the Quality of Medical Practice Barbara Spivak, MD, Chair
Referred to:	Reference Committee B Nicolas Argy, MD, JD, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(Item 1) (MMS *Policy Compendium*)** **(Item 2) The Committee on the Quality of Medical Practice (and MMS *Policy Compendium*)**
Informational Report:	**(Item 2) A-19**
Strategic Priority:	**Physician and Patient Advocacy**

1. That the MMS supports the general proposition that patients should have access to their medical notes from their medical records via patient portals or other cost-effective means, but acknowledges that such access may not always be appropriate. *(HP)*

2. That the MMS shall monitor the OpenNotes movement (i.e. which urges doctors, nurses and other health care professionals to share the medical notes with their patients) and keep members updated on its progress. *(D)*

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

ADOPTED AS AMENDED

Item #:	5
Code:	OMSS Report A-18 B-3
Title:	Impact of the High Capital Cost of Hospital EMRs on the Medical Staff
Sponsor:	Organized Medical Staff Section Frank Carbone Jr, MD, Chair
Referred to:	Reference Committee B Nicolas Argy, MD, JD, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**Organized Medical Staff (in consultation with) Committee on Informational Technology**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

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

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

Fiscal Note: (Out-of-Pocket Expenses)	One-Time Expense of $20,000
FTE: (Staff Effort to Complete Project)	Existing Staff

ADOPTED

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

HOUSE VOTE:	**Adopted**
Referred to:	**(MMS *Policy Compendium*)**
Informational Report:	**(NA)**
Strategic Priority:	**Physician and Patient Advocacy**

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

Billing and Collection Practices

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

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

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

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

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

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

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

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

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

(HP)

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

ADOPTED

Item #:	7
Code:	Resolution A-18 B-203
Title:	No-Cost Volunteer License to Practice Medicine
Sponsor:	Berkshire District Medical Society Basil Michaels, MD, President
Referred to:	Reference Committee B Nicolas Argy, MD, JD, Chair

HOUSE VOTE:	**Adopted**
Referred to:	**Committee on Legislation**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

1. **That the MMS advocate for the Massachusetts Board of Registration in Medicine (BORIM) to eliminate the fee for a volunteer license to practice medicine. *(D)***

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

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

ADOPTED AS AMENDED

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

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**The Committee on the Quality of Medical Practice**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

That the MMS advocate that third-party payers and pharmacy benefits managers must provide access to the medical director and/or the author of the prior authorization policy to the provider, to discuss the disputed care and the care management within 2 business days of the provider requesting such access. The request for such access to the medical director may be made by phone or in writing, whichever is most convenient for the provider who is administering care of said patient. *(D)*

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

REFERRED TO THE BOT FOR REPORT BACK AT A-19

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

HOUSE VOTE:	**Referred to the BOT for Report Back at A-19**
Referred to:	**Committee on Legislation (in consultation with) Committee on the Quality of Medical Practice**
Report for Action: (To HOD on whether to Adopt, Amend, Not Adopt)	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

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

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

ADOPTED

Item #:	10
Code:	Resolution A-18 B-206
Title	Equality in Reimbursement for Patient-Related Care
Sponsors:	Kevin Moriarty, MD Hampden District Medical Society Nikhil Thakkar, MD, President
Referred to:	Reference Committee B Nicolas Argy, MD, JD, Chair

HOUSE VOTE:	**Adopted**
Referred to:	**Committee on the Quality of Medical Practice**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

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

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

ADOPTED

Item #:	11
Code:	OMSS Report A-18 B-5
Title:	Hospital Disaster Plans and Medical Staffs
Sponsor:	Organized Medical Staff Section Frank Carbone Jr, MD, Chair
Referred to:	Reference Committee Nicolas Argy, MD, JD, Chair

HOUSE VOTE:	**Adopted**
Referred to:	**Organized Medical Staff Section (in consultation with) Committee on Preparedness**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

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

That the MMS:

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

(D)

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

ADOPTED

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

HOUSE VOTE:	**Adopted**
Referred to:	**Committee on Finance**
Informational Report:	**NA**
Strategic Priority:	**Physician and Patient Advocacy**

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

Fiscal Note: (Out-of-Pocket Expenses)	Annual Expense of $25,000 for Two Years Total Expense: $50,000
FTE: (Staff Effort to Complete Project)	Existing Staff

ADOPTED AS AMENDED

Item #:	13
Code:	OFFICERS Report A-18 B-7 [A-17 B-202]
Title:	Health Care Is a Basic Human Right
Sponsors:	MMS Presidential Officers: Henry Dorkin, MD, FAAP Alain Chaoui, MD, FAAFP Maryanne Bombaugh, MD, MSc, MBA, FACOG
Report History:	Resolution A-17 B-202 Original Sponsors: Michael Kaplan, MD, and Berkshire District Medical Society
Referred to:	Reference Committee B Nicolas Argy, MD, JD, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**MMS Presidential Officers (in consultation with) Ethics, Grievances and Professional Standards**
Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

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

That the MMS convene a conference on the implications of the MMS recognizing that health care is a basic human right and not a privilege, with a report back with recommendations by A-19. *(D)*

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

ADOPTED AS AMENDED

Item #:	14
Code:	CPH/CME Report A-18 B-8 [A-17 A-111]
Title:	Maximizing Function and Minimizing Disability
Sponsors:	Committee on Public Health Steven Ringer, MD, Chair Committee on Medical Education Kevin Hinchey, MD, Chair
Report History:	Resolution A-17 A-111 Original Sponsors: Janet Limke, MD, and Norfolk South District Medical Society
Referred to:	Reference Committee B Nicolas Argy, MD, JD, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(Item 1) (MMS *Policy Compendium*)** **(Item 2) Committee on Medical Education (in consultation with) Committee on Environmental and Occupational Health**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy & Physician Knowledge**

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

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

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

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

ADOPTED AS AMENDED

Item #:	15
Code:	CGM Report A-18 B-9 [A-17 B-207]
Title:	Recognition of Out-of-State DNR/Physician Orders for Life Sustaining Treatment (POLST) Forms in Massachusetts
Sponsor:	Committee on Geriatric Medicine Eric Reines, MD, Chair
Report History:	Resolution A-17 B-207 Original Sponsor: Keith Nobil, MD
Referred to:	Reference Committee B Nicolas Argy, MD, JD, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(Items 1-2) Committee on Geriatric Medicine** **(Item 3) Committee on Geriatric Medicine and MA AMA Delegation**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy & Physician Knowledge**

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

1. **That the MMS 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)***

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

3. **That the MMS 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. *(D)***

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

ADOPTED AS AMENDED

Item #:	16
Code:	CSPP Report A-18 B-10
Title:	Protecting the Patient-Physician Relationship: MassHealth ACO
Sponsor:	Committee on Sustainability of Private Practice Hugh Taylor, MD, Chair
Referred to:	Reference Committee B Nicolas Argy, MD, JD, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(Item 1) (MMS *Policy Compendium*)** **(Items 2-4) Committee on Legislation**
Informational Report:	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

1. **That the MMS reaffirms the primacy of the patient-physician and behavioral health-mental health relationship. *(HP)***

2. **That the MMS expeditiously request that MassHealth or other relevant state agencies recognize the importance of patient-physician continuity of care and honor all pre-existing patient-physician and behavioral health-mental health relationships. *(D)***

3. **That the MMS continue to engage MassHealth or other relevant state agencies to craft directives and policies that support and foster established patient-physician and behavioral health-mental health relationships. *(D)***

4. **That the MMS request that MassHealth develop measurement tools to assess the impact of the current accountable care organization implementation, particularly in regard to the effect that disruption of patient-physician and behavioral health-mental health relationships has on health status and overall health care costs. *(D)***

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

FINAL HOUSE VOTE:
REFERENCE COMMITTEE C: MMS Administration

Item #	Title	Code	Action	Referred to	Page
1	MMS Annual Strategic Plan	CSP Report A-18 C-1	Adopted	MMS Presidential Officers	xx
2	Establishing a Women Physicians Section	CWIM Report A-18 C-2	Adopted	Bylaws (Item 1)	xx
3	Sexual Orientation and Gender Identity Demographic Data Collection by the MMS	CLGBTQ Report A-18 C-3	Adopted as Amended	Membership	xx
4	MMS Leadership Promotion and Governance	OFFICERS Report A-18 C-4 [CWM Report I-16 C-3]	Adopted as Amended	Task Force on Governance	xx
(Section) 5a	Policy Sunset Process (Section: Reaffirm for 7 Years)	OFFICERS Report A-18 C-5 (SECTION A)	Adopted	(MMS *Policy Compendium*)	xx
(Section) 5b	Policy Sunset Process (Section: Amend and Reaffirm for 7 Years)	OFFICERS Report A-18 C-5 (SECTION B)	Adopted	(MMS *Policy Compendium*)	xx
(Section) 5c	Policy Sunset Process (Second: Reaffirm for 1 Year)	OFFICERS Report A-18 C-5 (SECTION C)	Adopted *(reaffirmed for 1 year for further review whether to reaffirm, sunset, or amend)*	**ETHICS: Genetic Information and Patient Privacy Item 1c)** Ethics, Grievances, and Professional Standards (Item 10 in consultation with Medical Education)	xx
			Adopted *(reaffirmed for 1 year for further review whether to reaffirm, sunset, or amend)*	**HEALTH SYSTEM REFORM (Item 2c)** The Quality of Medical Practice (Items 11, 13 in consultation with Legislation & item 12 in consultation with Professional Liability)	xx
			Adopted *(reaffirmed for 1 year for further review whether to reaffirm,*	**HOSPITALS: Mergers of Conversions (Item 3c)** The Quality of Medical Practice (Item B1 in	xx

			sunset, or amend)	consultation with Legislation)	
			Adopted *(reaffirmed for 1 year for further review whether to reaffirm, sunset, or amend)*	**MINORITIES: Race and Ethnicity Data (Item 4c)** Public Health and Diversity in Medicine	xx
			Adopted *(reaffirmed for 1 year for further review whether to reaffirm, sunset, or amend)*	**PROFESSIONAL LIABILITY: Physician Expert Witness (Item 5c)** Professional Liability	xx
			Adopted *(reaffirmed for 1 year for further review whether to reaffirm, sunset, or amend)*	**PUBLIC HEALTH: Human Medicine, Veterinary Medicine, and Environmental Sciences (Item 6c)** Public Health	xx
			Adopted *(reaffirmed for 1 year for further review whether to reaffirm, sunset, or amend)*	**QUALITY OF CARE: Measurement/Quality Improvement (Item 7c and 8c)** The Quality of Medical Practice	xx
6	Prescription Marketing Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)	CPH Report A-18 C-6 [A-17 C-2]	Adopted (Sunset)	(MMS *Sunset Compendium*)	xx
7	Ethics and Managed Care Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)	CEGPS/CQMP Report A-18 C-7 [A-17 C-2]	Refer to E,G, and PS	Ethics, Grievances, and Professional Standards	xx

8	Principles on Medical Professional Review of Physicians (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)	CQMP/CEGPS Report A-18 C-8 [A-17 C-2]	Adopted	(MMS *Policy Compendium*)	xx
9	Physician Call Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)	CQMP Report A-18 C-9 [A-17 C-2]	Adopted as Amended	(MMS *Policy Compendium*)	xx
10	Third-Party Insurers Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)	CQMP Report A-18 C-10 [A-17 C-2]	Adopted as Amended	(MMS *Policy Compendium*)	xx
11	Patient Safety Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)	CQMP Report A-18 C-11 [A-17 C-3]	Adopted	(MMS *Policy Compendium*)	xx
12	Delegates-at-Large	BOT Report A-18 C-12	Adopted	NA	xx

ADOPTED FIRST SESSION, SPEAKERS' CONSENT CALENDAR

13	Membership Dues for Calendar Year 2019	COF Report A-18 C-13	(Adopted)	NA	NA

ADOPTED

Item #:	1
Code:	CSP Report A-18 C-1
Title:	MMS Annual Strategic Plan
Sponsor:	Committee on Strategic Planning Alain Chaoui, MD, FAAFP, Chair

HOUSE VOTE:	**Adopted**
Referred to:	**MMS Presidential Officers**
Informational Report:	**NA**

That the Massachusetts Medical Society's strategic priorities for Fiscal Year 2018–2019 are the following: a focus on physician and patient advocacy, membership value and engagement, and professional knowledge and satisfaction. In order to advance the Society's mission and serve the needs of the physician community and their patients, the goals of our one-year strategic plan will be the following:

- ***Physician and Patient Advocacy*:**
  - **As a trusted and respected leadership voice in health care, ensure that the perspectives of physicians and patients are represented at the state and national level on the most important issues impacting physicians, the health care environment, and patient care and outcomes.**

- ***Membership Value and Engagement*:**
  - **Ensure that the Society is positioned to meet the changing needs of physicians across all demographic segments and practice settings.**
  - **Align member benefits, services, and communication channels with the needs of the physicians we serve, creating a clear membership value proposition.**
  - **Ensure that the Society's governance structure maximizes membership growth, diversity, and engagement and expands access to leadership opportunities.**
  - **Ensure that communication engages physicians and promotes the Society's efforts and achievements.**

- ***Professional Knowledge and Satisfaction:***
  - **Advance medical knowledge to develop and maintain the highest standards of medical practice and health care.**
  - **Support members in developing the skills and knowledge they need to further learning, transform the practice of health care, and achieve lifelong professional growth.**
  - **Build and promote a sense of community, professional satisfaction, and meaning in practice through support, networking, mentoring, education, and physician wellness programs.**
  - **Support physicians in building strong patient-physician relationships.**

(HP)

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

ADOPTED

Item #:	2
Code:	CWIM Report A-18 C-2
Title:	Establishing a Women Physicians Section
Sponsor:	Committee on Women in Medicine Kathryn Hughes, MD, Chair

HOUSE VOTE:	**Adopted**
Referred to:	**(Item 1) Committee on Bylaws**
Report for Action:	**I-18**
Strategic Priority:	**Membership Value and Engagement**

1. **That the Massachusetts Medical Society request that the Bylaws be amended as appropriate to create a Women Physicians Section (WPS). The Women Physicians Section would be composed of all women MMS members. Additionally, male MMS members would be welcome to "opt in" to become WPS members. The purpose of the Section would be to provide a forum for networking, mentoring, advocacy and leadership development for women physicians and medical students. The Section would be entitled to one delegate in the House of Delegates, and the delegate shall be elected annually by the section for a one-year term. *(D)***

2. **That the Committee on Women in Medicine be renamed to the Committee on Women's Health to refine its mission to address health issues that disproportionately or uniquely affect women patients. *(D)***

Fiscal Note: (Out-of-Pocket Expenses)	Annual Expense of $5,000 (Beginning FY20)
FTE: (Staff Effort to Complete Project)	Existing Staff

ADOPTED AS AMENDED

Item #:	3
Code:	CLGBTQ Report A-18 C-3
Title:	Sexual Orientation and Gender Identity Demographic Data Collection by the MMS
Sponsor:	Committee on LGBTQ Matters Carl G. Streed Jr., MD, Chair

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**Committee on Membership**
Informational Report:	**A-19**
Strategic Priority:	**Membership Value and Enagement**

That the MMS develop a plan to expand, and where appropriate handle confidentially, the demographics voluntarily provided by our members to include both sexual orientation and gender identity. *(D)*

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

ADOPTED

Item #:	4
Code:	OFFICERS Report A-18 C-4 [CWM Report I-16 C-3]
Title:	MMS Leadership Promotion and Governance
Sponsors:	MMS Presidential Officers: Henry Dorkin, MD, FAAP Alain Chaoui, MD, FAAFP Maryanne Bombaugh, MD, MSc, MBA, FACOG
Report History:	OFFICERS Report A-17 C-10 CWM Report I-16 C-3 Original Sponsor: Committee on Women in Medicine

HOUSE VOTE:	**Adopted**
Referred to:	**Task Force on Governance**
Informational Report:	**A-19**
Strategic Priority:	**Membership Value and Engagement**

That the Massachusetts Medical Society adopt in-lieu of OFFICERS Report A-17 C-10 the following:

That the Massachusetts Medical Society, when reviewing the current governance structure, consider the process for appointment to standing and special committees and opportunities for committee leadership to ascertain whether there are opportunities for improvement in process, inclusion, diversity, and representation of best practices. *(D)*

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

ADOPTED

Item #:	5a
Code:	OFFICERS Report A-18 C-5 (SECTION A)
Title:	Policy Sunset Process
Sponsors:	MMS Presidential Officers: Henry Dorkin, MD, FAAP Alain Chaoui, MD, FAAFP Maryanne Bombaugh, MD, MSc, MBA, FACOG
	Reviewers: Various MMS Committees and Sections

HOUSE VOTE:	**Adopted**
Referred to:	**(MMS *Policy Compendium*)**
Informational Report:	**NA**

Section A. That the Massachusetts Medical Society reaffirm for seven (7) years the following policies:

1a. ADVANCE CARE PLANNING/END-OF-LIFE CARE

The Massachusetts Medical Society supports patient dignity and the alleviation of pain and suffering at the end of life. *(HP)*

The Massachusetts Medical Society will provide physicians treating terminally ill patients with the ethical, medical, social, and legal education, training, and resources to enable them to contribute to the comfort and dignity of the patient and the patient's family. *(D)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Amended and Reaffirmed MMS House of Delegates, 12/3/11
(Item 3 of Original: Rescinded, MMS House of Delegates, 12/2/17)

ALLIED HEALTH PROFESSIONS AND SERVICES

****2a. Physicians and Physician Assistants***
[*Split between Sunset and Reaffirm]
…
The Massachusetts Medical Society adopts the following guidelines regarding the relationships of physicians and physician assistants:

- **a) The physician is ultimately responsible for managing the health care of patients in all settings.**
- **b) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice as defined by state law.**
- **c) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.**
- **d) The physician is responsible for the supervision of the physician assistant in all settings.**
- **e) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines for care that are developed by the**

physician and the physician assistant, and based on the physician's delegatory style.

f) The physician must be available for consultation with the physician assistant at all times either in person, through telecommunication systems, or other means.

g) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training and experience and preparation of the physician assistant as adjudged by the physician.

h) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

i) There should be a professional and courteous relationship between physician and physician assistant, with mutual acknowledgment of and respect for each other's contributions to patient care.

j) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for care.

k) The physician is responsible for clarifying and familiarizing the physician assistant with the physician's supervising methods and style of delegating patient care.

(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

3a. Radiological Technologists

The MMS will express support of measures that promote patient protection and health care workers safety in the appropriate and cost-effective use of fluoroscopic medical services. *(HP)*

MMS House of Delegates, 5/14/04
Item 2 of Original: Reaffirmed MMS House of Delegates, 5/21/11
(Item 1 of Original: Sunset)

4a. Blood Donation

The Massachusetts Medical Society will continue its efforts to encourage the voluntary donation of blood. *(HP)*

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

Drugs And Prescriptions

5a. Biosimilar Medications

The MMS will advocate via regulatory or legislative avenues that so-called bioequivalent (i.e., generic) substitutions for narrow therapeutic index agents (or those prescribed for treatment of conditions where potential harm of variable bioavailability, prescription to prescription, of said substitution is substantial) not be mandated and/or be limited to no more frequently than once a year, especially for economic reasons alone. This should apply not only to substitutions for branded agents, but also to other generic so-called bioequivalent agents of the same molecular structure. *(D)*

The MMS will advocate via regulatory or legislative avenues that biosimilar medications not be substituted without the express endorsement of the prescribing physician. *(D)*

MMS House of Delegates, 5/21/11

6a. Education Regarding Industry Marketing and Advertising

The MMS supports the concepts that (a) physicians maintain a heightened awareness at all times of the implied and perceived obligations regarding all interactions with the pharmaceutical and medical device industry, and that (b) perception of physicians' behavior should be considered with each contact with industry representatives. *(HP)*

MMS House of Delegates, 11/8/03
Reaffirmed MMS House of Delegates, 5/14/04
Item 2: Amended and Reaffirmed MMS House of Delegates, 5/21/11
(Item 1 of Original: Sunset)

7a. Prescription Writing/E-Prescribing

The Massachusetts Medical Society opposes psychologists obtaining prescription privileges in Massachusetts. *(HP)*

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

8a. Return of Unused and/or Expired Medications

The Massachusetts Medical Society supports the policy that all unused nursing home drugs, which are sealed and dated, be returned for credit. *(HP)*

The Massachusetts Medical Society, in collaboration with the Massachusetts chapter of the American Medical Directors Association and the Massachusetts chapter of the American Geriatric Society, urges the Massachusetts Department of Public Health to expand its current medication return list. *(D)*

The Massachusetts Medical Society urges Massachusetts Congressional members to draft legislation supporting the recycling of unused nursing home drugs, which are sealed and dated. *(D)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Item 1: Reaffirmed MMS House of Delegates, 5/14/10
Items 2 and 3: Amended and Reaffirmed MMS House of Delegates, 5/21/11

ETHICS

9a. Medical Education/Performing Procedures

The Massachusetts Medical Society urges medical schools to adopt and inform medical students of the policy that they may refuse to perform procedures during medical education that are contrary to their religious or moral beliefs without repercussions to the student. *(HP)*

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

FIREARMS: SAFETY AND REGULATION

10a. Handguns

The Massachusetts Medical Society is strongly opposed to legislative interference in the right of physicians and patients (or their parents or guardians) to discuss gun ownership, storage, and safety in the home. *(HP)*

The MMS records its opposition to any legislative or regulatory limits on a physician's ability to take a complete history and document relevant portions of the history into the permanent medical record. *(HP)*

The MMS will advocate that the AMA take a leadership role in opposing legislative interference in the physician-patient relationship and the physician's efforts to discuss and record the patient's history, including questions about gun safety. *(D)*

MMS House of Delegates, 5/21/11

HEALTH CARE DELIVERY

11a. Clinical Integration

The MMS will continuously monitor AMA activity regarding health care laws, regulations, and model organizational information for physicians (including independent, small groups) and medical staffs. This information will assist members with communicating, organizing, and participating in care processes for the high quality and efficient service delivery of health care that will permit independent physician practitioners and/or small groups to clinically integrate and provide accountable care. *(D)*

The MMS will make AMA activity regarding legal and model organizational information on practice integration available to MMS members, by electronic means — as well as on the MMS website — and in hard copy upon request. *(D)*

MMS House of Delegates, 5/21/11

12a. Telemedicine

The Massachusetts Medical Society affirms that any physician practicing telemedicine with a patient in Massachusetts should possess a full and unrestricted license in Massachusetts. *(HP)*

MMS House of Delegates, 11/21/97
Reaffirmed, MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

HEALTH INSURANCE/MANAGED CARE

13a. Health Insurance

Individual Choice and Support for a Pluralistic System

The Massachusetts Medical Society supports an individual's right to select, purchase, and own his/her health insurance and to receive similar tax treatment for individually purchased insurance as for employer purchased coverage. *(HP)*

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

HOSPITALS

14a. Hospital and Health Care Facility Closings

The Massachusetts Medical Society adopts the following principles regarding Health Care Facility Closure—

Physician Credentialing Records:

1. ***Governing Body to Make Arrangements***
   The governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility. The governing body shall send notification of the impending closure to all those physicians credentialed at that facility at least 30 days prior to the date of closure.

2. Transfer to New or Succeeding Custodian

Such a facility shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information. In the alternative, the facility shall seek to make arrangements with a reputable commercial storage firm. The new or succeeding custodian shall be obligated to treat these records as confidential.

3. Documentation of Physician Credentials

The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.

4. Maintenance and Retention

Physician credentialing information and CME information transferred from a closed facility to another hospital, other entity, or commercial storage firm shall be maintained in a secure manner intended to protect the confidentiality of the records. The records shall be maintained for a period of at least two years from the date the facility closes.

5. Access and Fees

The new custodian of the records shall provide timely access at a reasonable cost and in a reasonable manner that maintains the confidential status of the records. *(HP)*

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

MASSACHUSETTS MEDICAL SOCIETY ADMINISTRATION AND ORGANIZATION

15a. Membership and Dues

The MMS will work with the district medical societies to initiate consistent discounts for both state and district dues, which would provide simplification of the billing process and deliver more comprehensive invoices to the member. *(D)*

MMS House of Delegates, 5/21/11
(Item 1 of 3: Auto-Sunset)

16a. Student Dues

The Massachusetts Medical Society (MMS) will exempt dues for its Medical Student Membership. *(D)*

In order to offset expenses of exempt dues for Medical Student Membership, an alternative level of benefits will be provided for medical student members, including substitution of the *New England Journal of Medicine* (NEJM) *Online* for the printed NEJM subscription, and that medical students will no longer have MMS Internet account privileges. *(D)*

MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

17a. Membership Pilot Projects

The House of Delegates delegates to the Board of Trustees the authority to approve the use of pilot membership recruitment/retention projects involving variations of no more than 50% on the current MMS dues structure, as proposed by the Committee on Membership. *(D)*

Such pilot projects shall be required to have a defined time limit, as well as having the prior approval of the Committee on Finance. *(HP)*

The Committee on Membership shall report annually to the House of Delegates as to the impact of all current pilot projects. *(D)*

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

MEDICAID

18a. Preauthorizations

The Massachusetts Medical Society recommends to the Division of Medical Assistance that any requirements for preauthorizations by physicians be reviewed by MMS prior to implementation. *(HP)*

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Amended and Reaffirmed MMS House of Delegates, 5/21/11

MEDICARE/ MEDICAID SERVICES

19a. Practice Expenses

HCFA [CMS] should make efforts to broadly survey medical practices for actual expense data. *(HP)*

The complex surveys needed for practice expense determination should be funded, reimbursing contributing practices for their time and effort. *(HP)*

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

MINORITIES

20a. Minority and Immigrant Populations

The Massachusetts Medical Society, in its role as advocate for patients, will promote a coordinated strategy for: increasing access to medical care for minority populations; heightening awareness of cultural practices through education; and creating greater opportunities for minorities and immigrants within the medical profession, including participation in the Massachusetts Medical Society.

I. Increasing Access to Medical Care for Minority Populations

The Massachusetts Medical Society recognizes that access to medical care is the first step to ensuring quality and improved outcomes. Therefore, the Massachusetts Medical Society will continue to strive for universal access to medical care, regardless of race, ethnicity, socio-economic status or geographic location.

MMS will encourage and work with community outreach programs that address the health care needs of minority and immigrant communities. In addition, the Society will continue to develop links with community-based organizations and social service agencies to identify community-wide health problems and organize health education programs that are specifically tailored to the needs of those particular communities.

II. Heightening Awareness of Cultural Practices and Barriers through Education

The Massachusetts Medical Society should promote increased awareness and research among physicians and medical students on the ethnic and cultural differences between patients, physicians and other health care providers that

can create barriers to good quality health care and research. The Massachusetts Medical Society supports the expansion of educational opportunities for medical students, residents, and physicians in the areas of cultural awareness and ethnic diversity.

III. Creating Opportunities for More Diversity within the Medical Profession
The Massachusetts Medical Society supports the expansion of educational opportunities in biomedical careers for minority and immigrant populations. The Society encourages physicians and health care organizations to employ culturally diverse staff, at all levels, in order to address the needs of the community.
(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
(Item III: Amended and Reaffirmed MMS House of Delegates, 5/21/11)
(Item 5 of Original 5, Sunset: 5/21/11)

***21a.**
[*Split between Reaffirm and Sunset]
The Massachusetts Medical Society (MMS) will increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities. *(D)*

The MMS supports the elimination of racial and ethnic disparities in health care as an issue of high priority. *(HP)*
…

MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

PHYSICIAN PAYMENT

22a. Supervising Teaching Physicians
The Massachusetts Medical Society advocates that all payors reimburse the supervising teaching physician for services provided by a resident unless that resident's service is already fully and explicitly funded by that payor. *(HP)*

MMS House of Delegates, 5/16/97
Reaffirmed, MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

***23a. CPT Codes**
[*Split between Sunset and Reaffirm]
…
The MMS will continue to advocate for reimbursement for all physicians' services as reflected in the AMA's Current Procedural Terminology codebook. *(D)*

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

24a. Third Party Insurers
The Massachusetts Medical Society (MMS) will advocate for laws, regulations, or directives for all insurance carriers, including Medicaid and Medicare, to pay for mandated services required by law or regulation. *(D)*

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

25a. The Massachusetts Medical Society will advocate to payers and support legislation* to require payment to physicians and other health care providers for services rendered if — at the time of the patient's visit — the provider verified coverage through the insurer's available eligibility inquiry system(s), regardless of: future retroactive eligibility changes by the employer or patient, or errors in the insurer's eligibility system. *(D)

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

PHYSICIANS

26a. Gender Parity

The Massachusetts Medical Society endorses the American Medical Association's policy, "Gender Disparities in Physician Income and Advancement" that reads as follows:

Gender Disparities in Physician Income and Advancement

1. **That our American Medical Association encourage medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist;**
2. **That our AMA support physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations;**
3. **That our AMA urge medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession;**
4. **That our AMA collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession; and**
5. **That our AMA provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.**

(HP)

The MMS will advocate and raise awareness for gender parity, equal pay, and advancement as a fundamental professional standard to ensure equal opportunity within the medical profession in Massachusetts. *(D)*

MMS House of Delegates, 5/21/11

PREAUTHORIZATIONS

27a. Preauthorizations

The MMS opposes the use of preauthorization where the medication or procedure prescribed is a common and indicated one or commonly used medication for the indication as supported by peer-reviewed medical publications. *(HP)*

Any reviewer at any level of the preauthorization process be fully identified by full name, title, and location; educational level; and contact information of supervisor. *(HP)*

Third parties should make available to the Massachusetts Medical Society meaningful, aggregate statistics in usable form in a timely fashion (e.g., broken down by specialty, medication, diagnostic test, or procedure; indication offered and reason for denial and outcomes analysis) of percentages of acceptance or denial as well as other relevant

trending information. Individual medical group data should be made available upon request by each group. *(D)*

MMS House of Delegates, 5/14/11

28a.* The Massachusetts Medical Society (MMS) opposes pre-certification programs of third-party payers that interfere with the physician-patient relationship, delay medically necessary care, or impose an undue administrative burden on physicians. *(HP)

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

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

PROFESSIONAL LIABILITY

29a. Excess Professional Liability Insurance

In order to enhance freedom of choice in the selection of medical professional liability insurance coverage, the Massachusetts Medical Society will advocate with all health insurance plans, hospital staffs, and other pertinent health care entities that any mandatory malpractice insurance coverage limit requirement higher than the state minimum should be eliminated*. (D)*

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

30a.* The Massachusetts Medical Society will continue to advocate for legislation which requires that physician expert witnesses testifying in medical professional liability cases venued in the Commonwealth of Massachusetts must possess the following qualifications: (1) Hold a non-restricted medical license; (2) Be board certified in the same relevant specialty as the defendant physician; (3) Be actively practicing in the same specialty as the defendant physician; (4) Be available at trial if serving as the expert at the tribunal stage of the proceedings. *(D)

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

****31a.***
[*Split between Reaffirm and Reaffirm for One Year]
…
The MMS will collaborate with appropriate legal representatives, Massachusetts professional liability insurers, and the Massachusetts Board of Registration in Medicine for purposes of implementing the Expert Witness Testimony Standards in the form of MMS policy, an affirmation statement, and/or by other useful and effective means, to improve the quality of clinical evidence introduced at all stages of the litigation process. *(D)*

MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

RESEARCH

32a. Medical Research

The Massachusetts Medical Society in its program developments will take into consideration the importance of promoting and supporting medical research in the interest of the health and well-being of future generations. *(HP)*

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

SURGERY

33a. Standards of Care

The Massachusetts Medical Society (MMS) recognizes that minimum frequency standards may be appropriate for some surgical procedures. *(HP)*

The MMS will continue to monitor the literature and physician feedback concerning the impact and ethic of performing surgical procedures as it relates to surgical volume. *(D)*

The MMS will continue to monitor and provide feedback, when appropriate, to relevant agencies as they develop standards regarding surgical competency and minimum frequency. *(D)*

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

TOBACCO/ SMOKING

34a. Government Initiatives: Sale of Tobacco Products, Advertising, Prevention

The Massachusetts Medical Society strongly supports comprehensive prevention, education, cessation, and advocacy efforts to prevent morbidity and mortality associated with tobacco use. *(HP)*

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

VIOLENCE

35a. Domestic Violence Detection Education

The Massachusetts Medical Society supports the establishment of child abuse and domestic violence detection educational programs for physicians, physicians in training and medical students. In addition, the Massachusetts Medical Society strongly encourages and facilitates the participation of physicians, physicians in training and medical students in these programs. It is further recommended that physicians be allowed to use their participation in these programs toward the risk management requirement for relicensure. *(HP)*

MMS House of Delegates, 5/20/94
Reaffirmed MMS House of Delegates, 5/21/11

36a. Hate Crimes

The Massachusetts Medical Society recognizes the significant negative health outcomes and health care disparities caused by discrimination and hate violence against transgender individuals based on their gender identity and expression. *(HP)*

The Massachusetts Medical Society strongly supports legal protections against discrimination and hate violence against transgender individuals based on their gender identity and expression. *(HP)*

MMS House of Delegates, 5/21/11

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

ADOPTED

Item #:	5b
Code:	OFFICERS Report A-18 C-5 (SECTION B)
Title:	Policy Sunset Process
Sponsors:	MMS Presidential Officers: Henry Dorkin, MD, FAAP Alain Chaoui, MD, FAAFP Maryanne Bombaugh, MD, MSc, MBA, FACOG
	Reviewers: Various MMS Committees and Sections

HOUSE VOTE:	**Adopted**
Referred to:	**(MMS *Policy Compendium*)**
Informational Report:	**NA**

Section B. That the following policies eligible for sunsetting be amended and reaffirmed for seven (7) year (added text shown as "text" and deleted text shown as "~~text~~"):

1b. ADVANCE CARE PLANNING/END-OF-LIFE CARE

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

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

MMS House of Delegates, 5/21/11

DRUGS AND PRESCRIPTIONS

2b. Marijuana: Recreational Use of

The Massachusetts Medical Society affirms its opposition to ~~smoking~~ the use of marijuana for recreational purposes. *(HP)*

The Massachusetts Medical Society recognizes the importance of ~~clinical trials~~ research on the ~~medical~~ use of marijuana and its derivatives. All such trials should be approved by an Institutional Review Board process. *(HP)*

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

HEALTH EDUCATION

3b. Student Health

The MMS encourages local communities to provide age-appropriate comprehensive health education to students that incorporates information on the prevention of STIs, including HIV. *(D)*

MMS House of Delegates, 5/14/04
Item 2 of 2: Reaffirmed MMS House of Delegates, 5/21/11

MENTAL HEALTH

4b. Mental Health Services: Gestation and Postpartum

The MMS supports a culture of awareness, destigmatization, ~~and~~ screening, referral, and treatment for psychiatric illnesses during ~~gestation~~ pregnancy and postpartum to ensure that patients have access to effective and affordable mental health services. *(HP)*

The MMS will advocate for expanding health insurance coverage and reimbursement of medically necessary mental health services during ~~gestation~~ pregnancy and postpartum. *(D)*

The MMS will work with other appropriate organizations and specialty societies to support and promote awareness among patients, families, and providers of the risks of mental illness during pregnancy and postpartum. *(D)*

The MMS will work with all appropriate parties such as insurers, health care systems, providers, consumers, allied health care professionals, and the government to foster integration of mental health care with general medical care. *(D)*

MMS House of Delegates, 12/3/11

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

ADOPTED (Reaffirmed for One Year Pending Review)

Item #:	5c
Code:	OFFICERS Report A-18 C-5 (SECTION C)
Title:	Policy Sunset Process
Sponsors:	MMS Presidential Officers: Henry Dorkin, MD, FAAP Alain Chaoui, MD, FAAFP Maryanne Bombaugh, MD, MSc, MBA, FACOG
	Reviewers: Various MMS Committees and Sections

HOUSE VOTE:	**Adopted (Reaffirmed for One Year Pending Review)**
Referred to:	**1c: Committee on Ethics, Grievances, and Professional *Standards (Item 10 in consultation with Committee on Medical Education)***
	2c: Committee on the Quality of Medical Practice *(Items 11 and 13 in consultation with Committee on Legislation & Item 12 in consultation with Committee on Professional Liability)*
	3c: Committee on the Quality of Medical Practice *(Item B1 in consultation with Committee on Legislation)*
	4c: Committee on Public Health and Committee on Diversity in Medicine
	5c: Committee on Professional Liability
	6c: Committee on Public Health
	7c: Committee on the Quality of Medical Practice
	8c: Committee on the Quality of Medical Practice
Report for Action to HOD: (with Recommendation on Whether to Reaffirm, Sunset, or Amend)	**A-19**

Section C. That the Massachusetts Medical Society <u>reaffirm for one (1) year</u> the following policies:

ETHICS

1c. Genetic Information and Patient Privacy

The Massachusetts Medical Society will adopt the following General Principles on Genetic Information and Patient Privacy:

1. **Physicians should accord genetic information derived about their patients the highest possible confidentiality protection. Genetic information in the medical record should be handled so as to prevent inadvertent disclosure. Such information should be released to third parties only pursuant to the specific**

authorization of the patient. The possibility that genetic information derived about a patient might be of clinical importance to relatives or other third persons does not alter the physician's duty of confidentiality to his or her patients. The physician should, however, inform patients who are considering a genetic test about the potential importance of the data that could be derived there from to relatives. On very rare occasions, a physician may reveal otherwise confidential genetic information to a third person if withholding the genetic information derived from the patient will likely cause imminent and serious harm, injury or danger to that particular third person.

2. Physicians should strive to become aware of the special ethical, legal, social, financial, and personal issues that may arise when they or others compile genetic information about their patients.

3. Physicians engaged in genetic testing for clinical, therapeutic or research purposes should engage in such testing only with the full informed consent of the patient or, when appropriate, with the informed consent of the patient's legally authorized representative. Such informed consent should, at a minimum, involve a disclosure by the physician to the patient of the benefits, risks and costs associated with receiving the test, any appropriate alternative procedures or courses of treatment, the potential results of the test, any possible financial benefit to the physician, including any research interest, from either performing the test or utilizing the samples, and any other significant implications of receiving the test.

4. In cases where genetic samples have been intentionally donated for the purpose of genetics research in an anonymous manner (i.e., removed of or without identifiers), physicians need not obtain informed consent in order to engage in non-clinical use of such genetic testing results or samples.

5. Physicians should not order genetic testing of a child unless the test is intended to diagnose a disease or condition for which there is a recognized clinical benefit to acquiring the information before the child reaches the age of eighteen (18). Clinical benefit should be understood to include issues involving reproductive risks that are faced by adolescents (girls and boys), including those that arise in the context of an unplanned pregnancy. Such tests should be ordered only with the informed consent of the legally responsible person.

6. Physicians should participate in genetic research involving human subjects only if the research protocol has been approved by an institutional review board (IRB) or some comparable group that operates pursuant to federal guidelines involving human subjects research. They should satisfy themselves that adherence to the protocol will result in research subjects having adequate, fair disclosure concerning issues such as informational risk, long-term use and disposition of tissue samples, disclosure of research results to subjects, whether subjects will be recontacted if new information emerges, and relevant economic issues (such as whether the research is sponsored by a for-profit organization and/or whether a subject will or will not receive any economic benefit).

7. Genetic testing results can provide valuable information to be considered by individuals making reproductive choices. MMS opposes, however, the use of genetic testing results by persons or institutions, other than the patient[s] from

whom the genetic information was derived, to influence the reproductive choice of the patient[s] from whom the genetic information was derived.

8. The Massachusetts Medical Society hereby affirms existing policy regarding genetic discrimination in insurance coverage which reads as follows:

The Massachusetts Medical Society adopts the AMA Policy H-185.972 regarding Genetic Information and Insurance Coverage, which reads as follows:

(1) Health insurance providers should be prohibited from using genetic information, or an individual's request for genetic services, to deny or limit any health benefit coverage or establish eligibility, continuation, enrollment or contribution requirements.

(2) Health insurance providers should be prohibited from establishing differential rates or premium payments on genetic information or an individual's request for genetic services.

(3) Health insurance providers should be prohibited from requesting or requiring collection or disclosure of genetic information.

(4) Health insurance providers and other holders of genetic information should be prohibited from releasing genetic information without express prior written authorization of the individual. Written authorization should be required for each disclosure and include to whom the disclosure be made.

(HP)
(MMS House of Delegates, 11/21/97)
(Reaffirmed MMS House of Delegates, 5/14/04)
Reaffirmed (Entire Policy) MMS House of Delegates, 5/21/11

9. The Massachusetts Medical Society hereby affirms existing policy regarding genetic discrimination in the workplace, which reads as follows:

The Massachusetts Medical Society adopts the AMA policy E-2.132 regarding Genetic Testing by Employers which reads:

As a result of the human genome project, physicians will be able to identify a greater number of genetic risks of disease. Among the potential uses of the tests that detect these risks will be screening of potential workers by employers. Employers may want to exclude workers with certain genetic risks from the workplace because these workers may become disabled prematurely, impose higher health care costs, or pose a risk to public safety. In addition, exposure to certain substances in the workplace may increase the likelihood that a disease will develop in the worker with a genetic risk for the disease.

(1) It would generally be inappropriate to exclude workers with genetic risks of disease from the workplace because of their risk. Genetic tests alone do not have sufficient predictive value to be relied upon as a basis for excluding workers. Consequently, use of the tests would result in unfair discrimination against individuals who have positive test results. In addition, there are other ways for employers to serve their legitimate interests. Tests of a worker's actual capacity to meet the demands of the job can be used to ensure future employability and protect the public's safety. Routine monitoring of a worker's

exposure can be used to protect workers who have a genetic susceptibility to injury from a substance in the workplace. In addition, employees should be advised of the risks of injury to which they are being exposed.

(2) There may be a role for genetic testing in the exclusion from the workplace of workers who have a genetic susceptibility to injury. At a minimum, several conditions would have to be met:

(a) The disease develops so rapidly that serious and irreversible injury would occur before monitoring of either the worker's exposure to the toxic substance or the worker's health status could be effective in preventing harm.
(b) The genetic testing is highly accurate, with sufficient sensitivity and specificity to minimize the risk of false negative and false positive test results.
(c) Empirical data demonstrate that the genetic abnormality results in an unusually elevated susceptibility to occupational injury.
(d) It would require undue cost to protect susceptible employees by lowering the level of the toxic substance in the workplace. The costs of lowering the level of the substance must be extraordinary relative to the employer's other costs of making the product for which the toxic substance is used. Since genetic testing with exclusion of susceptible employees is the alternative to cleaning up the workplace, the cost of lowering the level of the substance must also be extraordinary relative to the costs of using genetic testing.
(e) Testing must not be performed without the informed consent of the employee or applicant for employment.

(3) That the Massachusetts Medical Society agrees that employers should be prohibited from requesting, obtaining, or using genetic information to hire or fire an employee, or set terms, conditions, privileges, or benefits of employment, unless the employment organization can prove this information is job related and consistent with CEJA opinion 2.132.

(4) That employers should be prohibited from disclosing genetic information.

(HP)
(MMS House of Delegates, 11/21/97)
(Reaffirmed, MMS House of Delegates, 5/14/04)
(Reaffirmed MMS House of Delegates, 5/21/11)

10. Appreciating the acceleration of new information in the field of genetics, the Massachusetts Medical Society will develop a plan to educate physicians throughout the state (through venues such as conferences and interactive or on-line learning tools and curricula suitable for Grand Rounds, etc.), regarding the basic and current principles of genetic information and testing, and the clinical, social and legal implications of such advancing technologies.

(HP)
(MMS House of Delegates, 11/6/99)
Reaffirmed (Entire Policy) MMS House of Delegates, 5/21/11

2C. HEALTH SYSTEM REFORM

The Massachusetts Medical Society adopts the following Principles for Health Care Reform:

1. ***Physician leadership*. Physician leadership is seen as essential for the implementation of new payment reform models. Strong leadership from primary care and specialty care physicians in both the administrative structure of accountable care organizations (ACOs) and other payment reform models, as well as in policy development, cost containment and clinical decision-making processes, is key.**

2. ***One size will not fit all*. One single payment model will not be successful in all types of practice settings. Many physician groups will have a great deal of difficulty making a transition due to their geographic location, patient mix, specialty, technical and organizational readiness, and other factors.**

3. ***Deliberate and careful*. Efforts must be undertaken to guard against the risk of unintended consequences in any introduction of a new payment system.**

4. ***Fee-for-service payments have a role*. While a global payment model could encourage collaboration among providers, care coordination, and a more holistic approach to a patient's care, fee-for-service payments should be a component of any payment system.**

5. ***Infrastructure support*. Sufficient resources for a comprehensive health information technology infrastructure and hiring an appropriate team of physician assistants, nurse practitioners, and other relevant staff are essential across all payment reform models.**

6. ***Proper risk adjustment*. In order to take on a bundled, global payment or other related payment models, funding must be adequate, and adequate risk adjustment for patient panel sickness, socioeconomic status, and other factors is needed. Current risk adjustment tools have limitations, and payers must include physician input as tools evolve and provide enough flexibility regarding resources in order to ensure responsible approaches are implemented. In addition, ACOs and like entities must have the infrastructure in place and individuals with the skills to understand and manage risk.**

7. ***Transparency*. There must be transparency across all aspects of administrative, legal, measurement, and payment policies across payers regarding ACO structures and new payment models. There must also be transparency in the financing of physicians across specialties. Trust is a necessary ingredient of a successful ACO or other payment reform model. The negotiations between specialists, primary care physicians, and payers will be a determining factor in establishing this trust.**

8. ***Proper measurements and good data*. Comprehensive and actionable data from payers regarding the true risks of patients is key to any payment reform model. Without meaningful, comprehensive data, it becomes impractical to take on risk. Nationally accepted, reliable, and validated clinical measures must be used to both measure quality performance and efficiency and evaluate patient experience. Data must be accurate, timely, and made available to physicians for both trending and the ability to implement quality improvement and cost effective care. The ability to correct inaccurate data is also important.**

9. ***Patient expectations*. Patient expectations need to be realigned to support the more realistic understanding of benefits and risks of tests and clinical services or procedures when considering new payment reform models. Physicians and payers**

must work together to provide a public health educational campaign, with an opportunity for patients to provide input as appropriate and engage in relevant processes.

10. ***Patient incentives*. Patient accountability coupled with physician accountability will be an effective element for success with payment reform. An important aspect of benefit design by payers is to exclude cost sharing for preventive care and other selected services.**

11. ***Benefit design*. Benefit designs should be fluid and innovative. Any contemplation of regulation and legislation with regard to benefit design should balance mandating minimum benefits, administrative simplification, with sufficient freedom to create positive transparent incentives for both patients and physicians to maximize quality and value.**

12. ***Professional liability reform*. Defensive medicine is not in the patient's best interest and increases the cost of healthcare. In an environment where physicians have the incentive to do less, but patients request more, physicians view litigation as an inevitable outcome unless there is effective professional liability reform.**

13. ***Antitrust reform*. As large provider entities, ACO definitions and behavior may collide with anti-trust laws. The state legislature may be the adjudicator of antitrust issues. Accountable care organizations and other relevant payment reform models should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.**

14. ***Administrative simplification*. Physicians and others who participate in new payment models, including ACOs, should work with payers to reduce administrative processes and complexities and related burdens that interfere with delivering care. Primary care physicians should be protected from undue administrative burdens or should be appropriately compensated for it.**

15. ***The incentives to transition*. In order to transition to a new model, incentives must be predominantly positive.**

16. ***Planning must be flexible*. Accommodations must be made to take into account the highly variable readiness of practices to move to a new system.**

17. ***Primary care physician.* All patients should be encouraged to have a primary care physician with whom they can build a trusted relationship and from whom they can receive care coordination.**

18. ***Patient access.* Health care reform must enable patient choice in access to physicians, hospitals and other services while recognizing economic realities.**

(HP)

MMS House of Delegates, 5/21/11

HOSPITALS

3c. Mergers or Conversions

Statement of Principles for Conversions and Mergers

A. Community Health Impact:

(1) Any proposed merger or conversion should assure access to high quality patient care and medically necessary services appropriate to the community's needs.

(2) The proposed new entity should be obligated to provide the same or enhanced levels of services in the following areas:

- **care to the uninsured and other vulnerable populations**
- **community health**
- **education and teaching**
- **research**

(3) The health services to be provided by the new entity should be defined prior to the approval of the conversion or merger and should be committed to for a defined period. Procedures should be established for effective independent monitoring of those services to assure compliance with the agreed upon commitments and assessment of their effect on the community health status.

(4) Public hearings should be held to assure full public discussion of the proposed new entity and community concerns should be given full hearing. The proposed new entity should develop a written plan which addresses those community concerns before final approval of the proposed conversion or merger.

B. Oversight Requirements

(1) There should be full compliance with all requirements set forth by the Office of the Massachusetts Attorney General and the Massachusetts Department of Public Health.

(2) An independent appraisal of assets should be completed prior to a for-profit conversion.

(3) Private inurement to officers, trustees, directors and employees of the converting or merging entities should be prohibited.

(4) All actual and potential conflicts of interest by officers, trustees, directors and employees of the converting or merging entities should be publicly disclosed.

(5) The mission of any charitable foundation that is established after a conversion should be limited to improving the health of the community. Such foundations should be governed by a local board of directors with meaningful community and physician participation.

(6) The level of compensation for officers, trustees, directors and employees of the newly formed entity and the charitable foundation, when applicable, should be at an appropriate market rate.

Implementation Strategies

(1) Issue: Staffing Levels – With respect to Principle A.1.: "Any proposed merger or conversion should assure access to high quality patient care . . .." One key determinant of the quality of patient care is the adequacy of medical staffing. Strategy: After the conversion or merger, staffing levels should be appropriate to provide high quality patient care.

(2) Issue: Service Changes – With respect to Principle A.3.: "The health services to be provided by the new entity should be defined prior to the approval of the conversion or merger . . ." Appropriate information needs to be made available to the community in a timely manner, so as to enable the community to provide effective input to the process. Strategy: The new entity should identify both current services and those services it proposes to provide. As further modifications of services are proposed, the community should be informed and their input sought.

(3) Issue: Monitoring – With respect to Principle A.3.: "Procedures should be established for effective independent monitoring . . .." Because the affected community has the most at stake, it should be given the mandate and resources needed to perform this task. Strategy: Effective monitoring may be achieved by a local advisory board with significant autonomy.

(4) Issue: Private Inurement – With respect to Principle B.3.: "Private inurement to officers, trustees, directors and employees of the converting or merging entities should be prohibited." Decisions regarding conversions and mergers should be made solely on the basis of the best interests of the converting or merging entity and the community it serves. Strategy: Such abuses of trust should be aggressively investigated and prohibited by law or regulation, with penalties for violations.

(5) Issue: Conflicts of Interest – With respect to Principle B.4.: "All actual and potential conflicts of interest by officers, trustees, directors and employees of the converting or merging entities should be publicly disclosed." The purpose of this recommendation is to inform the community about the possible motives of key decision-makers in the conversion or merger process. Strategy: All disclosures of conflicts of interest should be documented in writing.

(6) Issue: Charitable Foundations – With respect to Principle B.5.: "The mission of any charitable foundation that is established after a conversion should be limited to improving the health of the community. Such foundations should be governed by a local board of directors with meaningful community and physician participation." And, Principle B.6., states: "The level of compensation for officers, trustees, directors and employees of . . . the charitable foundation . . . should be at an appropriate market rate." Charitable foundations formed with the assets of a converting entity have great potential for being misused. Strategy: The mission, governance, operations and management of such foundations should be subject to public scrutiny and focused on health care.

(HP)

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

MINORITIES

4c. Race and Ethnicity Data

The Massachusetts Medical Society, recognizing that race and ethnicity are concepts that are sensitive and difficult to define, and yet important determinants of health outcomes, supports the use of the uniform and standardized classification system of the U.S. Bureau of the Census, during the voluntary collection of race and ethnicity data. *(HP)*

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

PROFESSIONAL LIABILITY

*5c. Physician Expert Witnesses

[*Split between Reaffirm for One Year and Reaffirm for Seven Years]

The Massachusetts Medical Society (MMS) adopts the following Expert Witness Testimony Standards, applicable to all physicians who testify as expert witnesses in professional liability cases in Massachusetts:

1. **The physician expert witness must hold a current, valid, nonrestricted medical license.**
2. **The physician expert witness must be board certified in the same specialty as the defendant physician when providing expert testimony on the standard of care provided by the defendant, or board certified in their specialty when providing any other relevant expert testimony in the case. Board certification shall be with a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association.**
3. **The physician expert witness must be actively engaged in the clinical practice of medicine.**
4. **The physician expert witness must be aware of and comply with the American Medical Association's (AMA) policies on Medical Testimony, False Testimony, Peer Review of Medical Expert Witness Testimony, Expert Witness Testimony, AMA-ABA Statement on Interprofessional Relations for Physicians and Attorneys, and other applicable expert witness testimony standards, guidelines, principles, and codes of ethics established by the American Medical Association.**
5. **The physician expert witness must acknowledge and comply with expert witness testimony standards, guidelines, principles, and codes of ethics established by the national specialty society for the testifying physician's specialty, and sign, if such exists, an affirmation of compliance.**
6. **The physician must be available at trial if rendering an opinion at the tribunal stage of the proceedings.**
7. **The physician expert witness must be aware that the Federation of State Medical Boards defines false, fraudulent, or deceptive testimony as unprofessional conduct, and that such testimony may be actionable by the Massachusetts Board of Registration in Medicine or any other state licensing boards with whom the physician expert witness holds licenses to practice medicine.**
8. **The physician expert witness must be willing to submit transcripts of depositions and courtroom testimony to independent peer review by the appropriate specialty society.**

(HP)

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MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

PUBLIC HEALTH

6c. Human Medicine, Veterinary Medicine, and Environmental Sciences

The Massachusetts Medical Society supports and promotes collaboration among the health professions to improve the integration of human medicine, veterinary medicine, and the environmental sciences. *(HP)*

The MMS will engage in a dialogue with the Massachusetts Veterinary Medical Association and the Massachusetts Public Health Association to determine and implement strategies for enhancing collaboration among the human medical, veterinary medical, and environmental sciences professions in medical education, clinical care, public health, and biomedical research. *(D)*

MMS House of Delegates, 12/3/11

QUALITY OF CARE

7C. Quality Measurement/Quality Improvement

The Massachusetts Medical Society adopts the following principles, for quality of medical care initiatives that the Society should undertake or embrace:

I. Definition of Quality
- **A. Institute of Medicine: "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"**
- **B. Physicians' perspective as patient advocates (in contrast with those of health plans, purchasers) focuses on appropriate clinical decision-making (related to knowledge and judgment) and performance skills**

II. Individual Physician Responsibility for Quality Management
- **A. There are professional privileges granted from society to physicians. In return, physicians have a professional responsibility to understand and apply scientific and technical knowledge for the benefit of patients (i.e., quality medical care)**
- **B. Physicians' claims to the public trust are derived from our unique role as patient advocates**

III. Responsibilities of the Massachusetts Medical Society (MMS)
- **A. Our mission states: "The purposes of the Massachusetts Medical Society shall be to do all things as may be necessary and appropriate to advance medical knowledge, to develop and maintain the highest professional and ethical standards of medical practice and health care, and to promote medical institutions formed on liberal principles for the health, benefit, and welfare of the citizens of the Commonwealth"**
- **B. MMS is the primary "grassroots" organization representing Massachusetts physicians**
- **C. Our own past history demonstrates concern for quality in areas such as continuing medical education (CME), advancement of medical knowledge through the ownership of *The New England Journal of Medicine,* and participation in guideline promulgation and implementation**
- **D. MMS has broad experience and readily available expertise in patient care, research, and education**

IV. Many policy decisions regarding medical practice (e.g., legislative and regulatory) are at the state level. Therefore, a state medical society is the most appropriate arena for many policy decisions.

V. Role of American Medical Association
- **A. Promote physician involvement in continuous quality improvement (CQI): data collection, analyses, and feedback loops**
- **B. Promote standards for physician profiling**
- **C. Promote effective quality improvement models**
- **D. Encourage development and provision of educational and training opportunities to improve patient care**
- **E. Encourage outcomes research**
- **F. Evaluate quality assurance programs**
- **G. Advocate nationally for quality in medicine**

(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

8c. Quality of Medical Care Initiatives, which the Massachusetts Medical Society undertakes, should have the following characteristics:

I. Quality Measures from Physicians' Perspective: i.e., Appropriate Clinical Decision-Making, Performance Skills, and Desired Outcomes

II. Medical Services Ranging from Those Performed for Individual Patients to Those Performed for the Public Health

III. Categories of specific physician groups as participants in quality initiatives
- **A. Geographic Area**
- **B. Specialty**
- **C. Impaired**
- **D. Outlier Practice Patterns**
- **E. Other Groups**

IV. Conceptual Frameworks for Quality Initiatives
- **A. Measurement: Profiling**
  - **(1) System Focus**
    - **a) Structures: (e.g. credentialing, liability)**
    - **b) Processes: (e.g. compliance to guidelines)**
    - **c) Outcomes: (e.g. mortality, quality of life)**
  - **(2) Role of Massachusetts Medical Society**
    - **a) Set standards for agencies to measure through the development of a set of attributes or criteria by an expert clinical panel**
    - **b) Direct role in the profiling of physicians**
- **B. Substantive Medical Management: Knowledge Base, Judgment, Decision-Making**
  - **(1) Curricula**
    - **a) Directly providing and organizing CME and Non-CME courses**
    - **b) Accrediting Other Physician-Affiliated Organizations**
    - **c) Implementing Scientific Advances in Physicians' Clinical Practices**
  - **(2) Mentoring**
  - **(3) Clinical Practice Guidelines: Refine, approve, implement, evaluate**
  - **(4) Other systems of support**

V. Physicians Partnering with Patients, along with other Providers: Academic Consortia, Hospitals, and other Professional Organizations

VI. Establishment of a Quality of Medical Care Program

VII. Clarity of Design and Focus of the Quality of Medical Care Program
- **A. Substantive content of medical program**
- **B. Program target population**
- **C. Definition of program outcomes**
- **D. Definition of program time-line**
- **E. Program evaluation component**

(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

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

FTE: Existing Staff
(Staff Effort to Complete Project

ADOPTED (Sunset)

Item #:	6
Code:	CPH Report A-18 C-6 [A-17 C-2]
Title:	Prescription Marketing Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsor:	The Committee on Public Health Steven Ringer, MD, Chair
Report History:	OFFICERS Report A-17 C-2 (Section C) Original Sponsor: MMS Presidential Officers

HOUSE VOTE:	**Adopted (Sunset Item)**
Referred to:	**(MMS *Sunset Compendium*)**
Informational Report:	**NA**

That the Massachusetts Medical Society sunset the prescription marketing policy reaffirmed at A-10, which reads as follows:

> **The Massachusetts Medical Society disapproves of the direct product specific advertising of prescription drugs to the public. *(HP)***
>
> ***MMS House of Delegates, 11/8/96***
> ***Reaffirmed, MMS House of Delegates, 5/2/03***
> ***Reaffirmed, MMS House of Delegates, 5/14/10***

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

REFERRED TO THE COMMITTEE ON ETHICS, GRIEVANCES, AND PROFESSIONAL STANDARDS

Item #:	7
Code:	CEGPS/CQMP Report A-18 C-7 [A-17 C-2]
Title:	Ethics and Managed Care Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsors:	Committee on Ethics, Grievances, and Professional Standards Ronald Arky, MD, Chair Committee on the Quality of Medical Practice Barbara Spivak, MD, Chair
Report History:	OFFICERS Report A-17 C2 Original Sponsor: MMS Presidential Officers (and Reviewing Committees)

HOUSE VOTE:	**Referred to Committee on Ethics, Grievances, and Professional Standards**
Referred to:	**Committee on Ethics, Grievances, and Professional Standards**
Report for Action to HOD: (with Recommendation on Whether to Reaffirm, Sunset, or Amend)	**A-19**
Strategic Priority:	**Physician and Patient Advocacy**

That the Massachusetts Medical Society adopt-in-lieu of the Ethics and Managed Care policy reaffirmed at A-10 the following:

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

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

Changes in the practice environment require physicians to examine their professional relationships even more closely. As health care has become more complex and costlier, new challenges have emerged. Payment models and incentive mechanisms intended to contain costs and improve quality may create conflicts of interest that work against the goal of providing care that is responsive to the unique needs, values, and preferences of individual patients.

The following principles are offered to reaffirm the primacy of the physician-patient relationship and the standards of conduct between and among colleagues. Further, they provide general recommendations related to physicians' ethical responsibilities to address questions of access to care, for individuals and for populations of patients, in their role as practicing clinicians, as leaders of health care organizations and institutions, and collectively as a profession.

These principles are offered as ethics guidance for physicians and are not intended to establish clinical practice guidelines or rules of law.

<u>PROFESSIONALISM IN HEALTH CARE SYSTEMS (Adapted from AMA CEJA Opinion 11.2.1)</u>

Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism, are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations should ensure that practices for financing and organizing the delivery of care:

- **(a) Are transparent.**
- **(b) Reflect input from key stakeholders, including physicians and patients.**
- **(c) Recognize that over reliance on financial incentives may undermine physician professionalism.**
- **(d) Ensure ethically acceptable incentives that:**
  - **(i) are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity,**

case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethics guidance;

(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;

(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;

(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.

(e) Encourage, rather than discourage, physicians (and others) to:

(i) provide care for patients with difficult to manage medical conditions;

(ii) practice at their full capacity, but not beyond.

(f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.

(g) Are routinely monitored to:

(i) identify and address adverse consequences;

(ii) identify and encourage dissemination of positive outcomes.

All physicians should:

(h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.

(i) Advocate for changes in health care payment and delivery models to promote access to high-quality care for all patients.

<u>PHYSICIAN STEWARDSHIP OF HEALTH CARE RESOURCES (Adapted from AMA CEJA Opinion 11.2.2)</u>

Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians' have a secondary obligation to promote public health and access to care. Part of this secondary obligation includes physician awareness of health care resource limitations. It is incumbent upon physicians to consider these limitations when making medical decisions. With this in mind, physicians should:

(a) Base recommendations and decisions on patients' medical needs.

(b) Use scientifically grounded evidence to inform professional decisions when available.

(c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals.

(d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals.

(e) Choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.

(f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making.

(g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:

(h) Encouraging health care administrators and organizations, including insurance companies, to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship.

(i) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect overall health care spending.

(j) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.

<u>ALLOCATING LIMITED HEALTH CARE RESOURCES (Adapted from AMA CEJA Opinion 11.1.3)</u>

Physicians' primary ethical obligation is to promote the well-being of their patients. Policies for allocating scarce health care resources may impede physicians' ability to fulfill that obligation.

As professionals dedicated to protecting the interests of their patients, physicians thus have a responsibility to contribute their expertise to developing allocation policies that are fair and safeguard the welfare of patients.

Individually and collectively through the profession, physicians should advocate for policies and procedures that allocate scarce health care resources fairly among patients.

Allocation policies should be based on criteria relating to medical need, including urgency of need, likelihood and anticipated duration of benefit, and change in quality of life and use of lower cost alternatives of equal quality. In limited circumstances, it may be appropriate to take into consideration the amount of resources required for successful treatment. It is not appropriate to base allocation policies on social worth, perceived obstacles to treatment, patient contribution to illness, past use of resources, or other non-medical characteristics.

<u>FINANCIAL BARRIERS TO HEALTH CARE ACCESS (Adapted from AMA CEJA Opinion 11.1.4)</u>

Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.

In view of this obligation:

(a) Individual physicians should help patients obtain needed care through public or charitable programs when patients cannot do so themselves.

(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.

(c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to appropriate health services.

(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure necessary access to appropriate health care for all people.

CONFLICTS OF INTEREST IN PATIENT CARE (AMA CEJA Opinion 11.2.2)

The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may physicians place their own financial interests above the welfare of their patients.

Treatment or hospitalization that is willfully excessive or inadequate constitutes unethical practice. Physicians should not provide wasteful and unnecessary treatment that may cause needless expense solely for the physician's financial benefit or for the benefit of a hospital or other health care organization with which the physician is affiliated.

Where the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority.

CONTRACTS TO DELIVER HEALTH CARE SERVICES (AMA CEJA Opinion 11.2.3)

Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires them to consider carefully the terms and conditions of contracts to deliver health care services before entering into such contracts to ensure that those contracts do not create untenable conflicts of interests. Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes may be intended to enhance quality, efficiency, and safety in health care, they may also put at risk physicians' ability to uphold professional ethical standards of informed consent and fidelity to patients and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

As physicians enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, or other entities—they should be mindful that while many arrangements have the potential to promote desired improvements in care, some arrangements also have the potential to impede patients' interests.

When contracting to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts or have a representative do so on their behalf to assure themselves that the arrangement:

(i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment

recommendations or direct what care patients receive, in keeping with ethics guidance;

(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;

(iii) allows the physician to appropriately exercise professional judgment;

(iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;

(v) permits disclosure to patients.

(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical standards.

<u>TRANSPARENCY IN HEALTH CARE (AMA CEJA Opinion 11.2.4)</u>

Respect for patients' autonomy is a cornerstone of medical ethics. Patients must rely on their physicians to provide information that patients would reasonably want to know to make informed, well-considered decisions about their health care. Thus, physicians have an obligation to inform patients about all appropriate treatment options, the risks and benefits of alternatives, and other information that may be pertinent, including the existence of payment models, financial incentives; and formularies, guidelines or other tools that influence treatment recommendations and care. Restrictions on disclosure can impede communication between patient and physician and undermine trust, patient choice, and quality of care.

Although health plans and other entities have primary responsibility to inform patient-members about plan provisions that will affect the availability of care, physicians may share in this responsibility.

Individually, physicians should:

(a) Disclose any financial and other factors that could affect the patient's care.

(b) Disclose relevant treatment alternatives, including those that may not be covered under the patient's health plan.

(c) Encourage patients to be aware of the provisions of their health plan. Collectively, physicians should advocate that health plans with which they contract disclose to patient-members.

(d) Plan provisions that limit care, such as formularies or constraints on referrals.

(e) Plan provisions for obtaining desired care that would otherwise not be provided, such as provision for off-formulary prescribing.

(f) Plan relationships with pharmacy benefit management organizations and other commercial entities that have an interest in physicians' treatment recommendations.

<u>CONSULTATION, REFERRAL, SECOND OPINIONS (AMA CEJA Opinion 1.2.3)</u>

Physicians' fiduciary obligation to promote patients' best interests and welfare can include consulting other physicians for advice in the care of the patient or referring patients to other professionals to provide care. When physicians seek or provide consultation about a patient's care or refer a patient for health care services, including diagnostic laboratory services, they should:

(a) Base the decision or recommendation on the patient's medical needs, as they would for any treatment recommendation, and consult or refer the patient to only health care professionals who have appropriate knowledge and skills and are licensed to provide the services needed.

(b) Share patients' health information in keeping with ethics guidance on confidentiality.

(c) Assure the patient that he or she may seek a second opinion or choose someone else to provide a recommended consultation or service. Physicians should urge patients to familiarize themselves with any restrictions associated with their individual health plan that may bear on their decision, such as additional out-of-pocket costs to the patient for referrals or care outside a designated panel of providers.

(d) Explain the rationale for the consultation, opinion, or findings and recommendations clearly to the patient.

(e) Respect the terms of any contractual relationships they may have with health care organizations or payers that affect referrals and consultation. Physicians may not terminate a patient-physician relationship solely because the patient seeks recommendations or care from a health care professional whom the physician has not recommended.

<u>FEE SPLITTING (Adapted from AMA CEJA Opinion 11.3.4)</u>

Patients must be able to trust that their physicians will be honest with them and will make treatment recommendations, including referrals, based on medical need, the skill of other health care professionals or facilities to whom the patient is referred, the quality of products or services provided, and consistent with all federal and state laws.

Payment by or to a physician or health care institution solely for referral of a patient is fee splitting and is unethical.

Physicians may not accept:

(a) Any payment of any kind, from any source for referring a patient other than distributions of a health care organization's revenues as permitted by law.

(b) Any payment of any kind, from any source for prescribing a specific drug, product, or service.

(c) Payment for services relating to the care of a patient from any health care facility/organization to which the physician has referred the patient.

(d) Payment for referring a patient to a research study.

Physicians in a capitated primary care practice may not refer patients based on whether the referring physician has negotiated a discount for specialty services.

(HP)

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

FTE: Existing Staff
(Staff Effort to Complete Project)

ADOPTED

Item #:	8
Code:	CQMP/CEGPS Report A-18 C-8 [A-17 C-2]
Title:	Principles on Medical Professional Review of Physicians (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsors:	Committee on the Quality of Medical Practice Barbara Spivak, MD, Chair Committee on Ethics, Grievances, and Professional Standards Ronald Arky, MD, Chair
Report History:	OFFICERS Report A-17 C-2 Original Sponsor: MMS Presidential Officers (and Reviewing Committees)

HOUSE VOTE:	**Adopted**
Referred to:	**(MMS *Policy Compendium*)**
Informational Report:	**NA**
Strategic Priority:	**Physician and Patient Advocacy**

That the Massachusetts Medical Society adopt as amended the Principles on Medical Professional Review of Physicians policy amended and reaffirmed at A-10 to reads as follows: *[*amending *item 10 of Massachusetts Medical Society Policy on Medical Professional Review of Physicians within Health Insurance Companies, and item 10 in Massachusetts Medical Society Policy Model Principles for Medical Peer Review of Physicians for Health Care Facilities]*

Principles on Medical Professional Review of Physicians

The Massachusetts Medical Society adopts the following amended *Principles on Medical Professional Review of Physicians within Health Insurance Companies and Medical Professional Review of Physicians within Health Care Facilities.*

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

Massachusetts Medical Society Policy on Medical Professional Review of Physicians within Health Insurance Companies

Introduction:

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

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

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

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

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

Section 11112 Standards for professional review actions

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

- **(1) in the reasonable belief that the action was in the furtherance of quality health care,**
- **(2) after a reasonable effort to obtain the facts of the matter,**
- **(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and**

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

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

(1) Notice of proposed action

The physician has been given notice stating –

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

(ii) reasons for the proposed action

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

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

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

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

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

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

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

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

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

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

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right –

(i) to representation by an attorney or other person of the physician’s choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

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

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.”

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

8. **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. Participants on a medical professional review panel or peer review committee should disclose relevant conflicts of interest and, when appropriate, recuse themselves from the corrective action or disciplinary proceeding. Additionally, the subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to the commencement of the proceedings. Such challenge would be part of the procedure specified in the health insurance company bylaws outside of peer review protections and not a part of the actual conduct of peer review and shall not be protected by peer review statutory protections.**
11. **Health plans should employ mechanisms to rotate service on their medical professional review panels or peer review committees among their credentialed, participating provider or contracted physicians.**
12. **Membership on the medical professional panel or peer review committee should be open to all credentialed, participating provider or contracted physicians in the health plan and not be restricted to one or more groups such as employed or salaried physicians only. The committee should include more than just medical directors, medical officers or other administrative officers of the health plan.**
13. **Only physicians are peers of the subject physician, and only physicians should be voting members of committees conducting medical professional review of physicians.**
14. **Whenever a medical professional review panel or peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the health plan while excluding direct economic competitors, or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution (e.g., medical specialty society) authorized to conduct peer review of physicians should be appointed in accordance with the health plan's bylaws if such actions fall within statutory medical professional/peer review protections.**

15. **Physicians serving on the medical professional review panel or peer review committee should receive information and, where available, training, in the elements and essentials of medical professional/peer review.**
16. **The health plan should ensure that the physicians serving on any medical professional review panel or peer review committee are provided with appropriate indemnification and insurance for medical professional/peer review acts taken in good faith. The health plan should also provide assistance to the panel or committee in abiding by the requirements of HCQIA to be eligible for federal immunity if applicable.**
17. **The medical professional review panel or peer review committee of a health plan should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination on matters of quality care or professional competency. When the matter before the medical professional review panel or peer review committee involves professional conduct, such as an allegation of disruptive behavior, the medical professional review panel or peer review committee should be guided by applicable professional ethical principles (e.g., MMS Code of Ethics, AMA Principles of Medical Ethics, relevant specialty society ethical codes). Those guidelines, standards, practices and principles should be made available in a timely manner to the subject physician before any hearing on the matter.**
18. **Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.**
19. **Wherever feasible, structured assessment instruments and, if available, multiple reviewers should be used to increase reliability.**
20. **Where feasible, statistical analysis to compare with peers' performance should be used with appropriate case mix adjustment.**
21. **Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.**
22. **All the pertinent information obtained by the medical professional review panel or peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.**
23. **To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.**
24. **Any conclusion reached or action recommended or taken should be based upon the information presented to the medical professional review panel or peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a "reasonably prudent person" standard.**
25. **If the conclusion reached is that improvement is necessary, any action recommended by a health plan should include, as an important focus, steps for remediation, as needed, for the subject physician.**
26. **The findings, recommendations and actions of the medical professional review panel or peer review committee of a health plan should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician's act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it**

should address what specific remediation, if any, is recommended for the physician (whenever feasible, in terms that permit measurement and validation of remediation, when completed).

27. **A process should be available to appeal any disciplinary finding of a health plan following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An appeals process before a disinterested third party, not connected to the health plan, should be made available to the subject physician within statutory medical professional/peer review protections. If the original action was part of a peer-review protected process, the appeal should be part of the peer-review protected process as well.**
28. **In all instances of medical professional review activities conducted within health insurance companies, the applicable processes and procedures should be clearly stated, with specific detail, in health plan provider manuals or written policies, of uniform application, made available in advance to the subject physician. Such processes and procedures should contain the particular due process, hearing and appeals rights available to the subject physician, and, to the extent that medical professional review or peer review privilege, confidentiality and immunity legal protections are available to such medical professional review activities, such processes and procedures should conform to the requirements of federal and state law. In conformity with Principle No. 12, to avoid or at least mitigate conflicts of interest, or the perception thereof, the medical professional review panels or peer review committees of health insurance companies should include as members with full participation and voting rights physicians who are not employees or contractors (other than contracting as a participating provider) of the health insurer.**
29. **The Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on the basis of cost containment. *(MMS Council, 5/17/91; Reaffirmed, House of Delegates, May 7, 1999)***
30. **These Model Principles for Medical Professional Review of Physicians within Health Insurance Companies are intended to apply to all medical professional review activities conducted by health insurance companies of their credentialed, participating provider or contracted physicians, however designated: e.g., professional review, peer review, credentialing appeals, corrective actions or otherwise.**

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

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

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

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

• Quality improvement
• Credibility in the process of medical peer review of physicians for health care facilities
• Fairness and due process
• Patient access — by not inappropriately removing or sanctioning physicians
• System approaches to patient safety and quality of care

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

1. **Patient safety and quality of care must be the goal.**
2. **Evaluation of circumstances surrounding an adverse event in a health care facility must not only include pre-event factors, but also the contributory effects of the health care system.**
3. **All the relevant information should be obtained promptly from the subject physician. In addition, relevant information from other sources should be obtained and made available to the subject physician to the fullest extent legally permissible followed by early discussion with the subject physician to evaluate the "incident" and explore alternate course of action.**
4. **The process must be mindful and attuned to prevention and recommend appropriate individual and system changes for remediation.**
5. **Triggers that initiate a medical peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied, with objective and evidence-based pre-screening, to all cases and physicians.**
6. **Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process.**
7. **At a minimum, the standards set by Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity must be followed if a disciplinary process is engaged during professional review. These standards are the most elementary safeguards of due process in a health care facility.**
   Section 1112 Standards for professional review actions
   "a. In general…professional review action must be taken–
   (1) in the reasonable belief that the action was in the furtherance of quality health care,
   (2) after a reasonable effort to obtain the facts of the matter,
   (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
   (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)."

   "Adequate notice and hearing–A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):
   (1) Notice of proposed action
   The physician has been given notice stating –
   (A) (i) that a professional review action has been proposed to be taken against a physician
   (ii) reasons for the proposed action

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

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

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

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

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

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

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

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

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

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

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right –

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

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

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, 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. Participants on a peer review committee should disclose relevant conflicts of interest and, when appropriate, recuse themselves from the peer review or disciplinary proceeding. Additionally, the subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to commencement of the proceedings. Such challenge would be a part of the procedures specified in the health care facility bylaws, outside of peer review protections and not part of the actual conduct of peer review and shall not be protected by peer review statutory protections.

11. **Physicians should rotate service on the peer review committee (round robin).**
12. **Membership on the peer review committee must be open to all physicians on the medical staff and not be restricted to one or more groups such as those practicing exclusively at a given institution, salaried physicians only or faculty physicians only.**
13. **Only physicians should be voting members of committees conducting medical peer review of physicians.**
14. **Whenever a peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the institution while excluding direct economic competitors or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution authorized to conduct peer review of physicians should be appointed in accordance with the medical staff bylaws and medical peer review protection statutes.**
15. **Physicians serving on the peer review committee should receive information and where available, training, in the elements and essentials of medical peer review.**
16. **The hospital or the organization on whose behalf the peer review is done must ensure that the physicians serving on any peer review committee are provided with appropriate indemnification and insurance for peer review acts taken in good faith. The organization must also provide assistance to the committee in abiding by the requirements of HCQIA to be eligible for federal immunity.**
17. **The peer review committee of a health care facility should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination. When the matter before the peer review committee involves professional conduct such as an allegation of disruptive behavior, the peer review committee should be guided by applicable professional ethical principles (e.g., the MMS Code of Ethics, the AMA Principles of Medical Ethics, relevant specialty society ethical codes). Those guidelines, standards and practices must be made available in a timely manner to the subject physician before any hearing on the matter.**
18. **Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.**
19. **Wherever feasible, structured assessment instruments and multiple reviewers should be used to increase reliability.**
20. **Where feasible, statistical analysis to compare with peers' performance must be used with appropriate case mix adjustment.**
21. **Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.**

22. **All the pertinent information obtained by the peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.**
23. **To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.**
24. **Any conclusion reached or action recommended or taken should be based upon the information presented to the peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a "reasonably prudent person" standard.**
25. **If the conclusion reached is that improvement is necessary, any action recommended by a health care facility should include, as an important focus, steps for remediation, as needed, for the subject physician and for the system.**
26. **The findings, recommendations and actions of the peer review committee of a health care facility should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician's act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it must address what specific remediation, if any, is recommended for the physician and what, if any, for the system (whenever feasible, in terms that permit measurement and validation of remediation, when completed).**
27. **A process should be available to appeal any disciplinary finding of a health care facility following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An appeals process before a disinterested third party, not connected to the medical staff or the hospital, should be made available to the subject physician within statutory peer review protections. If the original action was part of a peer-review protected process, the appeal should be part of the peer-review protected process as well.**
(MMS House of Delegates, November 8, 2003; Amended, 5/14/10)
28. **The Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on the basis of cost containment. *(MMS Council, 5/17/91; reaffirmed House of Delegates, May 7, 1999)***

MMS House of Delegates, 11/08/03
****Health Care Facilities Principles Amended and Reaffirmed,***
MMS House of Delegates, 5/08/09
Amended and Reaffirmed, MMS House of Delegates, 5/14/10
(Item 2 of Original: Sunset)

(HP)

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

FTE: Existing Staff
(Staff Effort to Complete Project)

ADOPTED

Item #:	9
Code:	CQMP Report A-18 C-9 [A-17 C-2]
Title:	Physician Call Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsor:	Committee on the Quality of Medical Practice Barbara Spivak, MD, Chair
Report History:	OFFICERS Report A-17 C-2 Original Sponsor: MMS Presidential Officers (and Reviewing Committees)

HOUSE VOTE:	**Adopted**
Referred to:	**(MMS *Policy Compendium*)**
Informational Report:	**NA**
Strategic Priority:	**Physician and Patient Advocacy**

That the Massachusetts Medical Society adopt as amended the physician call policy adopted at A-10 to reads as follows:

1a. The Massachusetts Medical Society adopts the following principles:

MMS On-Call Principles:

The MMS On-Call Principles apply to all physicians. These principles are separate and distinct from the formal regulations governing resident work hours that must be followed by hospitals for residency program accreditation by the Accreditation Council for Graduate Medical Education (ACGME). The term on-call includes hours providing patient care as well as administrative duties and hours awaiting call.

1. **The MMS opposes government regulation of physician work hours.**
2. **The MMS opposes uniform limits or any other consecutive time constraints, as these can compromise patient care and limit flexibility of scheduling within individual physician practices. Furthermore, the broad diversity of specialty practices indicates that a uniform or standardized approach to regulation of physician work hours would not be appropriate.**
3. **Physicians have an ethical duty to their patients and profession to provide safe, compassionate, quality medical care. These duties depend on a safe and healthy working environment for all physicians. To this end, clinical responsibilities must be organized in such a way as to prevent excessive patient care responsibilities, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation.**
4. **The individual physician can most appropriately determine whether the clinical schedule allows the physician to meet her/his ethical obligations to the patient.**

5. **There should be adequate backup if sudden, unexpected patient care needs create fatigue sufficient to jeopardize patient care during or following the on-call period. Institutions and other practice organizations should ensure that such backup is available if required. No institution or call system should require a physician to provide clinical care when the physician believes that she/he will not be able to meet her/his ethical obligations to the patient.**
6. **Health care delivery systems must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment.**
7. **As there are different duties defined by each specialty, guidelines for work-hour responsibilities should be made in consultation with each physician, given that responsibilities vary by setting, region, and specialty. In addition, what constitutes excessive fatigue and sleep deprivation will vary by physician.**
8. **Each specialty department should determine who among its members are required to serve on-call for the emergency department, subject to appropriate compensation to be determined at the local level. In making the determination for who is required to serve on-call, the specialty department may exempt from call service members above a certain age, or with a certain number of years service to the medical staff, or those serving in medical staff leadership positions. Other individual exemptions, for hardship, temporary disability, or other reasons may be granted by the chair on a case-by-case basis.**
9. **Physicians and hospitals should work collaboratively to develop solutions to on-call needs for emergency departments; adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage; the organization and function of on-call services should be determined through hospital policy and medical staff by-laws; and include methods for monitoring and assuring appropriate on-call performance.**
10. **It is in the best interests of patients when physicians practice in a fair, equitable, safe, healthy, and supportive environment.**
11. **Payment of physicians to be on call should be viewed as a fee for service, unless otherwise contracted, and when offered to some, be extended to all individuals or groups, not restricted only to some specialties.**

(HP)

2a. The MMS will advocate for malpractice reform to specifically address increased liability associated with emergency call coverage. *(D)*

MMS House of Delegates, 5/14/10

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

ADOPTED AS AMENDED

Item #:	10
Code:	CQMP Report A-18 C-10 [A-17 C-2]
Title:	Third-Party Insurers Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsors:	The Committee on the Quality of Medical Practice Barbara Spivak, MD, Chair Committee on Legislation Theodore Calianos, MD, Chair
Report History:	OFFICERS Report A-17 C2 Original Sponsor: MMS Presidential Officers (and Reviewing Committees)

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(MMS *Policy Compendium*)**
Informational Report:	**NA**
Strategic Priority:	**Physician and Patient Advocacy**

That the Massachusetts Medical Society adopt as amended the third-party insurers policy reaffirmed at A-10 to reads as follows:

1. **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)***

2. **The MMS will advocate for a uniform minimum time allowance for nonfederal claims of at least 90 days for:**
   - **(a) the initial submission of claims;**
   - **(b) the resubmission or initial submission of claims to another health plan, in which 90 days would be calculated from the date of the first insurer's remittance advice;**
   - **(c) the submission of additional information, in which 90 days would be calculated from the date the physician receives a communication from the health plan requesting additional information*;***
   - **(d) the submission of a claim to a new insurer after retroactive notification of loss of eligibility due to insurer change; and**
   - **(e) the submission of claim that was hindered by unforeseen circumstances.**

   (D)

3. **The MMS will monitor health plans' adherence to their filing-limit policies and communicate noncompliance to the appropriate parties. *(D)***

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

MMS House of Delegates, 11/9/02

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

5. The MMS will advocate for a clearly stated and accessible appeals process for claims denied based on time limitations of submissions. *(D)*

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

ADOPTED

Item #:	11
Code:	CQMP Report A-18 C-11 [A-17 C-3]
Title:	Patient Safety Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)
Sponsor:	The Committee on the Quality of Medical Practice Barbara Spivak, MD, Chair
Report History:	OFFICERS Report A-17 C-3 Original Sponsors: MMS Presidential Officers (and Reviewing Committees)

HOUSE VOTE:	**Adopted as Amended**
Referred to:	**(MMS *Policy Compendium*)**
Informational Report:	**NA**
Strategic Priority:	**Physician and Patient Advocacy**

That the Massachusetts Medical Society reaffirm the patient safety policy reaffirmed at A-10 and which reads as follows:

QUALITY OF CARE

Patient Safety

The Massachusetts Medical Society accepts the Institute of Medicine's (IOM) recommendations on Identifying Priority Areas for Quality Improvement, IOM Report *Priority Areas for National Action, Transforming Health Care Quality* (2003):

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

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

(equity); the generalizability of associated quality improvement strategies to many types of conditions and illnesses across the spectrum of health care (representativeness); and the breadth of change effected through such strategies across a range of health care settings and providers (reach).

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

4. **That the Agency for Healthcare Research and Quality (AHRQ), in collaboration with other private and public organizations, be responsible for continuous assessment of progress and updating of the list of priority areas. These responsibilities should include:**
    - **Developing and improving data collection and measurement systems for assessing the effectiveness of quality improvement efforts.**
    - **Supporting the development and dissemination of valid, standardized measures of quality.**
    - **Measuring key attributes and outcomes and making this information available to the public.**
    - **Revising the selection criteria and the list of priority areas.**
    - **Reviewing the evidence base and results, and deciding on updated priorities every 3 to 5 years.**
    - **Assessing changes in the attributes of society that affect health and health care and could alter the priority of various areas.**

- **Disseminating the results of strategies for quality improvement in the priority areas.**

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

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

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

(HP)

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

ADOPTED

Item #:	12
Code:	BOT Report A-18 C-12
Title:	Delegates-at-Large
Sponsor:	Board of Trustees Henry Dorkin, MD, FAAP, Chair

HOUSE VOTE:	**Adopted**
Referred to:	**NA**
Informational Report:	**NA**

That the following individuals be recommended to the House of Delegates at Annual 2018 as Delegates-at-Large:

Karen H. Antman, MD, Provost, Medical Campus and Dean, Boston University School of Medicine;

Sandro Galea, MD, MPH, DrPH, Dean, Boston University School of Public Health;

George Q. Daley, MD, PhD, Dean, Harvard Medical School;

Harris A. Berman, MD, Dean, Tufts University School of Medicine; and

Terence R. Flotte, MD, Dean, School of Medicine and Provost and Executive Deputy Chancellor, University of Massachusetts Medical School.
(D)

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