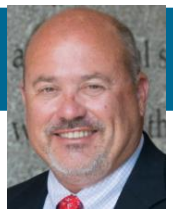
MASSACHUSETTS
MEDICAL SOCIETY

Online, each title below is linked — just point, click, or tap. Use bookmark to navigate.
To enable bookmark on a *MacBook using Safari*, open in Preview, go to View and select Table of Contents.

To access bookmark on an *iPad or an iPhone,* open in iBooks and click  or in Adobe Reader click  .
(Full PDF functionality may require downloading a PDF reader app or the latest version of Adobe Reader. Functionality may also be browser- or device-dependent.)

Delegates' Handbook Contents

The Speakers' Letter



Frank MacMillan Jr., MD, FACG
Speaker

McKinley Glover IV, MD, MHS
Vice Speaker

Massachusetts Medical Society

2018 Interim Meeting
November 30–December 1, 2018
MMS Headquarters and the Westin Hotel, Waltham

The following information is your guide to the 2018 Interim Meeting of the House of Delegates (HOD). **Please note start time for HOD both days is 9:00 a.m. and Reference Committee Hearings on Friday begin at 10:00 a.m.**

Interim Meeting Website

Please visit the Interim Meeting website at www.massmed.org/interim2018. The website includes the online *Delegates' Handbook*, online registration, hotel information, special event details, and the complete schedule.

Pre-registration

We strongly encourage all delegates to pre-register online by noon, Monday, November 26, at www.massmed.org/interim2018/register **for all Interim Meeting events.** By pre-registering, it allows for ***faster*** onsite check-in, an adequate number of seats for your district in the House of Delegates, and meals.

All registrations received by noon, Monday, November 26, will be processed. *After that date, you will be asked to register onsite*.

New Delegate Orientation Luncheon

Join us at the New Delegate Orientation Luncheon on Friday, November 30, at 12:30 p.m. New and experienced delegates are welcome!

Online HOD Resources/Materials

Parliamentary Training Video

Please visit www.massmed.org/parliamentary for a training video on parliamentary procedure.

Online Testimony for Reference Committees

Members may provide testimony for all reference committees online at http://community.massmed.org/hod

If you have lengthy testimony to provide,* we strongly encourage you to use the online site. Online testimony is in addition to the onsite testimony. You may comment as many times as you like until 8:00 a.m., Friday, November 30. Reference committee members will review online testimony in preparation for the meeting, and all delegates should review the site as well.

2018 Interim Meeting Schedule

Friday, November 30, 2018
MMS Headquarters

6:00 a.m.	Gentle Movement Yoga (hosted by the Committee on Young Physicians)
6:30 a.m.	Registration opens
7:00 a.m.	District Caucus Meetings (start times vary)
9:00 a.m.	HOD First Session
10:00 a.m.	Alliance Winter Quarterly Meeting
10:00 a.m.	Reference Committee Hearings
	Physicians Insurance (PIAM) Clinics
11:30 a.m.	Alliance Luncheon
12:00 p.m.	HOD Luncheon *(available until 2:00 p.m.)*
12:30 p.m.	13th Annual Research Poster Symposium
12:30 p.m.	Official Lunch Break for Reference Committee Hearings
	District Medical Society Secretaries and Treasurers Meeting/Luncheon
	New Delegate Orientation Luncheon
	Women's Delegate Luncheon
1:30 p.m.	Reference Committee Hearings reconvene *(if necessary)*
2:00 p.m.	Annual Oration
3:30 p.m.	Ethics Forum (Please note: three-hour event)
6:30 p.m.	MMS Minority Affairs Section Welcome and Celebration of Dr. John Van Surly DeGrasse

Saturday, December 1, 2018
Westin Hotel, Waltham

6:30 a.m.	Registration opens
7:00 a.m.	District Caucus Meetings (start times vary)
9:00 a.m.	HOD Second Session
12:30 p.m.	Cotting Luncheon

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***Important Note re: Testimony at the Meeting:** Testifiers will have two minutes and can testify two times per resolution/report at the hearings and HOD sessions. Your speakers have found that two minutes (versus three) is sufficient and practical in the interest of attendees' time. Each reference committee will also have a "For" and "Against" microphone.*

HOD Remote Observation

Remote observation allows delegates* who cannot attend the meeting to follow the HOD proceedings. Please visit www.massmed.org/interim2018/hod for more information.

**Please note: Remote observation does not count toward delegate attendance credit and does not allow for remote participation (testifying/voting) during the sessions.*

Informational Reports

Informational reports are posted online (only) at www.massmed.org/I18handbook. (A list of the informational report titles is included in the handbook front materials.) For adopted I-17/A-18 directives due for an informational report and whose status can be provided in a "short-form" manner, these updates are provided in two Report Status/ Implementation Charts. These charts also provide a reference point for all I-17/A-18 items.

Family-Friendly Space for HOD Second Session

Family-friendly space for remote viewing of the House of Delegates (HOD) Second Session on Saturday, December 1, is available for delegates. Pre-registration is required at www.massmed.org/IM2018/familyfriendly.

Late-File Resolution Deadline

The deadline for late-filed resolutions is Wednesday, November 14, at 5:00 p.m. Late files are reviewed by the Committee on Late and Deferred Resolutions and Reports at their November 29 meeting to determine the urgency of the submission, and late sponsors must testify to the committee. Late files must meet specific criteria. (Please see *MMS Procedures of the House of Delegates*, Procedure 4, online at www.massmed.org/policies.) For guidelines on submitting a late file, please visit www.massmed.org/resolutions.

Hotel Accommodations

The hotel deadline at the Westin Hotel, Waltham has passed. A limited number of overnight rooms at the MMS negotiated rate may be still available. Please contact Laura Bombrun at MMS Headquarters at (781) 434-7007 or lbombrun@mms.org for assistance with obtaining a reservation.

Current MMS policy allows delegates, when attending a meeting of the HOD, to be reimbursed for up to two nights' accommodation before or between sessions of the HOD at the negotiated MMS group single rate. The full MMS Delegate Reimbursement Policy and process is available under "hotel information" at www.massmed.org/interim2018.

District Caucus Meetings

Delegates are reminded to check-in at the registration desk for badges and caucus room locations.

Friday, November 30 — All Day One Caucus Meetings are being held at MMS Headquarters, Waltham

7:00 a.m.	Berkshire, Franklin, and Hampshire Districts
7:30 a.m.	Medical Student and Resident/Fellow Sections
	Norfolk District
	Suffolk District

Saturday, December 1 — All Day Two Caucus Meetings are being held at Westin Hotel, Waltham

7:00 a.m.	Berkshire, Franklin, and Hampshire Districts	
	Committee on Finance	
7:30 a.m.	Charles River District	Middlesex West District
	Essex North and Essex South Districts	Norfolk District
	Hampden District	Southeast Regional Districts
	Medical Student and Resident/Fellow Sections	Suffolk District
	Middlesex District	Worcester and Worcester North Districts
	Middlesex Central and Middlesex North Districts	

Interim Meeting 2018 Registration Form

Register online! It's quick and easy. Visit massmed.org/interim2018/register.
Pre-registration closes Monday, November 26 at Noon.

MMS Member ID #:_____ ☐ MD/DO ☐ Other Are you an MMS Delegate? ☐ Yes ☐ No

Registrant Name: _____ E-mail: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Guest Name (if applicable): _____ Guest Credentials: _____

Guest E-mail: _____

Emergency Contact:

In the event of an emergency at the meeting, please indicate someone to contact. Updates to this information can be made on-site at the meeting by visiting the registration desk.

First and Last Name: _____ Telephone: (____)_____ Relationship:_____

	Registrant	***Guest***	***All MMS Members and Guests and MMSA Members***	***Non-Members***
Event Registration for House of Delegates Meeting and Educational Events* *Friday, November 30 – MMS Headquarters, Waltham*				
House of Delegates Opening Session & Reference Committee Hearings – 9:00 a.m. & 10:00 a.m.			—	—
Research Poster Symposium – 12:30 p.m.			—	
HOD Luncheon – 12:00 p.m./12:30 p.m.**			—	—
Annual Oration – 2:00 p.m.			—	$70
Ethics Forum – 3:30 p.m.			—	$210
Event Registration for House of Delegates Meeting and Luncheon *Saturday, December 1 – Westin Hotel, Waltham*				
House of Delegates Second Session – 9:00 a.m.			—	—
House of Delegates Cotting Luncheon – 12:30 p.m.			—	—
			Total Payment	

*Special Needs/Allergies/Dietary Restrictions:*_____

Please return completed form and payment (if necessary) to:
Massachusetts Medical Society Finance Department
860 Winter Street
Waltham, MA 02451
or Fax to (781) 893-0413

Please visit www.massmed.org/interim2018 to read about additional events taking place at the Interim Meeting. Additional events include: Gentle Movement Yoga, Physician Insurance (PIAM) Clinic Appointments, MMS Minority Affairs Section Welcome and Reception in Celebration of Dr. John Van Surly DeGrasse, and Alliance events. ***Pre-registration for these additional events is available on the Interim Meeting website.*

*** There are several special event luncheons taking place on Friday, November 30 that focus on various aspects of the MMS House of Delegates or the District Medical Societies. There is also a casual luncheon offered with no formal program scheduled (House of Delegates Luncheon). Pre-registration is ***not required*** for the special event luncheons. Registering for the House of Delegates Luncheon will assure there is a meal you can obtain to attend one of the luncheons that are planned.*

Directions to MMS Headquarters
860 Winter Street
Waltham Woods Corporate Center
Waltham, MA 02451-1411
(800) 322-2303

From the East (Boston): West on the Mass. Pike/I-90 to Exit 15 (right toll booth) keep right beyond the toll booth and follow the signs for I-95/128 North.

- Follow 95/128 North for approximately 2 miles to Exit 27A-B (Third Avenue/Totten Pond Road/Waltham).
- Once on the exit ramp, keep left and follow the signs to Exit 27B (Totten Pond Road/Winter Street).
- At the lights turn right onto Wyman Street. Remain in the right lane and bear right onto Winter Street West.
- Remain in the right lane and cross back over Route 128.
- **Continue with "From all Directions" below.**

From the West (Worcester): East on the Mass. Pike/I-90 to Exit 14. Keep left beyond the tollbooth and follow the signs for I-95/128 North. Follow 95/128 North for approximately 2 miles to Exit 27A-B (Third Avenue/Totten Pond Road/Waltham).

- Once on the exit ramp, keep left and follow the signs to Exit 27B (Totten Pond Road/Winter Street).
- At the lights turn right onto Wyman Street. Remain in the right lane and bear right onto Winter Street West.
- Remain in the right lane and cross back over Route 128.
- **Continue with "From all Directions" below .**

From the North (Burlington/Lexington): South on Route 128/I-95 to Exit 27B (Winter Street).

- When coming off the exit, stay in the far right lane and follow Winter Street.
- **Continue with "From all Directions" below.**

From the South (Dedham/Newton): Follow 95/128 North to Exit 27A-B (Third Avenue/Totten Pond Road/Waltham).

- Once on the exit ramp, keep left and follow the signs to Exit 27B (Totten Pond Road/Winter Street).
- At the lights turn right onto Wyman Street. Remain in the right lane and bear right onto Winter Street West.
- Remain in the right lane and cross back over Route 128.
- **Continue with "From all Directions" below.**

FROM ALL DIRECTIONS

- Remain in the far right lane through two sets of lights.
- Pass the Embassy Suites on your left. Follow the signs for Winter Street.
- Travel around the Cambridge Reservoir (on right) for approximately 0.5 miles (pass Astra Zeneca on left).
- Turn left at granite sign announcing HealthPoint and Waltham Woods Corporate Center
- Travel up the hill following the signs to Waltham Woods Corporate Center for approximately 0.3 mile to a second granite sign for Waltham Woods ("860-890 Winter Street") on the left
- Immediately after sign, turn left into the parking lot for the Massachusetts Medical Society.

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Directions to Westin Hotel, Waltham

70 Third Avenue
Waltham, MA 02451
(781) 290-5600

From the East (Logan Airport & Boston/Cambridge Area)
Follow the signs to the Ted Williams Tunnel and then to I-90/Massachusetts Turnpike West. Continue to Route 128/I-95 North. Exit at 27A-B stay right for Exit 27A (Totten Pond Road). Make a sharp right turn onto Third Avenue, and the hotel will be on the left.

From the West
Take I-90/Massachusetts Turnpike East to Route 128/I-95 North. Take Exit 27A-B stay right for Exit 27A (Totten Pond Road). Make a sharp right onto Third Avenue, and the hotel will be on the left.

From the North
Take Route 128/I-95 South to Exit 27A (Totten Pond Road). Go over the bridge and at the first set of lights, turn right onto Third Avenue. The hotel will be on the left.

From the South
Take Route 128/I-95 North to Exit 27A-B stay right for Exit 27A (Totten Pond Road). Make a sharp right turn onto Third Avenue and the hotel will be on the left.

Operation Sock Drop

Supporting Friends of Boston's Homeless

Please consider bringing in a new pair of men's or women's socks on November 30, 2018. By participating you not only help keep our communities' neediest citizens safe, warm, and healthy, but help maintain their dignity and comfort during this difficult time in their lives.

There will be a donation drop box at the Alliance exhibit table all day.

MASSACHUSETTS MEDICAL SOCIETY ALLIANCE

Making a Difference

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

MMS HEADQUARTERS
AUDITORIUM

FRIDAY, NOVEMBER 30, 9:00 AM

ORDER OF BUSINESS
FIRST SESSION

1. Call to Order
   Frank MacMillan Jr., MD, FACG, Speaker
2. Quorum Report
3. Order of Business (vote)
4. Memorials
5. Committee on Late and Deferred Resolutions (vote)
6. Acceptance of Resolutions and Reports for Action
   - Withdrawals or Minor Word Changes
   - Object to Consideration
7. Consent Calendar: Informational Reports (vote)
8. Proceedings: April 26 and April 28, 2018, House of Delegates Meeting (vote)
9. Presentation of Scrapbook to Immediate Past President
10. President's Report
11. Election of AMA Delegates and Alternate Delegates (vote)
12. AMA Update
13. New Minority Affairs Section
14. Fiscal Notes Review
15. Announcements
16. Recess

Order of Reference Committee Report Presentation for HOD Second Session
(Reports available Saturday, December 1, at www.massmed.org/I18refcommreports)

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

WESTIN HOTEL, WALTHAM

SATURDAY, DECEMBER 1, 2018, 9:00 AM

ORDER OF BUSINESS
SECOND SESSION

1. Call to Order
   Frank MacMillan Jr., MD, FACG, Speaker

2. Quorum Report

3. Order of Business (vote)

4. Fiscal Notes Update

5. Reference Committee Reports: (vote)
   available at www.massmed.org/I18refcommreports

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

6. Fiscal Notes Totals

7. Announcements

8. Adjournment

MASSACHUSETTS MEDICAL SOCIETY

2018 Interim Meeting
Speakers' Consent Calendar

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

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

Item #	Title	Sponsor/Code
9	Special Committee Renewals	BOT Report I-18 C-5

Rationale for report placement on consent calendar:
Special Committee Renewals *are routine reports required every three years of each MMS special committee and have been thoroughly reviewed by both the MMS presidential officers and the BOT. Note: given that the MMS governance structure is currently under active discussion, the presidential officers recommended that these eight committees be renewed for one year (versus three) for FY20. At its October meeting, the BOT supported this recommendation.*

MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

October 16, 2018

MEMORANDUM TO THE HOUSE OF DELEGATES

Subj: ***NOMINATION OF AMA DELEGATES AND ALTERNATE DELEGATES***

The Committee on Nominations (CON) met on Thursday, September 20, 2018, at 4:00 p.m. at Society headquarters, Waltham, MA, with remote participation available. Committee Chair David T. Golden MD, presided.

There were 17 districts represented, constituting a quorum.

District/Section	Committee Members Present
Barnstable	David B. Elmer, MD
Berkshire	Bonnie Herr, MD
Bristol North	Brett S. Stecker, DO
Bristol South	Walter J. Rok, MD
Charles River	David T. Golden, MD, and Hubert I. Caplan, MD
Essex North	Joseph M. Heyman, MD and Glenn P. Kimball, MD
Essex South	Keith C. Nobil, MD and Sanjay Aurora, MD
Franklin	Flora F. Sadri-Azarbayejani, MD
Hampden	None
Hampshire	None
Middlesex	George E. Ghareeb, MD and Deanna P. Ricker, MD
Middlesex Central	Paula Jo Carbone, MD and Eileen Deignan, MD
Middlesex North	Alan T. Kent, MD
Middlesex West	Cecilia M. Mikalac, MD
Norfolk	John J. Looney, MD and Francis X. Rockett, MD
Norfolk South	John J. Walsh, MD
Plymouth	Philip E. McCarthy, MD and Elsa J. Aguilera, MD
Suffolk	Marian C. Craighill, MD
Worcester	Bruce G. Karlin, MD and Thomas L. Rosenfeld, MD
Worcester North	None
Medical Student Section	None
Resident Fellow Section	Monica Wood, MD

The Committee on Nominations carefully interviewed all of the candidates, paying particular attention to each candidate's experience and qualifications.

The Society is fortunate to have had many interested candidates. There were nine nominees running for six AMA Delegate positions. Ten candidates ran for eight AMA Alternate Delegate positions. One candidate ran for one AMA Alternate Delegate Resident position; and two candidates ran for one AMA Alternate Delegate Medical Student position.

After due deliberation, the Committee nominates the following individuals for approval by the House of Delegates:

MMS Delegates and Alternates to the AMA House of Delegates
January 1, 2019 through December 31, 2020

DELEGATES	**ALTERNATES**
Maryanne C. Bombaugh, MD, MSc, MBA, FACOG	Nicolas Argy, MD, JD
Alice A. Tolbert Coombs, MD, MPA	Henry L. Dorkin, MD, FAAP
Dennis M. Dimitri, MD	Christopher Garofalo, MD
Melody J. Eckardt, MD	Kathryn A. Hughes, MD
McKinley Glover IV, MD, MHS	Lynda G. Kabbash, MD
Richard S. Pieters, MD	Michael D. Medlock, MD
	Ellana Stinson, MD, MPH
	Carl G. Streed, Jr., MD

MMS Alternate Delegates to the AMA House of Delegates
January 1, 2019 through December 31, 2019

Matthew E. Lecuyer, MD (resident)
Maximilian J. Pany (medical student)

The Chair expresses his appreciation to the committee members for their participation at the meeting.

For the committee,

David T. Golden, MD
Chair
Committee on Nominations

REFERENCE COMMITTEES
INTERIM MEETING 2018

REFERENCE COMMITTEE A
Public Health

Ms. Marguerite Youngren (Chair)
Mr. Patrick Lowe
Mary Beth Miotto, MD
Shakti Sabharwal, MD
Mr. Akhil Uppalapati

Alternates
Odysseus Argy, MD
Mr. Jason Andrew Park

Staff Coordinators
Robyn Alie, Staff Liaison
Candace Savage, Staff Liaison
Sarah Bates, Staff Liaison
Brendan Abel, Esq., Legal Counsel
Lisa Smith, Assistant Staff Liaison

REFERENCE COMMITTEE B
Health Care Delivery

Heidi Foley, MD (Chair)
Tom Amoroso, MD, MPH
Donna Norris, MD
Gracia Perez-Lirio, MD
Steven Young, MD

Alternates
Kenneth Hekman, MD
Mr. Tyler Lang

Staff Coordinators
Bissan Biary, Staff Liaison
David Wasserman, Staff Liaison
Liz Rover Bailey, Esq., Legal Counsel
Carly Redmond, Assistant Staff Liaison

REFERENCE COMMITTEE C
MMS Administration

Mary Lou Ashur, MD (Chair)
John DeLoge, MD, MPH
Judd Kline, MD
Brita Lundberg, MD
Mr. Danny Vazquez

Alternates
Ms. Avneet Soin
Ms. Leah Yuan

Staff Coordinators
Bill Howland, Staff Liaison
Linda Howard, Staff Liaison
Roberta Coen, Esq., Legal Counsel
Brett Bauer, Assistant Staff Liaison

COMMITTEE ON LATE AND DEFERRED RESOLUTIONS

Luis Sanchez, MD (Chair)
Stephen Berkowitz, MD
Marian Craighill, MD, MPH
Melody Eckhardt, MD
Judd Kline, MD

Staff Coordinators
Karen Harrison, Staff Liaison
Charlie Alagero, Esq., Legal Counsel

Full Name	Last Name		Primary Position on the HOD	Secondary Position on the HOD	Specialty Society or Standing Committee
Todd E. Abbott, M.D.	Abbott	CR	Member		
Susan A. Abookire, M.D.	Abookire	N	Member		
George Abraham, M.D.,M.P.H.	Abraham	W	Member		
Janet C. Abrahamian, M.D.	Abrahamian	W	Member		
Ronald D. Abramson, M.D.	Abramson	MW	Member		
Paul C. Adjei, M.D.	Adjei	S	Resident/Fellow		
Sapna Aggarwal, M.D.	Aggarwal	MC	Member		
Jaya R. Agrawal, M.D.	Agrawal	HMS	Specialty Society Delegate		Massachusetts Gastroenterology Association
Elsa J. Aguilera, M.D.	Aguilera	PL	Member		
Cynthia O. Akagbosu, M.D.	Akagbosu	S	Member		
Geetanjali A. Akerkar, M.D.	Akerkar	MN	Member		
Alan J. Albert, M.D.	Albert	W	Member		
Roger A. Allcroft, M.D.	Allcroft	HMS	Member		
Carole E. Allen, M.D.,M.B.A.	Allen	M	Trustee		
Edward L. Amaral, M.D.	Amaral	W	Member		
Thomas A. Amoroso, M.D.	Amoroso	M	Member		
Michael S. Annunziata, M.D.	Annunziata	S	Trustee		
Essam M. Ansari, M.D.	Ansari	EN	Member		
Karen Antman, M.D.	Antman	S	Delegate At Large		
Nicolas Argy, M.D.	Argy	N	Member		
Odysseus Argy, M.D.	Argy	BS	Member		
Ronald A. Arky, M.D.	Arky	S	Chair, Standing Committee		Committee on Ethics, Grievances, and Professional Standards
Grayson W. Armstrong, M.D.	Armstrong	M	Member		
Mary Louise C. Ashur, M.D.	Ashur	N	Member		
Katherine J. Atkinson, M.D.	Atkinson	HMS	Member		
Lawrence F. Audino, M.D.	Audino	BS	Member		
Bruce S. Auerbach, M.D.	Auerbach	BN	MMS Past President		
Joseph E. August, M.D.	August	ES	Member		
Sanjay Aurora, M.D.	Aurora	ES	Member		
Canan Avunduk, M.D.	Avunduk	M	Member		
Ms. Asha Ayub	Ayub	S	Member		
David S. Babin, M.D.	Babin	BA	Member		
Donald M. Bachman, M.D.	Bachman	MW	Member		
Adarsha S. Bajracharya, M.D.	Bajracharya	M	Member		
Frederic Baker, M.D.	Baker	W	Member		
Mr. Annirudh Balachandran	Balachandran	S	Member		
Robert S. Baratz, M.D.	Baratz	NS	Member		
Richard M. Bargar, M.D.	Bargar	EN	Member		
Brian J. Battista, M.D.	Battista	NS	Member		
George E. Battit, M.D.	Battit	S	Member		
Tedi Begaj, M.D.	Begaj	ES	Member		
Renee Bennett O'Sullivan, M.D.	Bennett O'Sullivan	CR	Member		
Ernest W. Bergel, M.D.	Bergel	N	Member		
Joseph C. Bergeron, Jr., M.D.	Bergeron	MN	MMS Secretary-Treasurer		
Shelly Z. Berkowitz, M.D.	Berkowitz	HMS	Member		
Stephen B. Berkowitz, M.D.	Berkowitz	MW	Trustee		
Harris A. Berman, M.D.	Berman	S	Delegate At Large		
Michael F. Bierer, M.D.	Bierer	S	Specialty Society Delegate		MA Society of Addiction Medicine
Ms. Amanda E. Bilski	Bilski	S	Member		
Ihor J. Bilyk, M.D.	Bilyk	ES	Member		
Linda A. Bishop, M.D.	Bishop	BA	Member		
Paul A. Bizinkauskas, M.D.	Bizinkauskas	BA	Member		
Barbara H. Bjornson, M.D.	Bjornson	ES	Member		
Brian B. Bloom, M.D.	Bloom	PL	Member		
John W. Blute, Jr., M.D.	Blute	MC	Member		
John R. Bogdasarian, M.D.	Bogdasarian	WN	Alternate Trustee	District President	
Maryanne C. Bombaugh, M.D.,M.B.A.	Bombaugh	BA	MMS President Elect		
Kim E. Bowman, M.D.	Bowman	N	Member		
Ylisabyth S. Bradshaw, D.O.	Bradshaw	EN	Alternate Trustee		
Jeffry B. Brand, M.D.	Brand	ES	Member		
Richard A. Bream, M.D.	Bream	W	Member		
Rebecca W. Brendel, M.D.	Brendel	N	Member		
Mr. Jeffrey Breton	Breton	S	Member		
James B. Broadhurst, M.D.	Broadhurst	W	Trustee		
Cynthia B. Brown, M.D.	Brown	ES	Member		
Richard K. Brown, M.D.	Brown	M	Member		
Carl N. Brownsberger, M.D.	Brownsberger	CR	Member		
Jean M. Bruch, M.D.	Bruch	BA	Trustee		
Svend W. Bruun, Jr., M.D.	Bruun	WN	Member		
Frederick O. Buckley, Jr., M.D.	Buckley	ES	Member		
John W. Burress, M.D.	Burress	CR	Chair, Standing Committee		Committee on Public Health
William J. Burtis, M.D.	Burtis	MC	Secretary, Treasurer of District		
Marylou Buyse, M.D.	Buyse	CR	MMS Past President		
Helen E. Cajigas, M.D.	Cajigas	N	Member		
Theodore A. Calianos, II, M.D.	Calianos	BA	Alternate Trustee	Chair, Standing Committee	Committee on Legislation
Brian T. Callahan, Jr., M.D.	Callahan	MC	Member		
William E. Callahan, M.D.	Callahan	FR	MMS Past President		
Francis X. Campion, M.D.	Campion	N	Member		
Hubert I. Caplan, M.D.	Caplan	CR	Alternate Trustee		
Frank S. Carbone, Jr., M.D.	Carbone	ES	Member		
Paula Jo Carbone, M.D.	Carbone	MC	Alternate Trustee	District President	
John V. Chang, D.O.	Chang	M	Member		
Alain A. Chaoui, M.D.	Chaoui	ES	MMS President		
Roopa L. Chari, M.D.	Chari	EN	Member		
Marcia C.T. Chatfield, D.O.	Chatfield	EN	Member		
Ms. Melanie Chen	Chen	S	Member		
Cheng-Chieh Chuang, M.D.	Chuang	NS	Member		
Bartley G. Cilento, Sr., M.D.	Cilento	NS	District Secretary		
George J. Clairmont, Jr., M.D.	Clairmont	PL	Member		

Full Name	Last Name		Primary Position on the HOD	Secondary Position on the HOD	Specialty Society or Standing Committee
Emily Cleveland Manchanda, M.D.	Cleveland Manchanda	S	Resident/Fellow		
William R. Cohen, M.D.	Cohen	W	Member		
Robert B. Coit, M.D.	Coit	WN	District Secretary		
Corey E. Collins, D.O.	Collins	ES	Member		
Don Condie, M.D.	Condie	S	Member		
Peter H. Contompasis, M.D.	Contompasis	M	Member		
William A. Cook, M.D.	Cook	EN	Member		
Alice A. Coombs, M.D.	Coombs	NS	MMS Past President		
Marian C. Craighill, M.D.,M.P.H.	Craighill	S	Member		
Christopher L. Cua, M.D.	Cua	CR	Member		
Elizabeth T. Curtis, M.D.	Curtis	ES	Member		
Seth Curtis, M.D.	Curtis	WN	Member		
George Q. Daley, M.D.	Daley	N	Delegate At Large		
Lauren Grace Daniels, D.O.	Daniels	BA	Member		
Jatin K. Dave, M.D.	Dave	CR	Member		
Snehlata V. Dave, M.D.	Dave	MN	Member		
Allen B. Davis, M.D.	Davis	PL	Member		
Eileen M. Deignan, M.D.	Deignan	MC	Member		
Mary Lally Delaney, M.D.	Delaney	NS	Member		
Jose Delgado, M.D.	Delgado	PL	Member		
Sandra Delgado	Delgado	ALLIANCE	Alliance President		
John A. DeLoge, M.D.	DeLoge	MW	Alternate Trustee	District President	
Salvatore A. DeLuca, M.D.	DeLuca	M	Member		
Phillip M. Devlin, M.D.	Devlin	M	Specialty Society Delegate		MA Radiological Society
Uma V. Dhanabalan, M.D.,M.P.H.,F.A.A.F.P.	Dhanabalan	M	Member		
Dennis M. Dimitri, M.D.	Dimitri	W	MMS Past President		
Henry L. Dorkin, M.D.	Dorkin	S	MMS Immediate Past President		
Patricia Downs, M.D.	Downs	N	Member		
Karl J. D'Silva, M.D.	D'Silva	ES	Member		
Joseph M. Dulac, M.D.	Dulac	MN	Member		
Ronald W. Dunlap, M.D.	Dunlap	NS	MMS Past President		
Melody J. Eckardt, M.D.	Eckardt	NS	Trustee		
Howard M. Ecker, M.D.	Ecker	S	Member		
N. Lynn Eckhert, M.D.	Eckhert	W	Member		
Julia F. Edelman, M.D.	Edelman	BN	Trustee		
Heidi Eichenberger, M.D.	Eichenberger	S	Member		
David B. Elmer, M.D.	Elmer	BA	Member		
Stephen K. Epstein, M.D.	Epstein	N	District President		
Jason M. Erlich, M.D.	Erlich	NS	Member		
Jack T. Evjy, M.D.	Evjy	MN	MMS Past President		
Patricia Rose Falcao, M.D.	Falcao	CR	Member		
Louis Fazen, III, M.D.	Fazen	W	Member		
James A. Feldman, M.D.	Feldman	S	District President		
Marianne E. Felice, M.D.	Felice	W	Member		
Leonard M. Finn, M.D.	Finn	CR	Member		
Lloyd D. Fisher, M.D.	Fisher	W	Specialty Society Delegate		Mass. Chapter - American Academy of Pediatrics
Lisa Flaherty, M.D.	Flaherty	BA	Member		
Athanasios P. Flessas, M.D.	Flessas	PL	Member		
Richard G. Florentine, M.D.	Florentine	N	Member		
Terence R. Flotte, M.D.	Flotte	W	Delegate At Large		
Heidi J. Foley, M.D.	Foley	WN	Trustee		
Mr. Sina Foroutanjazi	Foroutanjazi	S	Member		
Lindsay A. Fox, M.D.	Fox	CR	Member		
Marcia L. Franklin, M.D.	Franklin	BA	Member		
Amanda B. Freeman, M.D.	Freeman	CR	Member		
Eli C. Freiman, M.D.	Freiman	S	Resident Alternate Trustee		
Mr. Jonathan Fried	Fried	N	Student		
Douglas P. Fusonie, M.D.	Fusonie	FR	District Secretary		
Sandro Galea, M.D.	Galea	S	Delegate At Large		
Jeffrey P. Gallo, M.D.	Gallo	W	Member		
Shaan-Chirag C. Gandhi, M.D.	Gandhi	S	Secretary, Treasurer of District		
Lawrence D. Garber, M.D.	Garber	W	Member		
Katherine Garlo, M.D.	Garlo	S	Member		
Christopher Garofalo, M.D.	Garofalo	BN	Alternate Trustee		
Wayne A. Gavryck, M.D.	Gavryck	FR	Member		
Kavitha Gazula, M.D.	Gazula	MC	Member		
Daniel P. George, M.D.	George	HMD	Member		
Susan V. George, M.D.	George	W	Member		
Linda E. Geraci, M.D.	Geraci	CR	Member		
James S. Gessner, M.D.	Gessner	N	MMS Past President		
George E. Ghareeb, M.D.	Ghareeb	M	Member		
Salman S. Ghiasuddin, M.D.	Ghiasuddin	EN	Member		
McKinley Glover, IV, M.D.	Glover	S	MMS Vice Speaker of the House		
Matthew D. Gold, M.D.	Gold	M	Specialty Society Delegate		MA Neurologic Association
David T. Golden, M.D.	Golden	CR	Trustee	Chair, Standing Committee	Committee on Nominations
Michael Goldstein, M.D.	Goldstein	ES	Member		
Joan R. Golub, M.D.	Golub	N	Member		
William S. Goodman, M.D.	Goodman	MW	Member		
Dennis S. Gordan, M.D.	Gordan	HMD	Member		
Allan H. Goroll, M.D.	Goroll	S	MMS Past President		
Michele J. Gottlieb, M.D.	Gottlieb	MW	Member		
David F. Gouveia, M.D.	Gouveia	BA	Member		
Herbert E. Gray, III, M.D.	Gray	BA	District Secretary		
Donald J. Greeley, Jr., M.D.	Greeley	BK	Member		
Marc A. Greenwald, M.D.	Greenwald	BA	Member		
Mr. Abhinav Gupta	Gupta	W	Member		
Ms. Emma Hadley	Hadley	S	Member		
Angela Haliburda, D.O.	Haliburda	BS	Member		
Kyle T. Halligan, M.D.	Halligan	W	Member		
Richard J. Hannah, M.D.	Hannah	ES	Member		

Full Name	Last Name		Primary Position on the HOD	Secondary Position on the HOD	Specialty Society or Standing Committee
Samantha Harrington, M.D.	Harrington	M	Resident/Fellow		
Gregory G. Harris, M.D.	Harris	N	Chair, Standing Committee		Committee on Interspecialty
Alan M. Harvey, M.D.	Harvey	N	MMS Past President		
Mark J. Hauser, M.D.	Hauser	N	Specialty Society Delegate		MA Psychiatric Society
Bessie L. Hazard, M.D.	Hazard	W	Member		
Ms. Heather M. Hechter	Hechter	S	Member		
Mr. Dylan Heckscher	Heckscher	S	Member		
Bernhard Heersink, M.D.	Heersink	EN	Member		
Kenneth Avery Heisler, M.D.	Heisler	BA	District President		
Kenneth J. Hekman, M.D.	Hekman	MC	Member		
Barbara Herbert, M.D.	Herbert	M	Member		
Pablo Hernandez-Itriago, M.D.	Hernandez-Itriago	W	Specialty Society Delegate		MA Academy of Family Physicians
Bonnie H. Herr, M.D.	Herr	BK	Member		
Douglas V. Herr, M.D.	Herr	BK	Member		
Robert Hertzig, M.D.	Hertzig	BK	Alternate Trustee		
Joseph M. Heyman, M.D.	Heyman	EN	MMS Past President		
Justin S. Holtzman, M.D.	Holtzman	NS	Member		
Cyrus C. Hopkins, M.D.	Hopkins	S	Member		
Hemant Hora, M.D.	Hora	N	Member		
Lisbeth M.B. Howe, M.D.	Howe	CR	Member		
Kathleen A. Hoye, M.D.	Hoye	BN	District Secretary		
Julian C. Huang, M.D.	Huang	NS	Member		
Pei-Li Huang, M.D.	Huang	CR	Member		
Heather J. Hue, M.D.	Hue	PL	Member		
Kathryn A. Hughes, M.D.	Hughes	BA	Member		
Joseph J. Jankowski, M.D.	Jankowski	CR	Member		
Subramanyan Jayasankar, M.D.	Jayasankar	S	Alternate Trustee		
Hans Jeppesen, M.D.	Jeppesen	ES	Member		
Lawrence P. Johnson, M.D.	Johnson	MN	District President		
Thomas F. Johnson, M.D.	Johnson	EN	Member		
Edith M. Jolin, M.D.	Jolin	PL	Alternate Trustee	District Secretary	
Bradley Judson, M.D.	Judson	MC	Specialty Society Delegate		MA College of Emergency Physicians
John N. Julian, M.D.	Julian	S	Member		
Lynda G. Kabbash, M.D.	Kabbash	N	MMS Asst Secretary-Treasurer		
Morton G. Kahan, M.D.	Kahan	CR	Member		
Brinda R. Kamat, M.D.	Kamat	S	Member		
Michael S. Kaplan, M.D.	Kaplan	BK	Member		
Bruce G. Karlin, M.D.	Karlin	W	Member		
Stephen S. Kasparian, M.D.	Kasparian	BS	District President		
David R. Kattan, M.D.	Kattan	HMD	District President		
Matthew S. Katz, M.D.	Katz	EN	Chair, Standing Committee		Committee on Communications
Jeffrey L. Kaufman, M.D.	Kaufman	HMD	Member		
James F.X. Kenealy, M.D.	Kenealy	MW	Member		
Joseph L. Kennedy, Jr., M.D.	Kennedy	N	Member		
Peter C. Kenny, M.D.	Kenny	HMS	District Secretary		
Alan T. Kent, M.D.	Kent	MN	Member		
David A. Kieff, M.D.	Kieff	CR	District Secretary		
Glenn P. Kimball, M.D.	Kimball	EN	Member		
James M. Kirshenbaum, M.D.	Kirshenbaum	N	Specialty Society Delegate		MA Chapter American College of Cardiology
Aaron Kithcart, M.D.	Kithcart	S	Member		
Laurence Klein, M.D.	Klein	FR	District President		
Teresa I. Klich-Nowak, M.D.	Klich-Nowak	HMD	Member		
Roger M. Kligler, M.D.	Kligler	PL	Member		
Judd L. Kline, M.D.	Kline	MW	Member		
Srilatha Kodali, M.D.	Kodali	MN	Member		
Claudia L. Koppelman, M.D.	Koppelman	HMD	Member		
Constantine Kostas, M.D.	Kostas	ES	Member		
Elliot Lach, M.D.	Lach	W	Specialty Society Delegate		MA Society of Plastic Surgery
Ms. Stephanie K. LaFollette	LaFollette	S	Member		
Nidhi K. Lal, M.D.	Lal	MN	Alternate Trustee		
Thomas A. LaMattina, M.D.	LaMattina	MC	Member		
Everett Lamm, M.D.	Lamm	BK	Member		
Raul A. Landa, M.D.	Landa	MW	Member		
Tyler Lang, M.D.	Lang	S	Student		
William G. Lavelle, M.D.	Lavelle	W	MMS Past President		
Robert A. Lebow, M.D.	Lebow	W	Specialty Society Delegate		MA Chapter of the American College of Physicians
Matthew E. Lecuyer, M.D.	Lecuyer	BS	Resident Trustee		
Joseph M. Lenehan, M.D.	Lenehan	NS	Member		
Mr. Emal Lesha	Lesha	NS	Member		
Ms. Alexis A. LeVee	LeVee	S	Member		
Peter E. Levesque, M.D.	Levesque	BN	Member		
Benjamin R. Levin, M.D.	Levin	BA	Member		
Michael A. Lew, M.D.	Lew	CR	Member		
Raymond H. Lewis, Jr., M.D.	Lewis	MN	Member		
Olivia C. Liao, M.D.	Liao	M	Member		
Ruth M. Liberfarb, M.D.	Liberfarb	CR	Member		
Janet C. Limke, M.D.	Limke	NS	Member		
Manuel Lipson, M.D.	Lipson	S	Member		
Amy C. Lisser, M.D.	Lisser	N	Member		
Alan M. Lobovits, M.D.	Lobovits	CR	Member		
Sten B. Lofgren, M.D.	Lofgren	MC	Member		
John J. Looney, M.D.	Looney	N	Member		
Mr. Patrick P. Lowe	Lowe	W	Member		
Brita E. Lundberg, M.D.	Lundberg	CR	Member		
Carolyn Lundy, M.D.	Lundy	S	Member		
Francis P. MacMillan, Jr., M.D.	MacMillan	EN	MMS Speaker of the House	District Secretary	
Mangadhara Rao Madineedi, M.D.	Madineedi	N	Trustee	Secretary, Treasurer of District	
B. Dale Magee, M.D.	Magee	W	MMS Past President		

Full Name	Last Name		Primary Position on the HOD	Secondary Position on the HOD	Specialty Society or Standing Committee
Arul Mahadevan, M.D.	Mahadevan	ES	Member		
Kelby G. Maher, D.O.	Maher	BS	Member		
Mr. Peter Makhoul	Makhoul	W	Student		
Mr. Joshua J. Man	Man	S	Member		
Anna A. Manatis, M.D.	Manatis	BA	Member		
Burton G. Mandel, M.D.	Mandel	M	Member		
Matthew B. Mandel, M.D.	Mandel	BK	District Secretary		
Barry M. Manuel, M.D.	Manuel	M	MMS Past President		
Sharon L. Marable, M.D.	Marable	MW	Member		
Eugenia Marcus, M.D.	Marcus	CR	Member		
Glenn R. Markenson, M.D.	Markenson	S	Member		
Navneet Marwaha, M.D.	Marwaha	HMS	Member		
Ms. Erica J. Mascarenhas	Mascarenhas	S	Member		
Mr. Pawan J. Mathew	Mathew	W	Member		
Lydia E. Mayer, M.D.,M.P.H.	Mayer	N	Member		
Beth Kurtz Mazyck, M.D.	Mazyck	WN	Member		
Nkechi Mbaebie, M.D.	Mbaebie	BK	Member		
Richard B. McArdle, M.D.	McArdle	PL	Member		
Laura L. McCann, M.D.	McCann	CR	District President		
Darrolyn McCarroll, M.D.	McCarroll	BN	Member		
Kevin E. McCarthy, M.D.	McCarthy	PL	District President		
Philip E. McCarthy, M.D.	McCarthy	PL	MMS Past President		
Helena McCracken, D.O.	McCracken	HMS	Member		
Julie A. McCullough, M.D.	McCullough	ES	Member		
Elizabeth Cooper McQuaid, M.D.	McQuaid	BN	Member		
Michael D. Medlock, M.D.	Medlock	ES	Member		
Darshan H. Mehta, M.D.	Mehta	CR	Member		
Mr. Saharsh Mehta	Mehta	W	Member		
Parthiv N. Mehta, M.D.	Mehta	HMD	Member		
Eric A. Meikle, M.D.	Meikle	MN	Member		
Irina Merport, M.D.	Merport	BS	Member		
Stephen A. Metz, M.D.	Metz	HMD	Chair, Standing Committee		Committee on Professional Liability
Robert G. Miceli, M.D.	Miceli	S	Member		
Basil M. Michaels, M.D.	Michaels	BK	Trustee	District President	
Jennifer L. Michaels, M.D.	Michaels	BK	Member		
Cecilia M. Mikalac, M.D.	Mikalac	MW	District Secretary		
Yelena Mikich, M.D.	Mikich	HMD	Member		
M Denise Mills, M.D.	Mills	MN	Member		
Mary Elizabeth A. Miotto, M.D.	Miotto	MW	Member		
Armineh Mirzabegian, M.D.	Mirzabegian	MW	Member		
Gerald J. Monchik, M.D.	Monchik	BS	Member		
Jason E. Mondale, M.D.	Mondale	ES	Member		
Marcelo Montorzi, M.D.	Montorzi	N	Member		
Barbara J. Moore, M.D.	Moore	NS	Member		
Sheila L. Morehouse, M.D.	Morehouse	MN	District Secretary		
Kevin P. Moriarty, F.A.C.S.	Moriarty	HMD	Trustee		
Thomas A. Morris, III, M.D.	Morris	PL	Member		
Leonard J. Morse, M.D.	Morse	W	MMS Past President		
Mr. Richard Moschella	Moschella	W	Member		
Michael Fred Moses, M.D.	Moses	PL	Member		
Alan P. Moss, M.D.	Moss	W	Member		
Mario E. Motta, M.D.	Motta	ES	MMS Past President		
Susan E. Moynihan, M.D.	Moynihan	ES	Member		
Mark J. Mullan, M.D.	Mullan	HMD	Secretary, Treasurer of District		
Kerim M. Munir, M.D.	Munir	N	IMG Delegate		
Thomas A. Murray, III, M.D.	Murray	ES	Member		
Katherine A. Murray Leisure, M.D.	Murray Leisure	PL	Member		
Kollegal S. Murthy, M.D.	Murthy	HMD	Member		
Nicole R. Mushero, M.D.,Ph.D.	Mushero	N	Member		
Lisa L. Nagy, M.D.	Nagy	BA	Member		
Faina Nakhlis, M.D.	Nakhlis	N	Specialty Society Delegate		MA Chapter of the American College of Surgeons
Saira Naseer, M.D.	Naseer	EN	Member		
Ronald J. Nasif, M.D.	Nasif	BA	Member		
Dilip Nataraj, M.D.	Nataraj	NS	Member		
Ronald R. Newman, M.D.	Newman	ES	District President		
Najmosama Nikrui, M.D.	Nikrui	S	Member		
Mr. Michael A. Nitz	Nitz	S	Student, Alternate Trustee		
Keith C. Nobil, M.D.	Nobil	ES	Alternate Trustee		
Donna M. Norris, M.D.	Norris	N	Member		
Matthias M. Nurnberger, M.D.	Nurnberger	MW	Member		
Kevin D. OBrien, M.D.	OBrien	BS	Member		
Daniel J O'Brien, M.D.	O'Brien	WN	Member		
Luke M. O'Connell, M.D.	O'Connell	NS	Specialty Society Delegate		MA Assoc. Practicing Urologists
Samia Osman, M.D.	Osman	N	Member		
Kimberley L. O'Sullivan, M.D.	O'Sullivan	CR	Member		
Donald M. Pachuta, M.D.	Pachuta	MW	Member		
Kelly C. Pajela, M.D.	Pajela	ES	Member		
Mr, Maximilian Pany	Pany	N	Student		
Mr. Jason Andrew Park	Park	S	Member		
Yeri Park, M.D.	Park	EN	Member		
Sahdev R. Passey, M.D.	Passey	W	Alternate Trustee	District President	
Samir K. Patel, M.D.	Patel	NS	Chair, Standing Committee		Committee on Membership
Diane F. Patrick, M.D.	Patrick	BS	Member		
Kenneth R. Peelle, M.D.	Peelle	MN	MMS Past President		
Gracia B. Perez-Lirio, M.D.	Perez-Lirio	CR	Member		
Lee S. Perrin, M.D.	Perrin	M	District President	Chair, Standing Committee	Committee on Bylaws
Mr. Nicholas D. Peterson	Peterson	W	Member		
Richard S. Pieters, M.D.	Pieters	PL	MMS Past President	Boston Medical Library President	
Anthony A. Pikus, M.D.	Pikus	ES	Member		
Roger A. Pompeo, M.D.	Pompeo	NS	Member		

Full Name	Last Name		Primary Position on the HOD	Secondary Position on the HOD	Specialty Society or Standing Committee
Paul JP Pongor, M.D.	Pongor	MW	Specialty Society Delegate		MA Orthopedic Association
Navin Popat, M.D.	Popat	MN	Trustee		
Brenda A. Pring, M.D.	Pring	CR	Member		
Jean E. Ramsey, M.D.	Ramsey	S	Specialty Society Delegate		MA Society of Eye Physicians & Surgeons (Ophthalmology)
Peter D. Rappo, M.D.	Rappo	PL	Member		
Harvey A. Reback, M.D.	Reback	BS	Member		
Mohammad G. Reda, M.D.	Reda	CR	Member		
Mr. Rajesh K. Reddy	Reddy	S	Member		
Muralidharan T. Reddy, M.D.	Reddy	MW	Member		
Eric J. Reines, M.D.	Reines	ES	District Secretary		
Keith M. Reisinger-Kindle, D.O.	Reisinger-Kindle	HMD	Member		
Meegan L. Remillard, M.D.	Remillard	M	Resident/Fellow		
Salah E. Reyad, M.D.	Reyad	PL	Member		
Jason E. Reynolds, M.D.	Reynolds	BS	Member		
Deanna P. Ricker, M.D.	Ricker	M	Secretary, Treasurer of District		
Ms. Alyssa Robinson	Robinson	S	Member		
Kristen M. Robson, M.D.	Robson	M	Member		
Barbara A. Rockett, M.D.	Rockett	N	MMS Past President		
Francis X. Rockett, M.D.	Rockett	N	MMS Past President		
William E. Rockett, M.D.	Rockett	MW	Member		
Grant V. Rodkey, M.D.	Rodkey	S	MMS Past President		
Janine T. Rodrigues-Saldanha, M.D.	Rodrigues-Saldanha	S	Member		
Walter J. Rok, M.D.	Rok	BS	Alternate Trustee		
Peter C. Roos, M.D.	Roos	PL	Member		
B. Hoagland Rosania, M.D.	Rosania	PL	Trustee		
Michael J. Rosenblum, M.D.	Rosenblum	HMD	Chair, Standing Committee		Committee on Medical Education
Philip G. Rosene, M.D.	Rosene	EN	Member		
Thomas L. Rosenfeld, M.D.	Rosenfeld	W	Member		
Barbara L. Rosenthal, M.D.	Rosenthal	BK	Member		
David A. Rosman, M.D.,M.B.A.	Rosman	S	MMS Vice President		
Samantha L. Rosman, M.D.	Rosman	S	Member		
Alicia O.M. Ross, M.D.	Ross	HMD	Member		
Tuhin K. Roy, M.D.	Roy	EN	Member		
Abhijit Roychowdhury, M.D.	Roychowdhury	W	Member		
Joel J. Rubenstein, M.D.	Rubenstein	CR	Member		
Eric J. Ruby, M.D.	Ruby	BN	District President		
Vincent J. Russo, M.D.	Russo	EN	Member		
Shakti S. Sabharwal, M.D.	Sabharwal	N	Member		
Flora F. Sadri-Azarbayejani, D.O.	Sadri-Azarbayejani	FR	Trustee		
Mr. Kian Samadian	Samadian	W	Student		
Luis T. Sanchez, M.D.	Sanchez	CR	Member		
George P. Santos, M.D.	Santos	CR	Member		
Ms. Laura F. Santoso	Santoso	W	Member		
Michele T. Sasmor, M.D.	Sasmor	EN	Member		
Ilana L. Schmitt, M.D.,M.P.H.	Schmitt	HMS	District President		
Peter B. Schneider, M.D.	Schneider	W	Member		
Lorraine M. Schratz, M.D.	Schratz	BN	Member		
Reiner Henson B. See, M.D.	See	S	Member		
J. Jeffery Semaan, M.D.	Semaan	ES	Member		
Alan Semine, M.D.	Semine	CR	Member		
Prerak D. Shah, M.D.,F.A.C.S.	Shah	EN	Specialty Society Delegate		Massachusetts Society of Otolaryngology
Jagdish R. Shah, M.D.	Shah	BS	District Secretary		
Natasha Shah, M.D.	Shah	ES	Member		
Pankaj M. Shah, M.D.	Shah	N	Member		
Kenath J. Shamir, M.D.	Shamir	BS	Trustee		
Fred E. Shapiro, D.O.	Shapiro	S	Member		
Mark M. Sherman, M.D.	Sherman	HMD	Alternate Trustee		
Mawya Shocair, M.D.	Shocair	CR	Member		
Khuloud Shukha, M.D.	Shukha	N	Member		
Manjul Shukla, M.D.	Shukla	W	Member		
Biljana Simikic, D.O.	Simikic	HMS	Member		
Michael S. Sinha, M.D.,M.P.H.,J.D.	Sinha	S	Member		
Nancy S. Slater, M.D.	Slater	M	Member		
Charles T. Smallwood, Jr., M.D.	Smallwood	PL	Member		
Christopher R. Smith, M.D.	Smith	MW	Member		
Vincent C. Smith, M.D.	Smith	N	Member		
Linda Smothers, M.D.	Smothers	BK	Member		
Renee E. Snow, M.D.	Snow	EN	Member		
Lauren Sobel, D.O.	Sobel	S	Member		
Ms. Avneet Soin	Soin	S	Student		
Robert W. Sorrenti, M.D.	Sorrenti	W	Member		
Spiro G. Spanakis, D.O.	Spanakis	W	Member		
Guenter L. Spanknebel, M.D.	Spanknebel	W	MMS Past President		
Ann B. Spires, M.D.	Spires	EN	Trustee		
Barbara S. Spivak, M.D.	Spivak	M	Chair, Standing Committee		Committee on the Quality of Medical Practice
Joshua H. St. Louis, M.D.	St. Louis	EN	District President		
Fatima Cody Stanford, M.D.,M.P.H.,M.P.A.	Stanford	S	Member		
Brett S. Stecker, D.O.	Stecker	BN	Member		
Lance M. Sterman, M.D.	Sterman	BK	Member		
Ellana Stinson, M.D.	Stinson	N	Member		
Leo L. Stolbach, M.D.	Stolbach	W	Member		
Sharon A. Stotsky, M.D.	Stotsky	M	Member		

Full Name	Last Name		Primary Position on the HOD	Secondary Position on the HOD	Specialty Society or Standing Committee
Carl G Streed, Jr., M.D.,M.P.H.	Streed	S	Member		
Subramony Subramonia Iyer, M.D.	Subramonia Iyer	HMD	Member		
Kevin G Sullivan, M.D.	Sullivan	S	Member		
Stephen R. Sullivan, M.D.	Sullivan	M	Member		
Thomas E. Sullivan, M.D.	Sullivan	ES	MMS Past President		
Preeyanka Sundar, M.D.	Sundar	BK	Member		
Shobita Sundar, M.D.	Sundar	BS	Member		
Ammu Thampi-Susheela, M.D.	Susheela	N	Member		
Sally A. Sveda, M.D.	Sveda	CR	Member		
William J. Swiggard, M.D.	Swiggard	HMS	Member		
Ms. Stella Szeto	Szeto	N	Member		
Irma OV Szymanski, M.D.	Szymanski	N	Member		
Ludwik S. Szymanski, M.D.	Szymanski	N	Member		
Helena Taylor, M.D.	Taylor	M	Member		
Hugh M. Taylor, M.D.	Taylor	ES	Trustee		
Sarah F. Taylor, M.D.	Taylor	MC	Trustee		
Nikhil M. Thakkar, M.D.	Thakkar	HMD	Member		
Philip H. Thielhelm, M.D.	Thielhelm	ES	Member		
Jennifer R. Thulin, M.D.	Thulin	MW	Member		
Stefan A. Topolski, M.D.	Topolski	FR	Member		
Erin E. Tracy, M.D.	Tracy	S	Specialty Society Delegate		MA Section - American Congress of Obstetricians & Gynecologists
Rajendra M. Trivedi, M.D.	Trivedi	M	Member		
Sita Ram Upadhyay, M.D.	Upadhyay	W	Member		
Mr. Akhil Uppalapati	Uppalapati	S	Student		
Rohit D. Vakil, M.D.	Vakil	W	Member		
Francis X. Van Houten, M.D.	Van Houten	MC	MMS Past President		
Ana-Cristina Vasilescu, M.D.	Vasilescu	M	Alternate Trustee		
Mr. Danny A. Vazquez	Vazquez	N	Member		
Joseph J. Viadero, M.D.	Viadero	FR	Member		
Anil M. Vyas, M.D.	Vyas	BA	Member		
Jerry Wacks, M.D.	Wacks	MC	Member		
Andrew C. Wagner, M.D.	Wagner	S	Member		
Sohail A. Waien, M.D.	Waien	FR	Member		
John Joseph Walsh, M.D.	Walsh	NS	District President		
Marie T. Walsh Condon, M.D.	Walsh Condon	M	Member		
Arthur C. Waltman, M.D.	Waltman	S	Member		
James K. Wang, M.D.	Wang	HMD	Member		
Myles David Webster, M.D.	Webster	BS	Member		
Nicholas A. Weida, M.D.	Weida	EN	Member		
Charles A. Welch, M.D.	Welch	S	MMS Past President		
Giles F. Whalen, M.D.	Whalen	W	District Secretary		
William M. Wheeler, M.D.	Wheeler	N	Member		
Simone S. Wildes, M.D.	Wildes	NS	Alternate Trustee		
David G. Wong, M.D.	Wong	NS	Member		
Monica J. Wood, M.D.	Wood	M	Resident/Fellow		
Alan C. Woodward, M.D.	Woodward	MC	MMS Past President		
Christopher Worsham, M.D.	Worsham	S	Member		
Caroline Yang, M.D.	Yang	CR	Member		
Ira S. Yanowitz, M.D.	Yanowitz	S	Member		
Michael W. Yogman, M.D.	Yogman	M	Member		
Lynda M. Young, M.D.	Young	W	MMS Past President	Chair, Standing Committee	Committee on Publications
Mr. Matthew H. Young	Young	S	Member		
Steven Young, M.D.	Young	S	Resident/Fellow		
Steven Young, M.D.	Young	S	Resident/Fellow		
Dr. M. Donna Younger, M.D.	Younger	S	Member		
Ms. Marguerite Youngren	Youngren	MW	Student Trustee		
Leah Yuan	Yuan	N	Student		
Shorta Yuasa, M.D.	Yuasa	MN	Member		
Aimie Zale, M.D.	Zale	FR	Member		
Tomislav Zargaj, M.D.	Zargaj	ES	Member		
Mr. Thomas M. Zink	Zink	S	Member		
Geoffrey M. Zucker, M.D.	Zucker	HMS	Trustee		

2018 Interim Meeting Informational Report Titles
(Reports Available at www.massmed.org/I18handbook)

Report #	TITLE	SPONSOR
1	Summary of Official Actions	Board of Trustees
2	Conference on Universal Health Care	Medical Education
3	Physician Burnout: A Status Report on the Work of the MMS-MHA Joint Task Force on Physician Burnout	MMS-MHA Joint Task Force on Physician Burnout
4	Report of the Secretary-Treasurer	Secretary-Treasurer
5	Charitable and Educational Fund	Charitable and Educational Fund Board of Directors
6	Status/Implementation Chart: I-17 Resolutions & Reports	
7	Status/Implementation Chart: A-18 Resolutions & Reports	

1a	Committee Reports on Goals and Activities	Board of Trustees

IMPORTANT REMINDERS TO DELEGATES

DELEGATES' HANDBOOK DISCLAIMER

A few general reminders to delegates when reviewing the *Delegates' Handbook*:

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

INFORMATIONAL REPORTS

Informational reports are posted online (only) at www.massmed.org/I18handbook. (A list of the informational report titles is included on next page.) For adopted I-17/A-18 directives due for an informational report and whose status can be provided in a "short-form" manner, these updates are provided in the Report Status/Implementation Charts.

HOUSE OF DELEGATES TWO SESSION ATTENDANCE REQUIREMENT

Please note, Section 3.15 of the MMS Bylaws states that:

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

The meetings that apply for the current two-year cycle are: Interim Meeting 2017, Annual Meeting 2018, Interim Meeting 2018, and Annual Meeting 2019.

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

GENERAL GOVERNANCE RESOURCES

The following governance resources are available on the MMS website:

- 2018 Annual Meeting *Proceedings* (www.massmed.org/recentproceedings)
- *Procedures of the House of Delegates* (www.massmed.org/procedures)
- *Bylaws* (www.massmed.org/policies)
- *Policy Compendium* (www.massmed.org/policies)

You must be logged on as an MMS member to access this information. If you would like to receive a printed copy, please contact the Department of Governance Meetings and Services at (800) 322-2303, extension 7573, or email to houseofdelegates@mms.org.

In addition, attached are a number Delegates' Resources designed specifically to help delegates navigate certain procedures and parliamentary processes used at our HOD meetings. Should you have any questions about any HOD procedure, please feel free to contact your speakers at speaker@massmed.org.

DELEGATES' RESOURCES

Section 1: Delegate Responsibilities

Overview

The HOD is the policy-making body of the Massachusetts Medical Society (MMS) and has the authority to establish two general types of policy: health policies and directives. Health policies are statements of philosophy based on professional principles and scientific standards. These policies define what the Society stands for as an organization. Directives are action items that articulate a strategy for accomplishing an objective and/or activate the Society's health policies. Health policies are based on a statement of philosophy or health policy. While a health policy sets forth the Society's position, a directive instructs the Society to take some action. The HOD also sets the long-range goals of the Society. Policies of the MMS may be found in the *MMS Policy Compendium.*

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

Composition

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

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

Reference Committees Hearings

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

Responsibilities of the HOD

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

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

Participation in the MMS Governance Process

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

1. Resolutions and Reports

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

2. Pre-Meeting Publication of House Business

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

3. Reference Committee Process

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

4. House First Session

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

After all testimony is heard, Reference Committees deliberate in executive session and determine whether to recommend that the House accept or reject its

resolutions/reports for action. A written report of the Reference Committee's recommendations is prepared for the House.

5. House Second Session

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

6. BOT implements the will of the HOD

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

Delegate Roles and Responsibilities

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

Qualifications

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

The Department of Governance Meetings and Services

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

Laura Bombrun
Executive Office Assistant
Ext. 7007
lbombrun@mms.org

Lacy Heffel
Governance Services Project Manager
Ext. 7573
lheffel@mms.org

Linda Healy
Director, Executive Office and Governance Services
Ext. 7008
lhealy@mms.org

Amy McInerney
Governance Assistant
Ext. 7208
amcinerney@mms.org

Karen Harrison
Manager, Executive Office and Governance
Ext. 7463
kharrison@mms.org

Annemarie Tucker
Manager, Governance Policy Administration
Ext. 7332
atucker@mms.org

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

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

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

Presentation of Late Resolutions and Reports

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

Withdrawal or One- or Two-Word Change by Resolution/Report Sponsor

Resolution/report sponsors to may present a one- or two-word change in any resolution/report for action. Sponsors may also withdrawal their resolution/report.

Speakers' Consent Calendar

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

Objection to Consideration

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

Steps for Delegates to Objection to Consideration

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

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

2. A second is not required, and there will be no debate. The Speaker will acknowledge that an objection to consideration of resolution/report(s) has been proposed.

To sustain the objection to consideration, a two-thirds vote in the ***negative*** *i*s required. The Speaker will state that those in *favor* of consideration of the resolution/report for action should say "aye." All those *objecting* to consideration of the resolution/report should say "no."

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

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

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

2. A second is not required, and there will be no debate. The Speaker will acknowledge that the item(s) have been extracted and will be sent to a reference committee.

Section 3: Request to Close Debate and Vote Immediately

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

Step 1: Obtain the Floor

Delegate should proceed to any microphone. (Motion cannot interrupt a speaker.)

Step 2: Make Motion to Close Debate and Vote Immediately and Specify Which Pending Motion(s) This Applies To

After being recognized by the Speaker, the delegate should state that (he/she) would like to *"make a motion to close debate and vote immediately."* If more than one motion is pending (for example, a primary and secondary amendment, plus the main motion) specify which motion(s) you are requesting to close debate on: *"… on all pending motions," or "… on the immediately pending motion – the secondary amendment."*

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

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

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

Closing Debate and Vote Immediately on "All Pending Matters"

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

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

Procedure 15: Precedence of Motions

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

Type of Motion	Debate	Amendable	Vote Required
10) Table	No	No	2/3*
9) Vote Immediately	No	No	2/3*
8) Limit Debate	Limited	Limited	2/3
7) Postpone Definitely	Limited	Limited	Majority
6) Refer to the Committee on Ethics, Grievances, and Prof Standards	Limited	Limited	Majority
5) Refer for Decision	Limited	Limited	Majority
4) Refer	Yes	No	Majority
3) Amend: Second Order	Yes	Yes	Majority
2) Amend	Yes	Yes	Majority
1) Main Motion	Yes	Yes	Majority

**Not debatable*

Online, each title below is linked — just point, click, or tap. Use bookmark to navigate.
To enable bookmark on a *MacBook using Safari*, open in Preview, go to View and select Table of Contents.

To access bookmark on an *iPad or an iPhone,* open in iBooks and click  or in Adobe Reader click  .
(Full PDF functionality may require downloading a PDF reader app or the latest version of Adobe Reader. Functionality may also be browser- or device-dependent.)

Reference Committee A — Public Health

Hearing Order

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	1
Code:	Resolution I-18 A-101
Title:	Oversight of Home Health Aides
Sponsor:	Ihor Bilyk, MD
Referred to:	Reference Committee A Ms. Marguerite Youngren, Chair

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

Whereas, The MMS has the following relevant policies:

AGING
Nursing Homes/Skilled Nursing Facilities
The Massachusetts Medical Society will investigate and take appropriate action through educational and legislative means to facilitate appropriate state and federal funding to improve the status of patient care in nursing homes. (HP)
MMS House of Delegates, 11/6/00;
Amended and Reaffirmed MMS House of Delegates, 11/3/07;
Reaffirmed MMS House of Delegates, 5/17/14

PUBLIC HEALTH
Elder Care *(Please see additional policy under Healthy Lifestyle/Aging)*
The Massachusetts Medical Society will disseminate information to physicians and the public, through its existing communications vehicles, about services offered by the state Executive Office of Elder Affairs for frail elders. (D)

The Massachusetts Medical Society will educate its members, through existing communications channels, about challenges faced by family caregivers. (D)
MMS House of Delegates, 4/29/17

; and

Whereas, The MMS has no policy on home health aides; and

Whereas, A typical scenario of families dealing with a serious illness is the following: Someone becomes sick, injured, or disabled; a family member becomes the primary caretaker, then eventually realizes that they get “burned-out” and that the arrangement is not sustainable; family member becomes exhausted and desperate; family member often hires a home health aide with little background check and rarely a CORI check; and

Whereas, Most home health aides offer vital care to the frail and the aged and are undoubtedly compassionate caregivers. However, with the serious lack of oversight and regulation, there are some home health aides with bad intentions and who take

advantage of these clients that are vulnerable to manipulation, fear, theft, and murder[1]; and

Whereas, Although the home care industry already has lax standards, Massachusetts in comparison to other states lags further in regulating caregivers. As an example, home aides can voluntarily get more training to earn titles such as home health aide or certified nurse aide, but Massachusetts requires less training for these certifications (75 hours for each) than any other New England state except Connecticut[2]; and

Whereas, Other states have taken much stronger action to regulate the industry and to reduce crimes by aides. California, being one of the most proactive, has established the Home Care Services Consumer Protection Act, which requires home care agencies be licensed and includes a public registry of aides who have had background checks completed. California licenses home care agencies and conducts unannounced visits to their offices; and

Whereas, Seventeen states have started requiring FBI background checks for some or all home health agency workers, but Massachusetts is not one of them; and

Whereas, Twelve states require agencies to conduct a periodic background check on their employees, but Massachusetts is not one of them. Another state, New Jersey, closely tracks and makes publicly available abuse and other patient-related crimes by home health aides; and

Whereas, Freelance home health aides, although costing less than what agencies charge, are even less regulated or checked. Out of 47 Massachusetts criminal cases involving home aides in recent years, 27 of them were not agency employees. Many of the crimes against the frail and the aged go unreported and unpunished because the victims are too sick or do not have the energy to testify[3]; and

Whereas, The Massachusetts Department of Public Health has a License Verification website, but it has limited information and is unreliable given that there was no record of at least eight cases of home care workers with criminal records, including one who went to jail for stealing an elderly client's money; therefore, be it

RESOLVED, That the Massachusetts Medical Society advocate for better regulation of the home health aide industry to make it safer for the frail and aged clients. *(D)*

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

FTE: Existing Staff
(Staff Effort to Complete Project)

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[1] https://www.bostonglobe.com/metro/2018/09/15/stranger-worse-house-frail-seem-elderly-people-scarcely-know-many-aides-they-invite-into-their-homes-leaving-them-vulnerable-theft/XJOMrmv46Ruu94B2ZbTZgK/story.html

[2] Paraprofessional Healthcare Institute, Home Health Aide Training Requirements by State https://phinational.org/advocacy/home-health-aide-training-requirements-state-2016/

[3] https://www.bostonglobe.com/metro/2018/09/15/stranger-worse-house-frail-seem-elderly-people-scarcely-know-many-aides-they-invite-into-their-homes-leaving-them-vulnerable-theft/XJOMrmv46Ruu94B2ZbTZgK/story.html

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	2
Code:	CME/CGM Report I-18 A-1
Title:	Alzheimer's Disease and Dementia Education
Sponsors:	Committee on Medical Education Michael Rosenblum, MD, Chair Committee on Geriatric Medicine Asif Merchant, MD, Chair
Referred to:	Reference Committee A Ms. Marguerite Youngren, Chair

Background

According to the Centers for Disease Control and Prevention, Alzheimer's disease, the most common cause of dementia, is the sixth leading cause of death in the United States and in the Commonwealth of Massachusetts. It currently affects an estimated 5.5 million adults in the United States and is expected to affect 13.8 million aged 65 and over by 2050.[1] In Massachusetts, 1,504 emergency department visits were reported per 1,000 people in 2015, along with a 22.5% dementia patient hospital readmission rate.[2]

Alzheimer's disease and dementia not only impact patients but also have a strong impact on their families and support systems. The Alzheimer's Association reports that in Massachusetts alone, there are 337,000 caregivers, providing 384,000,000 total hours of unpaid care representing a total value of $4,845,000,000 of unpaid care. Caring for a person with Alzheimer's or dementia can be challenging.[3] As symptoms worsen, the care required of family members can result in increased emotional stress and depression, new or exacerbated health problems, and depleted income and finances due in part to disruptions in employment and paying for health care or other services for themselves and their care recipients.[4]

In August 2018, a new Massachusetts law entitled "An Act Relative to Alzheimer's and Related Dementias in the Commonwealth" was passed that seeks improvements in the diagnosis and treatment of Alzheimer's disease and dementia. The law mandates that physicians, physician's assistants, and nurses are required to complete the continuing education requirement of a one-time course of training and education on the diagnosis, treatment, and care of patients with cognitive impairments including, but not limited to, Alzheimer's disease and dementia pursuant to sections 2, 9F, 74, and 74A of chapter 112 of the General Laws.

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[1] Ortman, JM, Velkoff, VA, Hogan, H. An aging nation: the older population in the United States. Population estimates and projections. May 2014. www.census.gov/prod/2014pubs/p25-1140.pdf. Accessed October 16, 2018.

[2] Alzheimer's Association. Alzheimer's disease facts and figures. www.alz.org/getmedia/f6574a92-def2-4869-b7de-9667e0ccf8ce/statesheet_massachusetts. October 16, 2018.

[3] Alzheimer's Association. Caregiver stress. www.alz.org/help-support/caregiving/caregiver-health/caregiver-stress. Accessed October 16, 2018.

[4] *Alzheimer's & Dementia*. April 2016: 12(4); 459–509.

Current MMS Policy

PUBLIC HEALTH

Elder Care

The Massachusetts Medical Society will educate its members, through existing communications channels, about challenges faced by family caregivers. (D)

MMS House of Delegates, 4/29/17

Relevance to MMS Strategic Priorities

Professional knowledge and satisfaction is an MMS strategic priority.

Discussion

The Committee on Medical Education discussed this topic at its September 24, 2018, meeting and is in support of the MMS developing an online educational activity to help physicians and other health care professionals meet the state's new educational requirements.

The Committee on Geriatric Medicine discussed the new law requiring physicians who treat adult patients to obtain one-time training and education on the diagnosis, treatment, and care of patients with cognitive impairments, including Alzheimer's disease and dementia. Members recommended that the training be brief and to the point and be inclusive of physicians, physician assistants, and registered and practical nurses. A further recommendation is to include recognition of the role of caregivers, caregiver burnout, the burdens of care 24/7, and the potential for elder abuse. The committee also noted that dementia patients can also be abusive of their caregiver(s), particularly emotionally. This also emphasizes the need for physicians to urge their patients to execute advance care planning documents prior to/pre-dementia.

Conclusion

The Massachusetts Medical Society's Committee on Medical Education and Committee on Geriatric Medicine are in support of developing an online educational activity to help physicians and other health care professionals meet this new educational requirement.

Recommendation:

That the Massachusetts Medical Society develop an online educational activity for physicians and other health care professionals on the diagnosis and management of patients with cognitive impairments including, but not limited to, Alzheimer's disease and dementia, and which addresses the role of caregivers including the burden of round-the-clock care, caregiver burnout, and the potential for abuse. *(D)*

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	3
Code:	LGBTQ Report I-18 A-2
Title:	Evidence-Based Care of Individuals Born with Differences in Sex Development (DSD)/Intersex
Sponsor:	MMS Committee on LGBTQ Matters Carl Streed Jr., MD, MPH, Chair
Referred to:	Reference Committee A Ms. Marguerite Youngren, Chair

Background and Discussion

Between .05% and 1.7% of people are born with sex characteristics, including chromosomes, gonads, genitals, and other reproductive structures, that do not fit typical notions of either "male" or "female" bodies.[1] "Intersex" is an umbrella term that describes these congenital variations, although the term "differences in sex development" (DSD) is also sometimes used. Beginning in the 1950s, a paradigm arose of performing irreversible, medically unnecessary "genital-normalizing" surgeries.[2] Today, intersex children continue to receive early cosmetic genital surgery, such as clitoral reductions and vaginoplasties, at medical institutions across the United States.[3] It is estimated that as many as 100–200 surgeries are performed each year in the US.[2]

Outcome studies and patient narratives highlight that a significant number of patients who underwent these surgeries suffer long-lasting distress and physical consequences, including diminished or absent sexual sensation, sexual dysfunction, chronic pain, sterilization, urinary incontinence, depression, post-traumatic stress disorder, suicidality, and incorrect gender assignment leading to gender dysphoria.[4] The rate of incorrect assignment ranges from 5 to 60 percent, depending on the intersex condition.[5,6] Multiple health organizations have issued statements regarding intersex surgeries. In 2014, the World Health Organization (WHO) issued a statement that called for the cessation of medically unnecessary surgeries on individuals born intersex.[7] In 2016, the Gay and Lesbian Medical Association (GLMA): Health Professionals Advancing LGBT Equality issued a recommendation to delay all medically unnecessary surgeries on intersex children until they can consent (excepting procedures addressing emergent medical

[1] Free & Equal United Nations. Fact Sheet: Intersex. Published September 4, 2015. Accessed June 15, 2018.
[2] Beh HG, Diamond M. An emerging ethical and medical dilemma: should physicians perform sex reassignment surgery on infants with ambiguous genitalia? *Michigan Journal of Gender & Law.* 2000;7(1):1-63
[3] Human Rights Watch. A changing paradigm: US medical provider discomfort with intersex care practices. https://www.hrw.org/news/2017/10/26/us-doctors-need-intersex-care-standards. Published October 26, 2017. Accessed April 28, 2018
[4] Anthony E, Aspinall CL, Baratz AB, et al. *Consortium on the Management of Disorders of Sexual Development, Clinical Guidelines for the Management of Disorders of Sexual Development in Childhood*. Rohnert Park CA: Intersex Society of North America. (2006), 28
[5] Lee PA, Houk CP, Faisal Ahmed S, et al. Consensus Statement on Management of Intersex Disorders. *Pediatrics*. 2006;118(2), doi:10.1542/peds.2006-0738
[6] Furtado PS, Moraes F, Lago R, Barros LO, Toralles MB, Barroso U Jr. Gender dysphoria associated with disorders of sex development. Nat Rev Urol. 2012; 9(11):620–627 doi:10.1038/nrurol.2012.182.
[7] OHCHR, UN Women, UNAIDS, et. al., Eliminating forced, coercive and otherwise involuntary sterilization—an interagency statement. Switzerland: World Health Organization, May 2014. http://www.unaids.org/sites/default/files/media_asset/201405_sterilization_en.pdf. Accessed June 28, 2018.

need).[8] In 2017, three former US Surgeons General, Dr. Joycelyn Elders, Dr. David Satcher, and Dr. Richard Carmona, determined that current research does not support performing cosmetic genitoplasty on infants.[9] Also in 2017, the American Medical Student Association and Physicians for Human Rights made similar statements.[10,11] Available data show doctors are still performing surgeries to alter the sex characteristics of children born intersex even when no emergent medical need presents.[12,13] Recently published journal articles indicate the practice continues in Massachusetts as well.[14]

All intersex organizations and patient advocacy groups agree that intersex individuals must be able to access medically necessary care, including procedures that are desired and consented to by the intersex individual, as well as a small subset of procedures that are necessary to address an urgent risk to physical health before the individual can consent.[15] However, it is crucial for the medical community to clearly delineate what is a treatment for the preservation of life and physical functioning. Policies and regulations regarding the treatment of intersex children have become necessary as certain procedures continue to be presented in practice as urgent when data do not uphold these claims. For example, in its 2013 report, the Australian Senate Community Affairs Committee discussed in depth the controversies over how cancer risk data have been presented, including in the 2006 Consensus Statement. While some intersex individuals may be at sufficient risk of gonadal malignancy such that gonadectomy may be necessary prior to the individual reaching an age at which they can participate in the decision, in other cases, gonadectomy has been recommended and presented as necessary when the equivalent level of risk in a non-intersex individual would not prompt the same recommendation.[16]

Although there is general acceptance of parental/guardian authority to make medical decisions for a non-independent minor, several specialty and medical associations have begun to address this issue. Most recently, the American Academy of Family Physicians

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[8] Toler J. Medical and surgical intervention of patients with differences in sex development. GLMA policy and government affairs committee. https://interactadvocates.org/wp-content/uploads/2016/11/11-2-16-GLMA-Position-Medical-Surgical-Intervention-of-Patients-with-DSD.pdf. Published October 3, 2016. Updated November 2, 2016. Accessed June 16, 2018.

[9] Elders J, Satcher D, Carmona R. Re-thinking genital surgeries on intersex infants. Palm Center Blueprints for Sound Public Policy. June 2017.

[10] American Medical Student Association. AMSA Issues Statement to Defer Gender "Normalizing" Surgeries for Children Born as Intersex. AMSA. https://www.amsa.org/about/amsa-press-room/amsa-issues-statement-defer-gender-normalizing-surgeries-children-born-intersex/. Published October 26, 2017. Accessed August 25, 2018.

[11] Physicians for Human Rights. Unnecessary Surgery on Intersex Children Must Stop. PHR. http://physiciansforhumanrights.org/press/press-releases/intersex-surgery-must-stop.html. Published October 10, 2017. Accessed August 25, 2018.

[12] Nokoff NJ, Palmer B, Mullins AJ, et al. Prospective assessment of cosmesis before and after genital surgery. *J Pediatr Urol.* 2017 13(1):28.e1-28.e6. doi: 10.1016/j.jpurol.2016.08.017.

[13] Ellens RE, Bakula DM, Mullins AJ. Psychological Adjustment of Parents of Children Born with Atypical Genitalia 1 Year after Genitoplasty. *J Urol*. October 2017; *198*(4), 914-920. doi: 10.1016/j.juro.2017.05.035

[14] Diamond DA, Swartz J, Tishelman A, Johnson J, Yee-Ming C. Management of pediatric patients with DSD and ambiguous genitalia: Balancing the child's moral claims to self-determination with parental values and preferences. *Journal of Pediatric Urology*. 2018;pii: S1477-5131(18)30222-5. https://doi.org/10.1016/j.jpurol.2018.04.029.

[15] Human Rights Watch. "I Want to Be Like Nature Made Me": Medically Unnecessary Surgeries on Intersex Children in the US. https://www.hrw.org/news/2017/07/25/us-harmful-surgery-intersex-children. Published July 25, 2017. Accessed April 20, 2017.

[16] Senate Community Affairs Reverences Committee — 43rd and 44th Parliament. Involuntary or coerced sterilization of intersex people in Australia. October 25, 2013. Commonwealth of Australia. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Involuntary_Sterilisation/Sec_Report/index. Accessed July 3, 2018.

(AAFP) Board of Directors opposed "medically-unnecessary genital surgeries performed on intersex children."[17] Additionally, the American Medical Association (AMA) Board of Trustees recognized in a 2016 report the unique circumstance of an intersex infant, calling for the deferment of elective or cosmetic procedures until the child can participate in the decision.[18] Although the AMA has not yet adopted the Board of Trustees' recommendation, other doctors and scholars have also recognized that in medical decision-making for intersex children, reliance on parental consent has the potential to prioritize addressing parental preferences and anxiety at the expense of the autonomy of the child.[19] In addition, parents of intersex children are sometimes presented with unsubstantiated statements concerning the benefits of procedures like clitoral reductions and vaginoplasties, while the risks are often not mentioned or fully discussed.[3]

One common argument in support of early "normalizing" surgeries is that children will suffer psychological damage from having genitalia that may be considered atypical. However, this assumption has never been substantiated by evidence, and, in fact, recent studies have shown intersex individuals who have grown up without undergoing surgery to be generally psychologically healthy.[20] There is little evidence that infant genitoplasty is necessary to reduce psychological damage or that it cannot be reasonably deferred until the individual can participate in the decision-making process. Yet there is evidence that these surgeries carry substantial risks of physical and psychological harm. Intersex individuals who underwent surgery in childhood, to which they did not and could not consent, report feelings of shame, stigma, and distress related to the procedures.[21]

Recognizing that the care of intersex children presents greater challenges than many other medical contexts, the 2006 Consensus Statement recommended forming multidisciplinary teams to navigate decisions regarding intersex infants' treatment.[5] While an increasing number of hospitals are installing these teams, barriers to the effective treatment of intersex patients include a lack of standardization across sites, a lack of engagement with the position of the intersex patient community, and a prevailing impression that early surgery is the best or safest option. Reviews point out the importance of physicians staying up to date on recommendations especially as they continue to evolve.[22] The recommendations themselves, however, must be informed by patient perspectives and experiences, which to date include overwhelming reports of harm suffered as a result of unnecessary childhood surgeries. The development and dissemination of clear recommendations for patient-centered care would improve treatment of this population.

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[17] American Academy of Family Physicians (AAFP). Genital Surgeries in Intersex Children. Board of Directors. July 2018. https://www.aafp.org/about/policies/all/genital-surgeries-intersexchildren.html. Accessed September 12, 2018.

[18] Harris P. Report of the board of trustees: Supporting autonomy for patients with differences of sex development. BOT Report 7-I-16. November 12-15, 2016. https://assets.ama-assn.org/sub/meeting/documents/i16-handbook-combined.pdf. Accessed July 3, 2018.

[19] Hazel Glen Beh and Milton Diamond. David Reimer's Legacy: Limiting Parental Discretion. *Cardozo Journal of Law and Gender.* 12(5) (2005). https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1446966.

[20] Bougneres P, Bouvattier C, Cartigny M, Michala L. Deferring surgical treatment of ambiguous genitalia into adolescence in girls with 21-hydroxylase deficiency: a feasibility study. *International Journal of Pediatric Endocrinology*. 2017;2017(3). doi: 10.1186/s13633-016-0040-8; Callens N, van der Zwan YG, Drop SLS, et al. Do surgical interventions influence psychosexual and cosmetic outcomes in women with disorders of sex development? *ISRN Endocrinology*. 2012:1-8. doi: 10.5402/2012/276742.

[21] Elders J, Satcher D, Carmona R. Re-thinking genital surgeries on intersex infants. Palm Center Blueprints for Sound Public Policy. June 2017.

[22] Gomez-Lobo V. Multidisciplinary care for individuals with disorders of sex development. *Curr Opin Obstet Gynecol*. 2014;26:366. doi: 10.1097/GCO.0000000000000101.

Finally, recent patient-led political advocacy in numerous states has led to a rise in legislative activity related to this issue. Bills prohibiting medically unnecessary surgery in infancy have been introduced in Nevada, Texas, and Indiana. In August of this year, the California State Legislature passed SCR-110, a non-binding resolution supporting the bodily autonomy of intersex patients and calling for increased attention from those in the medical community.[23]

Current MMS Policy

There is no specific policy addressing this topic.

Relevance to MMS strategic Priorities

This initiative relates to the strategic priority of physician and patient advocacy.

Conclusion

The evidence highlights that the needs and bodily autonomy of individuals born with differences in sex development/intersex characteristics have not been acknowledged. As such, the following recommendations align the MMS with current evidence and patients.

Medical student Natalie Mulkey is to be credited for writing this report and bringing it to the attention of the Committee on LGBTQ Matters.

Recommendations:

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

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

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

[23] Fitzsimons, T. 'A baby cannot provide ... consent': Calif. lawmakers denounce infant intersex surgeries. August 28, 2018. https://www.nbcnews.com/feature/nbc-out/baby-cannot-provide-consent-calif-lawmakers-denounce-infant-intersex-surgeries-n903686. Accessed August 29, 2018.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	4
Code:	Resolution I-18 A-102
Title:	Guidelines for Sexual Education in Schools
Sponsors:	Aimie Zale, MD Carl Streed Jr., MD, MPH Katherine Atkinson, MD
Referred to:	Reference Committee A Ms. Marguerite Youngren, Chair

Whereas, An MMS strategic priority is physician and patient advocacy, and

Whereas, The MMS has the following policy:

HEALTH EDUCATION
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 Original: Reaffirmed MMS House of Delegates, 5/21/11
(Item 1 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 4/28/18

; and

Whereas, Existing MMS policy does not address a multitude of issues including sexual violence education, abstinence-only education, prevention of pregnancy, and consent; and

Whereas, The AMA has addressed these topics in its policies H-170.977 and H-170.968 (see appendix); and

Whereas, The AMA has further stated in policy H-170.986 that “State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs”; and

Whereas, The Commonwealth of Massachusetts currently has no mandate for sex education and HIV education, and no guidelines for what sex education should include if it is provided[1]; and

Whereas, Sexual violence and consent have become increasingly visible issues in our society, and children and youth may not be given context to understand these events; and

[1] Sex and HIV Education. Guttmacher Institute Website. https://www.guttmacher.org/state-policy/explore/sex-and-hiv-education, Updated October 1, 2018. Accessed October 6, 2018.

Whereas, Only eight states, **not** including Massachusetts, in the US require sex education to include discussion of consent[2]; and

Whereas, The Massachusetts Legislature is currently considering "An Act Relative to Healthy Youth" (S.234, H.3704), which addresses sexual education in schools[3]; and

Whereas, According to the Massachusetts Department of Education, in 2015 approximately 24% of high school students reported having their activities monitored by someone they were dating (keeping track of where a person is going, who they're with, who they're talking to, checking their emails, text messages, or phone log), 9% reported being physically hurt by someone they were dating, 22% reported using alcohol or drugs before having intercourse, and 8% of students reported being forced to do sexual activities by someone they were dating[4]; and

Whereas, Per the same report, 16% of middle school students who had ever been on a date reported having their activities monitored by someone they were dating (keeping track of where a person is going, who they're with, who they're talking to, checking their emails, text messages, or phone log)[4]; and

Whereas, Only 64% of surveyed Massachusetts students reported having ever been taught in school about birth control methods[4]; and

Whereas, Abstinence-only sexual education programs have either been shown to have no effect on sexual behaviors[5,6] or have been linked to higher and riskier sexual behavior among adolescents[7,8]; and

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[2] Maxouris C. and Ahmed S. Only these 8 states require sex education classes to mention consent. CNN Website. https://www.cnn.com/2018/09/29/health/sex-education-consent-in-public-schools-trnd/index.html. Published September 29, 2018. Accessed October 6, 2018.

[3] Bill H.3704 "An Act Relative to Healthy Youth." https://malegislature.gov/Bills/190/H3704, Accessed October 6, 2018.

[4] Massachusetts Department of Education. 2015 Report on Health & Risk Behaviors of Massachusetts Youth Executive Summary. http://www.doe.mass.edu/sfs/yrbs/2015report.pdf. Accessed October 6, 2018.

[5] Kirby D. Emerging Answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases. The National Campaign to Prevent Teen and Unplanned Pregnancy. Available at https://powertodecide.org/sites/default/files/resources/primary-download/emerging-answers.pdf. Accessed Oct 15, 2018.

[6] Trenholm C, Devaney B, Fortson K, et al. Impacts of four Title V, Section 510 abstinence education programs: Final Report. *Mathematica Policy Research* 2007. Available at https://files.eric.ed.gov/fulltext/ED496286.pdf. Accessed Oct 15 2018.

[7] Shepherd LM, Sly KF, Girard JM. Comparison of comprehensive and abstinence-only sexuality education in young African American adolescents. *J. Adolesc.* 2016 61: 50-63.

[8] The Society for Adolescent Health and Medicine. Abstinence-Only-Until-Marriage Policies and Programs: an Updated Position Paper of the Society for Adolescent Health and Medicine. *J. Adolesc Health.* September 2017, 61:3, 400-403.

Whereas, More comprehensive sexual education programs including consent, STIs, and contraceptive use have been shown to be associated with an increase in contraception use and safer sexual practices[9,10,11]; and

Whereas, The current administration has focused resources and attention on abstinence-only sexual education and away from comprehensive sexual education,[12] including prematurely ending grants provided under the Teen Pregnancy Prevention Program[13] to researchers studying effective, culturally competent sexuality programs for youth; and

Whereas, A majority of parents on both ends of the political spectrum feel that sex education including comprehensive topics including birth control, STDs, and abstinence are important[14,15]; therefore, be it

1. **RESOLVED, That the MMS supports sexual health education that:**

    a. **Is comprehensive, medically accurate, and culturally and religiously aware; and**
    b. **Promotes healthy sexuality, including a perception of one's own sexuality, that is free from shame, blame, and stigma; and**
    c. **Prepares individuals to make healthy sexual decisions; and**
    d. **Includes essential concepts and issues such as:**
        i. **Sexual orientation and gender identity; and**
        ii. **Power dynamics inherent in sexual relationships, especially as related to age, gender, and substance use; and**
        iii. **Sexual health and access to sexual and reproductive health care; and**
        iv. **Intimate partner violence and sexual exploitation; and**
        v. **Relationships based on mutual respect, communication, and personal responsibility; and**
        vi. **Risks for HIV and other sexually transmitted infections and unplanned pregnancy; and**
        vii. **The benefits and risks of barrier methods (including condoms) and other contraceptive methods**

(HP)

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[9] Jaramillo N, Buhi ER, Elder JP, Corliss HL. Associations Between Sex Education and Contraceptive Use Among Heterosexually Active, Adolescent Males in the United States. *J Adolesc Health*. 2017 May;60(5):534-540.

[10] Denford S, Abraham C, Campbell R, Busse H. A comprehensive review of reviews of school-based interventions to improve sexual-health. *Health Psychol Rev.* 2017 Mar;11(1):33-52.

[11] Chin HB et al. The Effectiveness of Group-Based Comprehensive Risk-Reduction and Abstinence Education Interventions to Prevent or Reduce the Risk of Adolescent Pregnancy, Human Immunodeficiency Virus, and Sexually Transmitted Infections: Two Systematic Reviews for the Guide to Community Preventive Services. *Am J of Prev Med.* March 2012, 42:3, 272-294.

[12] Belluck P. Trump Administration Pushes Abstinence in Teen Pregnancy Programs. *The New York Times.* April 23, 2018. Available at https://www.nytimes.com/2018/04/23/health/trump-teen-pregnancy-abstinence.html. Accessed Oct 15, 2018.

[13] Przybyla H. HHS agrees to protect some funds for teen pregnancy prevention program. *NBC News.* March 28, 2018. Available at https://www.nbcnews.com/politics/white-house/hhs-agrees-protect-some-funds-teen-pregnancy-prevention-program-n860581. Accessed Oct 15, 2018.

[14] Kantor L, Levitz N. Parents' views on sex education in schools: How much do Democrats and Republicans agree? *Plos One.* 2017; 12(7).

[15] Eisenberg ME, Bernat DH, Bearinger LH, Resnick MD. Support for comprehensive sexuality education: perspectives from parents of school-age youth. *J. Adolesc Health.* 2008 Apr;42(4):352-9.

; and, be it further

2. RESOLVED, That the MMS advocate for comprehensive evidence-based sexual health education to be required in schools receiving public funding, that:

a. Is based on rigorous, peer-reviewed science; and
b. Incorporates sexual violence prevention including comprehensive discussion on consent and the relationship of substance use to sexual violence; and
c. Shows promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted infections and for becoming pregnant; and
d. Includes an integrated strategy for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; and
e. Utilizes classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of sexual and gender minority youth; and
f. Appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; and
g. Includes ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and
h. Is part of an overall health education program; and
i. Includes culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils without sacrificing comprehensiveness.

(D)

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

FTE: Existing Staff
(Staff Effort to Complete Project)

APPENDIX
AMA POLICY

H-170.977
Comprehensive Health Education
(1) Educational testing to confirm understanding of health education information should be encouraged.
(2) The AMA accepts the CDC guidelines on comprehensive health education. The CDC defines its concept of comprehensive school health education as follows:

(a) a documented, planned, and sequential program of health education for students in grades kindergarten through 12;
(b) a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., human immunodeficiency virus (HIV) infection, drug abuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages;
(c) activities to help young people develop the skills they will need to avoid:
(i) behaviors that result in unintentional and intentional injuries;
(ii) drug and alcohol abuse;
(iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies;
(v) imprudent dietary patterns; and
(vi) inadequate physical activity;
(d) instruction provided for a prescribed amount of time at each grade level;
(e) management and coordination in each school by an education professional trained to implement the program;
(f) instruction from teachers who have been trained to teach the subject;
(g) involvement of parents, health professionals, and other concerned community members; and
(h) periodic evaluations, updating, and improvement.

(Year Last Modified: 2009)

H-170.968
Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools
(1) Recognizes that the primary responsibility for family life education is in the home, and additionally, supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that:
(a) are based on rigorous, peer reviewed science;
(b) incorporate sexual violence prevention;
(c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant;

(d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases;
(e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth;
(f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities;
(g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program;
(h) are part of an overall health education program; and
(i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;

(9) Supports the development of sexual education curriculum that integrates dating

violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and

(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

(Year Last Modified: 2018)

H-170.986
Health Information and Education

(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.

(2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.

(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.

(4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.

(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.

(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.

(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.

(8) Information on health and health care should be presented in an accurate and objective manner.

(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.

(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.

(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.

(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.

(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.

(Year Last Modified: 2015)

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	5
Code:	CVIP Report I-18 A-3
Title:	Equitable Health Care Regardless of Immigration Status
Sponsor:	Committee on Violence Intervention and Prevention Wendy Macias-Konstantopolous, MD, Chair
Referred to:	Reference Committee A Ms. Marguerite Youngren, Chair

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EXECUTIVE SUMMARY

According to the Massachusetts Immigration and Refugee Advocacy Coalition, one in six Massachusetts residents is an immigrant. One in every four children in the United States lives with at least one immigrant parent.

Physicians have an obligation to uphold and advocate for the right of immigrant patients to receive needed medical care without regard for legal status, and to protect the designation of health care facilities as sensitive locations where immigration enforcement actions should not occur.

In January of this year, the Society's immediate past president, referencing the US Department of Health and Human Services' formation of a "Conscience and Religious Freedom" Division, stated, "As physicians, we have an obligation to ensure patients are treated with dignity while accessing and receiving the best possible care to meet their clinical needs. We will not and cannot, in good conscience, compromise our responsibility to heal the sick based upon a patient's racial identification, national or ethnic origin, sexual orientation, gender identity, religious affiliation, disability, immigration status, or economic status."

As physicians, we seek to provide compassionate care that respects the dignity and promotes the well-being of all our patients, regardless of immigration status.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	5
Code:	CVIP Report I-18 A-3
Title:	Equitable Health Care Regardless of Immigration Status
Sponsor:	Committee on Violence Intervention and Prevention Wendy Macias-Konstantopolous, MD, Chair
Referred to:	Reference Committee A Ms. Marguerite Youngren, Chair

Background

The 43 million immigrants residing in the United States (as of 2016) account for roughly 13 percent of the population. One in every 4 children in the United States lives with at least one immigrant parent. Eighty-eight percent of these children are US citizens. Data from the US Census Bureau's American Community Survey indicates that approximately 1 in 6 Massachusetts residents was born in another country, and almost 1 in 3 Massachusetts children live in an immigrant family.[1]

Some of these residents arrived in the United States seeking asylum due to persecution related to their ethnicity, religion, sexuality, political opinions, or membership in particular social groups. Others fled human rights violations, armed conflict, gang violence, intimate partner violence, or devastation from natural disasters.[2] Another subset arrived seeking better employment or education, or reunification with family members already in the United States. Some have received long term legal status by becoming naturalized US citizens or green card holders; others possess temporary legal status through visas or programs like Deferred Action for Childhood Arrivals (DACA) and Temporary Protected Status (TPS); and still others are undocumented.

All are building their lives in their adopted communities as they pursue the American dream. Nonetheless, with the evolving rules and laws surrounding immigration, refugee, and asylum-seekers, documented and undocumented residents may face daily racism, xenophobia, and discrimination.[3]

Current MMS Policy

Medical Ethics

The Massachusetts Medical Society adopts as its Code of Ethics the revised American Medical Association's Principles of Medical Ethics (adopted June 17, 2001) (*numbers 1, 3, 7, and 8 are relevant to this report*), which read as follows:

Principles of Medical Ethics:

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

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[1] Migration Policy Institute website. Published February 8, 2018. www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states. Accessed October 15, 2018.

[2] Amnesty International website. www.amnesty.org Updated 2018. Accessed October 12, 2018.

[3] Amnesty International website. www.amnesty.org Updated 2018. Accessed October 12, 2018.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09

Nondiscrimination
The MMS reaffirms its commitment to working for the best possible health care for every patient in the Commonwealth regardless of racial identification, national or ethnic origin, sexual orientation, gender identity, religious affiliation, disability, immigration status, or economic status. (HP)

MMS House of Delegates, 12/3/16

Current AMA Policy

Improving Medical Care in Immigrant Detention Centers D-350.983
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.

Res. 017, A-17

Patient and Physician Rights Regarding Immigration Status H-315.966
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Res. 018, A-17

Care of Women and Children in Family Immigration Detention H-350.955
1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.

Res. 002, A-17

Financial Impact of Immigration on American Health System D-160.988
Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals

to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid.

Res. 235, A-06 Reaffirmation I-10

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.

2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.

3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.

5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921

Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.

Res. 232, I-17

Financial Impact of Immigration on the American Health System H-160.920

Our AMA supports legislative and regulatory changes to require the federal government to make reasonable payments to physicians for the federally mandated care they provide to patients, regardless of the immigration status of the patient.

CMS Rep. 3, A-07 Reaffirmed: CMS Rep. 01, A-17

Visa Complications for IMGs in GME D-255.991

1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between

the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs' inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.
Res. 844, I-03 Reaffirmation A-09 Reaffirmation I-10 Appended: CME Rep. 10, A-11
Appended: Res. 323, A-12

Medical Care Must Stay Confidential H-270.961
Our AMA will strongly oppose any federal legislation requiring physicians to establish the immigration status of their patients.
Res. 214, A-04 Reaffirmed: CEJA Rep. 8, A-14

Intimate Partner Violence Policy and Immigration D-515.979
Our AMA: (1) encourages appropriate stakeholders to study the impact of mandated reporting of domestic violence policies on individuals with undocumented immigrant status and identify potential barriers for survivors seeking care; and (2) will work with community based organizations and related stakeholders to clarify circumstances that would trigger mandated reporting of intimate partner violence and provide education on the implications of mandatory reporting on individuals with undocumented immigrant status.
Res. 002, I-17

Relevance to MMS Strategic Priorities
This report relates to the 2018–2019 MMS strategic priority of physician and patient advocacy.

Discussion
Immigration laws affect everyone who is not a US citizen, including those holding Permanent Resident Cards (green cards) and those who have lived in the United States for many years.[4] These laws also indirectly affect many US citizens who live in proximity to our nation's borders; who have immigrant family members, neighbors, and colleagues; or who rely on foreign medical graduates via H1B visa programs for access to care in underserved US communities.

[4] Immigration. Massachusetts Legal Help website.www.masslegalhelp.org/immigration. Updated September 2017. Accessed October 15, 2018.

The MMS adopted its Code of Ethics from the revised American Medical Association's Principles of Medical Ethics in 2001.[5] The very first principle states that "[a] physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights." This principle closely aligns with the profession of medicine — dedicated to caring for life, one individual at a time, and to improving the health of entire populations through public health interventions.

Compassion, respect, and the affirmation of human rights require us to acknowledge the dignity present in every person; arbitrarily chosen attributes should not exclude anyone — from social inclusion, health care services, or our compassion.

As such, physicians have an obligation to uphold and advocate for the right of immigrant patients to receive needed medical care without regard for legal status, and to protect the designation of health care facilities as sensitive locations where immigration enforcement actions should not occur. Imperative, too, is working with community-based organizations and government agencies to study and mitigate the implications of mandatory reporting laws so that immigrants can continue to receive necessary protective services without fear of consequences to their immigration status. The National Immigration Law Center provides information for physicians and health care facilities regarding immigrant patients' rights on its website.[6] Physicians should also seek to protect public health by opposing measures that threaten the physical and emotional well-being of immigrant communities, including public charge rules, arbitrary family separations, and prolonged detentions without access to appropriate medical care.

Conclusion

As physicians, we seek to provide compassionate care that respects the dignity and promotes the well-being of all our patients, regardless of immigration status. For the sake of public health, a clear line must be drawn between immigration enforcement and health care services to ensure that all residents can access appropriate medical care without fear.

Recommendations:

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

1. **That the Massachusetts Medical Society recognizes the negative health consequences of the detention of families seeking safe haven. *(HP)***

2. **That the Massachusetts Medical Society opposes the expansion of family immigration detention, due to the negative health consequences of detention. *(HP)***

3. **That the Massachusetts Medical Society opposes the separation of parents from their children who are detained while seeking safe haven. *(HP)***

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[5] Code of Ethics. American Medical Association website. www.ama-assn.org. Published June 17, 2001. Accessed October 12, 2018.

[6] Healthcare Provider and Patients' Rights. National Immigration Law Center website. www.nilc.org/issues/immigration-enforcement/healthcare-provider-and-patients-rights-imm-enf. April 2017. Accessed October 15, 2018.

4. **That the Massachusetts Medical Society will advocate for safe access to health care for immigrants and refugees in the Commonwealth regardless of immigration status. *(D)***

5. **That the Massachusetts Medical Society:**
   - **Advocate for and support legislative efforts to designate healthcare facilities as sensitive locations by law *(D)***
   - **Work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of health care facilities as sensitive locations where US Immigration and Customs Enforcement (ICE) enforcement actions should not occur *(D)***
   - **Encourage health care facilities to clearly demonstrate and promote their status as sensitive locations *(D)***
   - **Oppose the presence of ICE enforcement at health care facilities *(HP)***

6. **That the Massachusetts Medical Society:**
   - **Encourage appropriate stakeholders to study the impact of mandated reporting laws on individuals with undocumented immigrant status and identify potential barriers for survivors seeking care *(D)***
   - **Work with community-based organizations and related stakeholders to study and mitigate the implications of mandated reporting laws, so that immigrants can continue to receive necessary protective services without fear of consequences to their immigration status *(D)***

7. **That the Massachusetts Medical Society advocate for legislative/regulatory changes that will protect the civil rights, safety, and well-being of all patients by drawing a clear line between immigration enforcement and health care. *(D)***

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	6
Code:	Resolution I-18 A-103
Title:	Support for Evidence-Based Metrics to More Accurately Characterize the Urban Soundscape
Sponsor:	Mr. Prithwijit Roychowdhury
Referred to:	Reference Committee A Ms. Marguerite Youngren, Chair

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Whereas, An MMS strategic priority is sustainable health care delivery; and

Whereas, The MMS has the following relevant existing policy:

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

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

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

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

MMS House of Delegates, 4/29/17

Whereas, Sound is a pervasive stressor in urban, suburban, and rural environments that can lead to a wide range of adverse health outcomes and recently epidemiological studies have begun to show that exposure to increasing environmental noise is linked with a wide range of stress-and-cardiovascular-related response, such as elevated cortisol;[1] blood pressure;[2]

[1] Selander J, Bluhm G, Theorell T, et al. Saliva cortisol and exposure to aircraft noise in six European countries. *Environ Health Perspect.* 2009; 117(11): 1713–1717. doi:10.1289/ehp.0900933
[2] Haralabidis AS, Dimakopoulou K, Vigna-Taglianti F, et al. Acute effects of night-time noise exposure on blood pressure in populations living near airports. *Eur Heart J.* 2008: 29(5): 658–664. doi:10.1093/eurheartj/ehn013

hypertension;[3,4,5] myocardial infarction;[1,5] antihypertensive, anxiolytic, and antacid medication use;[6] cardiovascular-related hospital admissions;[7,8] and mortality;[8] and

Whereas, Recent studies have also demonstrated the link between low frequency noise specifically and poor cardiovascular outcomes[8,9,10] as well as other adverse health outcomes;[11] and

Whereas, Beyond stress and cardiovascular responses, according to a 2017 *Centers for Disease Control Vital Signs* report released by the CDC, nearly one in four US adults show signs of noise-induced hearing loss,[12] making it the third most common chronic condition, just behind diabetes and cancer;[13] and

Whereas, Hearing loss alone is associated with a decrease in social, psychological, and cognitive function as well as an increase of distress, somatization, depression, and loneliness among groups of all ages and is also associated with low employment rates, lower worker productivity, and high health care costs demonstrating a strong economic burden that the condition places on the US economy; in fact, the cost to society is estimated to be around $297,000 for every affected person over his or her lifetime;[14,15] and

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[3] Bluhm GL, Berglind N, Nordling E, Rosenlund M. Road traffic noise and hypertension. *Occupational and Environmental Medicine,* 2007: 64(2); 122–126. doi:10.1136/oem.2005.025866

[4] Bodin T, Albin M, Ardo J, Stroh E, Ostergren PO, Bjork J. Road traffic noise and hypertension: results from a cross-sectional public health survey in southern Sweden. *Environ Health*. 2009: 8; 38. doi:10.1186/1476-069X-8-38

[5] Babisch W, Beule B, Schust M, Kersten N, Ising H. Traffic noise and risk of myocardial infarction. *Epidemiology*. 2005: 16(1), 33–40.

[6] Floud S, Vigna-Taglianti F, Hansell A, et al. Medication use in relation to noise from aircraft and road traffic in six European countries: results of the HYENA study. *Occup Environ Med*. 2011: 68(7); 518–524. doi:10.1136/oem.2010.058586

[7] Correia AW, Peters JL, Levy JI, Melly S, Dominici F. Residential exposure to aircraft noise and hospital admissions for cardiovascular diseases: multi-airport retrospective study. *BMJ*. 2013: 347; f5561. doi:10.1136/bmj.f5561

[8] Hansell AL, Blangiardo M, Fortunato L, et al. Aircraft noise and cardiovascular disease near Heathrow airport in London: small area study. *BMJ*. 2013: 347; f5432. doi:10.1136/bmj.f5432

[9] Walker ED, Brammer A, Cherniack MG, Laden F, Cavallari JM. Cardiovascular and stress responses to short-term noise exposures — a panel study in healthy males. *Environmental Research*. 2016: 150; 391–397. doi: 10.1016/j.envres.2016.06.016

[10] Wang VS, Lo EW, Liang CH, Chao KP, Bao BY, Chang TY. Temporal and spatial variations in road traffic noise for different frequency components in metropolitan Taichung, Taiwan. *Environ Pollut*. 2016: 219; 174–181. doi:10.1016/j.envpol.2016.10.055

[11] Alves-Pereira M, Castelo Branco, NAA. Vibroacoustic disease: biological effects of infrasound and low-frequency noise explained by mechanotransduction cellular signalling. *Progress in Biophysics and Molecular Biology*. 2007: 93(1); 256–279. doi: 10.1016/j.pbiomolbio.2006.07.011

[12]Carroll YI, Eichwald J, Scinicariello F, et al. Vital Signs: Noise-induced hearing loss among adults — United States 2011–2012. *MMWR Morb Mortal Wkly Rep*. 2017: 66(5); 139–144. doi:10.15585/mmwr.mm6605e3

[13] Blackwell, DL, Lucas, JW, Clarke, TC. Summary health statistics for U.S. adults: national health interview survey, 2012. *Vital Health Stat.* 2014: 10(260), 1–161.

[14] National Academies of Sciences, Engineering, and Medicine. *Hearing Health Care for Adults: Priorities for Improving Access and Affordability*. Washington, DC: The National Academies Press; 2016.

[15] Themann C, Suter AH, Stephenson MR. National Research Agenda for the Prevention of Occupational Hearing Loss — Part 1. *Semin Hear*. 2013: 34(03); 145–207. doi:10.1055/s-0033-1349351

Whereas, Looking forward, the total cost of first-year hearing loss treatment is projected to increase from $8.2 to $51.4 billion (fivefold) between the years of 2002 and 2030;[16] and

Whereas, In addition to the direct cost burden from hearing loss, we must also consider the effects of noise pollution on cardiovascular health as well and according to a CDC Vital Signs published in 2018, “approximately 16.3 million [cardiovascular] events and $173.7 billion in hospitalization costs could occur during 2017–2021 without preventive intervention”;[17] and

Whereas, The scale of cost associated with cardiovascular disease alone is overwhelming and as there is abundant recent evidence about the connections between urban sound and stress and cardiovascular disease, there is precedent to reevaluate the way we think about and regulate sounds; and

Whereas, The inability for communities to abate environmental noise or to influence or introduce noise regulatory policy leads residents with a general feeling of loss of control over their lives and according to a recent noise survey conducted in the Greater Boston area responses from a survey asking residents why they felt so annoyed by community noise, the main reasons for annoyance were the following: it is unwanted (97%); it is uncontrollable (95%); if they complain, nothing will be done (84%), and it is impacting their health (65%);[18] and

Whereas, Specific examples of this include the recent decision by the Mayor’s Office of Consumer Affairs and Licensing to expand the number of concert dates held at Fenway Park over the Summer of 2018 that came with pushback by many residents who felt that their voices were not being heard in the discussion;[19] and

Whereas, There is recent evidence that seems to suggest that like other forms of environmental pollution (air, chemical), noise pollution also represents a health inequity that disproportionality affects low-income communities of color,[20,21] and evidence also suggest that adults with hearing loss are more likely to have low income and be unemployed or underemployed than adults with normal hearing;[11,12] and

Whereas, This is particularly concerning when taken in conjunction with the previously cited evidence regarding noise pollution as a health inequity as well as the findings from a recent retrospective cohort analysis that has shown an association between racial/ethnic minority

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[16] Stucky SR, Wolf KE, Kuo T. The economic effect of age-related hearing loss: national, state, and local estimates, 2002 and 2030. *J Am Geriatr Soc*. 2010; 58: 618–9. http://dx.doi.org/10.1111/j.1532-5415.2010.02746.x

[17] Ritchey MD, Wall HK, Owens PL, Wright JS. Vital Signs: state-level variation in nonfatal and fatal cardiovascular events targeted for prevention by Million Hearts 2022. *MMWR Morb Mortal Wkly Rep*. 2018: 67(35); 974–982. doi:10.15585/mmwr.mm6735a3

[18] Walker E, Roman JC, Luna M. Perceptions — 2016 Greater Boston noise report. 2016. http://boston.noiseandthecity.org/sound-perceptions. Retrieved September 25, 2018.

[19] https://thebostonsun.com/2018/03/01/fenway-park-granted-12-concert-dates-causing-mixed-results-between-residents-and-business-owners

[20] Casey JA, Morello-Frosch R, Mennitt DJ, Fristrup K., Ogburn EL, James P. Race/ethnicity, socioeconomic status, residential segregation, and spatial variation in noise exposure in the contiguous United States. *Environmental Health Perspectives*. 2017: 125(7); 077017. doi: 10.1289/EHP898

[21] Seltenrich N. Inequality of noise exposures: a portrait of the United States. Environmental Health Perspectives. 2017: 125(9); 094003. doi: 10.1289/EHP2471

status and low socioeconomic status and increased risk of hearing loss among participants aged 12–19 years;[22]; and

Whereas, The scope of health effects and economic costs associated with noise pollution is clearly quite extensive, the federal government has not addressed the issue in a comprehensive manner and while Congress did pass the Noise Pollution and Abatement Act of 1972, which sought to protect human health and minimize annoyance of noise to the public by placing emission standards for a variety of vehicles and appliances,[23] funding for the act was ended in 1981. As a result, much of the responsibility regarding noise regulation has ended up in the hands of state and local governments;[24] and

Whereas, Regulatory bodies at the state and local level generally regulate sound via the use of noise ordinances, which may or may not be strictly enforced, and further, beyond haphazard enforcement, the metrics employed tend to focus on a sound's loudness — using the A-weighted decibel — to evaluate environmental and industrial noise; and

Whereas, A-weighting involves the use of a frequency-dependent curve to evaluate the way a given sound pressure level will be perceived by the human ear, and while A-weighting is useful for understanding a sound's loudness in its attempt to model the human ear, the system greatly discounts the contributions from low-frequency and high-frequency ranges. High-frequency sounds, such as birds chirping and highway traffic, are generally sharper in nature while low-frequency sounds, such as thunder or a bus engine, are those that are rumbling in nature. Sound exposure assessments have demonstrated that sounds with dominant low- and high-frequency sounds are ubiquitous in our environment — especially in communities inundated with industrial land use, frequent construction, major roads and rail lines, and aircraft flights; and

Whereas, Reports and studies have demonstrated that although A-frequency is often mandated for most noise measurements, it is poorly suited for environmental sound sources for which it is most often used;[25] and

Whereas, The negative human health effects of low frequency noise are characterized in the literature[8,9,10,26] but often underappreciated in policies regarding noise regulation; and

Whereas, In conclusion, the resolution sponsor requests MMS's support for appropriate agencies and stakeholders to explore evidence-based metrics beyond A-weighting public soundscape and ensure that the negative health effects from low-frequency noise are also being evaluated effectively when establishing levels for noise ordinances or regulations; therefore, be it

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[22] Su BM, Chan DK. Prevalence of hearing loss in us children and adolescents: findings from NHANES 1988–2010. *JAMA Otolaryngology – Head & Neck Surgery.* 2017: 143(9); 920–927. doi: 10.1001/jamaoto.2017.0953

[23] Noise Control Act of 1972, P.L. 92-574, 86 Stat. 1234, 42 U.S.C. § 4901 - 42 U.S.C. § 4918.

[24] Noise Pollution | Health Impact Assessments — UCLA SPH. www.hiaguide.org. Retrieved December 21, 2015.

[25] Pierre RLS, Maguire DJ, Automotive CS. The impact of A-weighting sound pressure level measurements during the evaluation of noise exposure. 2004.

[26] Leventhall G, Pelmear P, Benton S. A review of published research on low frequency noise and its effects. Report for Department for Environment, Food and Rural Affairs, London. 2003.

RESOLVED, That the MMS supports governmental/environmental agencies and/or relevant stakeholders exploring the feasibility of an evidence-based metric beyond purely A-weighted noise to more accurately capture lower-frequencies in the public soundscape. *(HP)*

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	7
Code:	CDM Report I-18 A-4
Title:	Social Determinants of Health
Sponsor:	Committee on Diversity in Medicine Simone Wildes, MD, Chair
Referred to:	Reference Committee A Ms. Marguerite Youngren, Chair

Background

Social determinants of health are the conditions in which people are born, grow, live, learn, work, and age that affect a wide range of health and quality-of-life outcomes and risks. Social determinants of health are widely recognized as a primary approach to reducing health disparities and have become a public health focus at the global, national, state, and local levels.[1,2,3]

Numerous studies in recent decades have demonstrated the significant role nonmedical factors play in physical and mental health. In 2000, approximately 245,000 deaths were attributable to low education, 176,000 to racial segregation, 162,000 to low social support, 133,000 to individual-level poverty, and 119,000 were due to income inequality.[4]

Food insecurity, for example, is associated with increased risk for diseases and conditions like diabetes, hypertension, and depression in adults, and with increased risk for impaired brain development, hospitalizations, iron-deficiency anemia, mental health, and behavioral disorders in children.[5,6,7,8,9]

Housing insecurity and homelessness are related to poorer physical health, including higher rates of tuberculosis, hypertension, asthma, diabetes, and HIV/AIDS and higher rates of medical hospitalizations. Even after adjusting for demographics and socioeconomics, those who are housing insecure are more

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[1] https://www.cdc.gov/nchhstp/socialdeterminants/faq.html#c.
[2] http://www.who.int/social_determinants/thecommission/en/.
[3] https://www.cdc.gov/socialdeterminants/.
[4] http://annals.org/aim/fullarticle/2678505/addressing-social-determinants-improve-patient-care-promote-health-equity-american.
[5] Hunger and Health: The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being. Food Research and Action Center (FRAC). 2017.
[6] Hunger and Health: The Role of the Federal Child Nutrition Programs in Improving Health and Well-Being. Food Research and Action Center (FRAC). 2017.
[7] Olsen CM. Nutrition and Health Outcomes Associated with Food Insecurity and Hunger. *Journal of Nutrition*. 1999;129(2):5215-5245.
[8] Cook JT, Frank DA, Berkowitz C, Black MM, Casey PH, Cutts DB, et al. Food Insecurity is Associated with Adverse Health Outcomes among Human Infants and Toddlers. *Journal of Nutrition.* 2004;134(6):1432-1438.
[9] Gundersen C, Ziliak JP. Food insecurity and health outcomes. *Health Affairs.* 2015;34(11):1830-1839.

likely to delay doctors' visits and to report 14 days or more of poor physical or mental health limiting daily activity for 14 or more out of 30 days.[10,11, 12]

Physicians across the country recognize the impact these determinants are having to their patients' health outcomes. The Physicians Foundation 2018 Survey of America's Physicians found that most physicians (87.9%) say that "some, many or all" of their patients are affected by a social condition that presents a serious impediment to their health.

In a 2015 report, the Blue Cross Blue Shield of Massachusetts Foundation noted that "there is strong evidence that increased investment in selected social services as well as various models of partnership between health care and social services can confer substantial health benefits and reduce health care costs for targeted populations." For example, providing housing support for low-income, high-need individuals can result in net savings due to reduced health care costs, ranging from $9,000 per person per year to nearly $30,000 per person per year, and partnerships between health care and housing service providers have been effective in improving health outcomes in certain high-need populations.[13]

Current MMS Policy

PUBLIC HEALTH
Food Insecurity Screen
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)

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)

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

MMS House of Delegates, 4/28/18

PUBLIC HEALTH
Healthy Lifestyle/Aging
The MMS recommends that adults consume a diet higher in vegetables, fruits, whole grains, low- or non-fat dairy, seafood, legumes, and nuts; lower in red and processed meat; and low in sugar-sweetened foods and drinks and refined grains. (HP)

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[10] Zlotnick & Zerger, 2008, https://www.ncbi.nlm.nih.gov/pubmed/18564196.
[11] Kushel et al., 2001.
[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4509099/.
[13] https://bluecrossmafoundation.org/sites/default/files/download/publication/Social_Equity_ExecSumm_final.pdf.

The MMS supports government-sanctioned guidelines outlining a diet higher in vegetables, fruits, whole grains, low- or non-fat dairy, seafood, legumes, and nuts; lower in red and processed meat; and low in sugar-sweetened foods and drinks and refined grains; as well as policy and regulations promoting the production and distribution of elements of such a diet. (HP)

The MMS recommends increased physical activity for all adults and supports policies and regulations to promote physical activity, such as safe neighborhoods in which to walk. (HP)

The MMS supports policy and regulations to promote maintenance of meaningful involvement of elders in all spheres of social and work life, including employment, transportation, and housing. (HP)

MMS House of Delegates, 5/7/16

VIOLENCE

Domestic Violence Detection Education

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

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10 (Items 2 and 3 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 4/29/17

Relevance to MMS Strategic Priorities

MMS strategic priorities include: physician and patient advocacy; membership value and engagement; and sustainable health care delivery, which states that the MMS will "play a leadership role in developing a sustainable model of health care delivery by promoting the integration of public health, behavioral health, and the social determinants of health across physician practices."

Discussion

Social determinants of health are major predictors of illness and the magnitude of health inequalities. Residents of our Commonwealth whose social determinants of health are overwhelming positive can expect to live up to 30 years longer and in good health when compared to residents whose social determinants of health are overwhelmingly negative, thus clearly detrimental to their well-being.

While the US leads the world in health care spending, it has been suggested that the poor US performance on certain health indicators may be attributed to its very low investment in social services, such as housing, employment programs, and family supports.[14]

The World Health Organization defined social determinants of health as "the circumstances in which people are born, grow up, live, work and age, *and the*

[14] https://www.healthaffairs.org/do/10.1377/hpb20140821.404487/full/.

systems put in place to deal with illness" (emphasis added). State, local, and national entities are beginning to adopt policies focusing on health in all policies, and social determinants of health. Recognizing the critical roles of physicians and the health care system, a number of national physicians' health care associations have stressed the important role of the physician.

The American Academy of Pediatrics adopted policy in 2016 acknowledging that "Poverty and related social determinants of health can lead to adverse health outcomes in childhood and across the life course, negatively affecting physical health, socioemotional development, and educational achievement. The American Academy of Pediatrics advocates for programs and policies that have been shown to improve the quality of life and health outcomes for children and families living in poverty. With an awareness and understanding of the effects of poverty on children, pediatricians, and other pediatric health practitioners in a family-centered medical home can assess the financial stability of families, link families to resources, and coordinate care with community partners."[15]

In 2012, the American Academy of Family Physicians adopted policy supporting the need for physicians to "know how to identify and address social determinants of health in order to be successful in promoting good health outcomes for individuals and populations;" and which states in part:

"Family physicians take a leading role in addressing the social determinants of health by partnering and collaborating with public health departments, social service agencies, and other community resources. Family physicians are integral within the continuum of care and use their skills and expertise in caring for patients across the lifespan to reach out to their communities, bridge health care gaps, and strive for better health for all."[16]

The American College of Physicians, earlier this year adopted policy acknowledging that understanding and addressing social factors that affect health outcomes is a pressing issue for physicians and medical professionals in the communities they serve, and recommended, in part:

"…increased efforts to evaluate and implement public policy interventions with the goal of reducing socioeconomic inequalities that have a negative impact on health;…

"…that social determinants of health and the underlying individual, community, and systemic issues related to health inequities be integrated into medical education at all levels.

"Health care professionals should be knowledgeable about screening and identifying social determinants of health and approaches to treating patients whose health is affected by social determinants throughout their training and medical career.

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[15] http://pediatrics.aappublications.org/content/early/2016/03/07/peds.2016-0339.
[16] https://www.aafp.org/about/policies/all/social-determinants.html.

"… increased interprofessional communication and collaborative models that encourage a team-based approach to treating patients at risk to be negatively affected by social determinants of health.

"… [and that] policymakers adopt a 'health in all policies' approach and supports the integration of health considerations into community planning decisions through the use of health impact assessments."[17]

The American Hospital Association is developing a series of guides addressing social determinants of health to support hospitals and health systems, including reports, case studies and webinars on food insecurity, housing stability, transportation, education, social support, violence, and employment.[18]

Patient care organizations around the state and the country are working to develop innovative programs to sustainably and effectively address their social determinants of health in order to improve their patients' health outcomes and quality of life, while reducing overall health care costs.

Conclusion

Social determinants of health are among the most influential factors that determine the health outcomes of individuals. Addressing the social determinants of health for patients and communities is important to achieving health equity and improving health outcomes for all people in the Commonwealth, and supports the mission, vision, and strategic priorities of the MMS.

Recommendations:

1. **That the Massachusetts Medical Society acknowledges that social determinants of health play a key role in health outcomes and health disparities, and that addressing the social determinants of health for patients and communities is critical to the health of our patients, our communities, and a sustainable, effective health care system. *(HP)***

2. **That the Massachusetts Medical Society will, as appropriate, advocate for policies aimed at improving social determinants of health for the people of Massachusetts. *(D)***

3. **That the Massachusetts Medical Society encourages physicians and health systems to work to develop sustainable care delivery models that incorporate innovative and creative ways of improving the social determinants of health for all patients. *(HP)***

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

[17] https://www.acponline.org/acp_policy/policies/addressing_social_determinants_to_improve_patient_care_2018.pdf.

[18] https://www.aha.org/social-determinants-health.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	8
Code:	CPREP Report I-18 A-5 [A-17 B-211]
Title:	Stop the Bleed/Save a Life
Sponsor:	Committee on Preparedness Eric Goralnick, MD, MS, Chair
Report History:	BOT Informational Report I-17-02 Resolution A-17 B-211
Referred to:	Reference Committee A Ms. Marguerite Youngren, Chair

Background

At, A-17, the House of Delegates referred Resolution A-17 B-211, Stop the Bleed/Save a Life, to the Board of Trustees for Decision (BOT). The BOT assigned this item to the Committee on Preparedness for a report with recommendations at the October 2017 BOT meeting. The committee presented amendments to the resolution and also current policy, and the BOT voted to amend and reaffirm the current policy in lieu of the resolution to read as follows:

1. The Massachusetts Medical Society (MMS) will advocate for the availability of accessible automated external defibrillators (AEDs) and severe bleeding kits that include tourniquets in schools, colleges, and other areas experiencing sustained or periodic high-concentrated populations. *(HP)*

2. The MMS will work with school districts and community agencies, including the American Heart Association, to ensure that a rapid emergency response system that includes automated external defibrillators, severe bleeding kits that include tourniquets, and cardiopulmonary resuscitation-trained personnel is in place at school and college sporting events. *(D)*

3. That the Massachusetts Medical Society promote widespread population awareness of the “Stop the Bleed” initiative to control severe hemorrhage in disaster and trauma events. *(D)*

4. That the Massachusetts Medical Society coordinate and collaborate with appropriate partners to promote the training of physicians, first-responders, and the lay public in severe hemorrhage control (including the proper use of tourniquets). *(D)*

5. That the Massachusetts Medical Society advocate for the training of physicians as instructors in severe hemorrhage control (including the proper use of tourniquets), such that they might promote community education of bleeding control. *(D)*

6. That the Massachusetts Medical Society advocate for severe hemorrhage control training and deployment of severe bleeding kits that include tourniquets to all first responders such as police officers and firefighters. *(D)*

Fiscal Note: $10,000 (Items 2, 3, 4 One-Time Expense)
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

The directives were assigned to the Committee on Preparedness for implementation and a report at I-18. The following is an outline of implementation progress thus far and a new recommendation from the committee.

Discussion

The following activities were carried out in accordance with Resolution A-17, B-211 Stop the Bleed/Save a Life, directives:

1. The Committee on Preparedness (committee) reviewed the recommendations on bleeding control principles and training recommendations put forth by the Stop the Bleed Campaign including the American College of Surgeons and The Hartford Consensus™.
2. The committee developed and approved an action plan for implementation of Resolution A-17, B-211 Stop the Bleed/Save a Life.
3. The MMS added a link to "Stop the Bleed" information to the MMS website.
4. The committee planned and conducted two bleeding control education sessions for physicians at the MMS Annual Meeting (A-18) and trained 72 clinicians. Utilizing a train-the-trainer model, participants received in-person, hands-on professional instruction[1] in severe hemorrhage control including the proper use of tourniquets. In-person hemorrhage control training for laypersons is currently the most efficacious means of enabling bystanders to act to control hemorrhage.[2] Both sessions reached capacity and the demand was such that a waiting list was necessary.
5. "Stop the Bleed" awareness materials and information were exhibited at the MMS interim (I-17) and annual meetings (A-18). A list of physicians who are interested in future trainings was collected.
6. MMS Human Resources offered bleeding control training and naloxone training which was completed by 30 MMS non-clinical (layperson) personnel.

The MMS has long recognized that emergency or life-threatening events can occur at any moment with the potential to cause severe morbidity and mortality. Moreover, the MMS has been at the forefront of promoting advance knowledge of, and training in, specific techniques of emergency response as the best way to prepare for both foreseeable and unexpected events.

The MMS connected with the Massachusetts Chapter of the American College of Surgeons (MCACS) regarding its "Stop the Bleed" advocacy efforts in support of legislation which would require all public buildings in Massachusetts, including schools;

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[1] Instructors trained by the American College of Surgeons Committee on Trauma Bleeding Control Education and Information Program.

[2] Goralnick E, Chaudhary MA, McCarty JC, et al. Effectiveness of Instructional Interventions for Hemorrhage Control Readiness for Laypersons in the Public Access and Tourniquet Training Study (PATTS): A Randomized Clinical Trial. *JAMA Surg*. 2018;153(9): 791-799.doi:10.1001/jamasurg.2018.1099.

libraries; transportation facilities; recreational facilities; entertainment and sporting venues; and government buildings; to house at least one centrally located bleeding control kit and someone trained to use it; and has had discussions on ways to work collaboratively on our shared goal to reduce or eliminate preventable death from bleeding. On October 10, 2018, MCACS held a Surgical Advocacy Day Stop-the-Bleed Training at the Massachusetts State House training over 30 legislators, legislative staff and high school students.[3] MMS Committee on Preparedness Chair Eric Goralnick, MD, MS, provided the "Stop the Bleed" primer at the event.

The American College of Surgeons, the Hartford Consensus™ together with the military, the National Security Council, the Department of Homeland Security, the Federal Bureau of Investigation, law enforcement, fire rescue, and EMS began the national initiative: "Stop the Bleed" Campaign to raise awareness about the importance of bleeding control in saving lives.[4] It is important to note that there is no direct funding associated with the "Stop the Bleed" campaign[5] making the private sector the only source of funds to support the initiative.

The Hartford Consensus™ III noted that "The most significant preventable cause of death in the prehospital environment is external hemorrhage."[6] Uncontrolled bleeding can occur not just in cases of mass casualty events but in the event of bleeding from injuries caused by car and motorcycle accidents, farm injuries, and even lawnmower and bicycle injuries. Knowing basic hemorrhage control, wound packing and tourniquet application can save lives.[7]

In its 2018 Progress Report, BleedingControl.org notes that "the power of 'Stop the Bleed' is in the numbers…the more people who learn how to stop the bleed, the more lives will be saved."[8] Equally important is that any tourniquet selected for use in the prehospital environment be used in the right place, at the right time, and with adequate training.[9]

In June 2016, the American Medical Association (AMA) adopted the following policy[10] in support of hemorrhage control training:

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[3] Link to MCACS Advocacy Day agenda and photos: http://mcacs.org/advocacy

[4] https://www.bleedingcontrol.org. American College of Surgeons/Committee on Trauma *Stop the Bleed* program, includes compendium of the Hartford Consensus. Accessed October 11, 2018.

[5] https://www.dhs.gov/stb-resources. Department of Homeland Security. Last Published Date: October 11, 2016. Accessed October 12, 2018.

[6] Jacobs, L and Joint Committee to Create a National Policy to Enhance Survivability From Intentional Mass Casualty Shooting Events. The Hartford Consensus III: Implementation of Bleeding Control. Published July 1, 2015. Accessed October 11, 2018. http://bulletin.facs.org/2015/07/the-hartford-consensus-iii-implementation-of-bleeding-control/#The_Hartford_Consensus_III_Implementation_of_Bleeding_Control.

[7] Stop the Bleed | 2018 Progress Report. Page 8. Accessed October 11, 2018. https://www.bleedingcontrol.org/~/media/bleedingcontrol/files/2018_stb_progressreport.ashx.

[8] Stop the Bleed | 2018 Progress Report. Page 8. Accessed October 12, 2018. https://www.bleedingcontrol.org/~/media/bleedingcontrol/files/2018_stb_progressreport.ashx.

[9] Drew, Brendon et al. Application of Current Hemorrhage Control Techniques for Backcountry Care: Part One, Tourniquets and Hemorrhage Control Adjuncts. Wilderness & Environmental Medicine, Volume 26, Issue 2, 236–245.

[10] American Medical Association Policy: Support for Hemorrhage Control Training H-130.935. https://policysearch.ama-

Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.

Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.

Increasing severe bleeding control awareness and instruction is crucial for both physicians and the public. Training and/or refamiliarizing physicians and other health care professionals in hemorrhage control, wound packing, and tourniquet application so they can train, engage, and empower other professionals and the public is an effective way to expand our capacity to respond to mass casualty events and other emergencies.[11]

Relevance to MMS Strategic Priorities

The MMS has identified ensuring Physician and Patient Advocacy and Professional Knowledge and Satisfaction as strategic priorities.

Conclusion

Recent shootings, bombings, and/or other unfortunate but increasingly frequent events, continue to illustrate the need for people to be trained and ready to respond to such emergencies. To prepare for these situations, it is critically important to ensure that they have the necessary tools and knowledge available to apply tourniquets and bleeding control techniques when needed.

As a recognized and respected leader, the MMS has an essential role in raising awareness and providing trustworthy information and reliable resources for both physicians and the public on severe bleeding control.

The MMS is also in a unique position to take action and increase physician familiarity with, and knowledge of, bleeding control techniques by facilitating the training of physicians and other health professionals in proper hemorrhage control techniques so that physicians can in turn teach lay people in their communities how to stop uncontrolled bleeding. Creating a network of well-trained individuals to act immediately in the event of a disaster will provide a safer environment throughout the Commonwealth

Recommendations:

1. **That the MMS implement a three-year bleeding control "train the trainer" demonstration project to provide hands-on regional instruction for physicians and allied health professionals in bleeding control, wound packing, and tourniquet application in order to increase the number of individuals trained in bleeding control in the Commonwealth. *(D)***

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assn.org/policyfinder/detail/Support%20for%20Hemorrhage%20Control%20Training%20H-130.935?uri=%2FAMADoc%2FHOD-130.935.xml.

[11] Goralnick E, Van Trimpont F, Carli P. Preparing for the Next Terrorism Attack Lessons From Paris, Brussels, and Boston. *JAMA Surg*. 2017;152(5):419–420. doi:10.1001/jamasurg.2016.4990.

2. **That the MMS develop a comprehensive bleeding control resource and information page on its website to support the demonstration project and increase bleeding control awareness. *(D)***

3. **That the MMS review and assess the efficacy and impact of the bleeding control "train the trainer" demonstration project. *(D)***

Fiscal Note: (Out-of-Pocket Expenses)	$60,000 (Total Expense)
	$30,000 year one *$15,000 year two* *$15,000 year three*
FTE: (Staff Effort to Complete Project)	Existing Staff

Appendix

General References:

www.bleedingcontrol.org. The American College of Surgeons BleedingControl.org. Website. Includes 2018 Progress Report. Copyright © 2016-2018 by the American College of Surgeons. Accessed October 11, 2018.

Tourniquet use at the Boston Marathon bombing: Lost in translation. King DR, Larentzakis A, Ramly EP; Boston Trauma Collaborative. *J Trauma Acute Care Surg*. 2015 Mar;78(3):594-9. https://www.ncbi.nlm.nih.gov/pubmed/25710432

de Jager E, Goralnick E, McCarty JC, Hashmi ZG, Jarman MP, Haider AH. 2018. Lethality of Civilian Active Shooter Incidents With and Without Semiautomatic Rifles in the United States. *JAMA*. 320(10), 1034-1035.

McCarty JC, Caterson EJ, Chaudhary MA, Herrerra-Escobar JP, Hashmi ZG, Goldberg SA, ... Goralnick E. 2018. Can They Stop the Bleed? Evaluation of Tourniquet Application by Individuals with Varying Levels of Prior Self-Reported Training. *Injury*.

Goolsby C, Rouse E, Rojas L, Goralnick E, Levy MJ, Kirsch T, ... Hurst N. 2018. Post-Mortem Evaluation of Potentially Survivable Hemorrhagic Death in a Civilian Population. *Journal of the American College of Surgeons*.

Levy-Carrick NC, McCarty JC, Chaudhary MA, Caterson EJ, Haider AH, Eyre AJ, ... Goralnick E. 2018. Hemorrhage Control Training Promotes Resilience-Associated Traits in Medical Students. *Journal of surgical education*.

Stop the Bleed Public Safety Announcement from New England Patriots/Brigham and Women's Hospital. https://www.youtube.com/watch?v=FzdHh2z9Yag.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	9
Code:	CPH Report I-18 A-6 [I-17 A-105]
Title:	Urine Drug Screens in Prisoners
Sponsor:	Committee on Public Health John Burress, MD, Chair
Report History:	Resolution I-17 A-105 Original Sponsors: Mirret El-Hagrassy, MD, Mark Kashtan, MD
Referred to:	Reference Committee A Ms. Marguerite Youngren, Chair

Background

At I-17, the House of Delegates referred to the Board of Trustees (BOT) for report back at I-18 Resolution I-17 A-105, Urine Drug Screens in Prisoners. The BOT referred this resolution to the Committee on Public Health for a report back with recommendations to the HOD at I-18. The resolution states:

1. That the MMS encourages education and training on the appropriate use of urine drug screening and scientifically validated confirmatory testing interpreted by qualified health care practitioners for all administrators, staff, and health care practitioners who administer urine drug screens or initiate legal or punitive action based on urine drug screen results as part of their professional duties. *(HP)*

2. That the MMS encourages the mandatory use of appropriate, scientifically validated confirmatory testing interpreted by qualified health care practitioners for all instances in which presumptive positive urine drug screens would lead to legal or punitive action excepting situations in which the individual in question waives their right to a confirmatory test. *(HP)*

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

Reference Committee and HOD Testimony

At I-17 the reference committee recommended that this resolution/report be not adopted. The following is the reference committee's rationale:

Your reference committee reviewed online and heard in person mixed testimony on this resolution. A primary concern raised by opponents is that an MMS policy dictating best practices of drug testing in prisons could be perceived as an implicit endorsement of drug testing in this setting for punitive purposes. Instead, many argued, MMS should be advocating that substance use disorder is a disease, and the policy focus in this setting should be treatment rather than punishment for expression of a symptom of the disease. In addition, online testimony from the sponsor indicated that the Massachusetts houses of

correction have amended their policies to include confirmatory testing, perhaps mitigating the need for policy, especially in light of the initial concerns raised here. Your reference committee recommends not adoption.

This policy was extracted by the HOD. Testimony referenced drug testing as an important and complex public health issue. Testimony also addressed the critical need for treatment of incarcerated individuals who have a substance use disorder and the MMS's obligation to advocate for comprehensive treatment.

Current MMS Policy

The MMS has no existing policy on the topic of urine drug screening for prisoners or other vulnerable populations. However, the MMS does have policy that supports provision of providing medication-assisted treatment to incarcerated individuals who have a substance use disorder.

PRESCRIPTION AND NON-PRESCRIPTION DRUGS

Opioids/Nasal Naloxone

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

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

MMS House of Delegates, 4/29/17

Discussion

The Committee on Public Health (CPH) reviewed the original Resolution I-17 A-105 and submitted testimony not to adopt the proposed policy. The committee's testimony reflected grave concern about the unintended consequences of adopting a policy that supports testing for punitive purposes. The CPH asserted drug screening should only be conducted if the test results will be utilized for the purpose of treatment and argued that is not the intent of the criminal justice system's urine testing policy. The Committee on Public Health's position is aligned with the position of the MMS Task Force on Opioid Therapy and Physician Communication.

Following the Interim 2017 House of Delegates decision to refer the resolution to the BOT for Report Back at A-18, the Committee on Public Health once again reviewed the proposed policy, including the discussion which took place during the reference committee and the HOD. The Committee on Public Health restated its position that urine testing in jails and prisons is conducted for punitive purposes only. The use of the term *screening* in the context of urine testing is not reflective of efforts to promote treatment or intervention. MMS policy should focus on treatment of individuals with substance use disorder; testing should be considered as a part of voluntary treatment program.

Medication Assisted Treatment in Jails and Prisons, Innovative Harm Reduction

In keeping with the Committee on Public Health position, and the work of the MMS Task Force on Opioid Therapy and Physician Communication, the MMS has been a strong and vocal advocate at the state level with respect to provision of medication-assisted treatment

in jails and prisons. The MMS is grateful for the opportunity to work with Governor Baker and the state legislature to combat the opioid epidemic and, as data continues to confirm the feasibility and efficacy of MAT in jail and prison settings, urges that policies enacted to do so have a strong grounding in scientific literature. Evidence compiled by the Massachusetts Department of Public Health demonstrates that the opioid-related overdose death rate is 120 times higher for recently incarcerated persons. The MMS advocated for the passage of legislation that would change that statistic by requiring correctional facilities throughout the Commonwealth to provide all three forms of medication-assisted treatment, as is already offered in Franklin County. Chapter 208 of the Acts of 2018, "An Act for Prevention and Access to Appropriate Care and Treatment of Addiction" (CARE ACT), enacted in summer 2018, includes a provision requiring that all three forms of medication-assisted treatment will be offered in jails and prisons through a pilot program. The MMS would have preferred to see full statewide availability of medication assisted in jails and prisons, but it is very pleased with this development. The Committee on Public Health urges continued advocacy focused on treatment.

Conclusion

The Committee on Public Health recommends that the HOD not adopt Resolution I-17 A-105 and instead urges continued advocacy for the comprehensive provision of medication-assisted treatment to incarcerated individuals with a substance use disorder.

Recommendation:

That the Massachusetts Medical Society not adopt Resolution I-17 A-105 which reads as follows:

1. **RESOLVED, That the MMS encourages education and training on the appropriate use of urine drug screening and scientifically validated confirmatory testing interpreted by qualified health care practitioners for all administrators, staff, and health care practitioners who administer urine drug screens or initiate legal or punitive action based on urine drug screen results as part of their professional duties; and, be it further *(HP)***

2. **RESOLVED, That the MMS encourages the mandatory use of appropriate, scientifically validated confirmatory testing interpreted by qualified health care practitioners for all instances in which presumptive positive urine drug screens would lead to legal or punitive action excepting situations in which the individual in question waives their right to a confirmatory test. *(HP)***

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	10
Code:	COL Report I-18 A-7 [A-17 A-103 Item 14(b)]
Title:	Streamlining Human Immunodeficiency Virus Testing of Source Patients following an Occupational Exposure
Sponsor:	Committee on Legislation Theodore Calianos, II, MD, FACS, Chair
Report History:	CPH/COL/MA AMA/OMSS Report A-18 A-5 Resolution A-17 A-103
Referred to:	Reference Committee A Ms. Marguerite Youngren, Chair

Background (from A-17 and A-18)

At A-17, the House of Delegates referred to the Board of Trustees (BOT) for report back Resolution A-17 A-103, Streamlining Human Immunodeficiency Virus Testing of Source Patients following an Occupational Exposure. The BOT referred the resolution to the Committees on Public Health, Legislation, the MA AMA Delegation, and the Organized Medical Staff, who submitted Report A-18 A-5. The report recommended:

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

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

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

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

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

Reference Committee Testimony and HOD Discussion

At A-18, the reference committee concurred with the committees' recommendation that the original resolution not be adopted. The reference committee noted:

Your reference committee heard passionate testimony on both sides of this issue. Much of the testimony in favor of testing for HIV without informed consent described personal experiences where those testifying, or their colleagues, had been potentially exposed to bloodborne pathogens, and experienced significant anxiety and stress at the prospect of HIV infection or post exposure prophylaxis. Others testified that there is no longer a stigma associated with HIV; it is a treatable disease. Testimony in favor of this report highlighted the hypocrisy of MMS's advocating for mandatory patient testing and disclosure of HIV status without physicians' being required to disclose their own HIV status to patients. There was also very strong ethical opposition to testing or performing an action on a patient without the patient's informed consent.

The Committee on Public Health testified to the lengthy discussion and debate about this topic in its efforts to develop recommendations that would facilitate informed consent to HIV testing in ways that would help protect health care workers from unnecessary anxiety or treatment, while protecting and respecting patients and their rights to informed consent. In its discussions, including with hospital counsel and patient advocacy groups, the committee noted the ethical, legal, and procedural issues which made its considered recommendations impracticable.

Your reference committee appreciates that, on one hand, the risk of an occupational exposure converting to HIV infection is almost zero, and almost all patients consent to testing, yet, on the other hand, in rare cases where consent cannot be obtained, the stress on the exposed individual can be extremely unsettling.

Therefore, your reference committee attempted to develop amendments that would reflect the testimony and address the concerns on both sides. However, because the testimony was in such discord, particularly on the issue of whether or not patients should have a right to informed consent, after discussing this issue at great length, your Reference Committee, like the authors of the report, was unable to find compromise language. Your reference committee recommends this report be adopted.

At the House second session, the report was extracted and multiple amendments were proposed. Delegates testified from personal experience about the stress physicians go through when stuck by a needle when the source is not known, and that HIV should be treated as any other disease. Others testified that patients with known HIV still experience stigma, including in the health care setting. Other testimony highlighted the apparently self-serving nature of this resolution, which would aim to protect physicians, but not patients or non-physicians who may be exposed in a hospital setting. COL and legal counsel testified that item 14b was already covered by the current law. Many wanted to ensure that the language would protect all exposed individuals, not just physicians, and were concerned about wordsmithing without an understanding of the law and its implications. Delegates continued to debate whether patients should have the right to opt out

The report was divided into item 14(a) and 14(b). 14(a) was adopted as amended, and 14(b) was referred for report back at A-18. (For reference, adopted as amended item 14(a) is under "Current Policy" on the following page.)

The BOT referred item 14(b) item to the Committee on Legislation in consultation with the Committee on Public Health for a report back with recommendations to the HOD.

Item 14(b) states:

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

FTE: Existing Staff
(Staff Effort to Complete Project)

Current MMS Policy
The MMS has the following policy:

Procedural Consent Documents/Occupational Exposure
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)
MMS House of Delegates, 4/28/18

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

...

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

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

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

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

Discussion

The Committee on Public Health reviewed the referral, as well as the related policy adopted at A-18, above. CPH/COL/MA AMA/OMSS Report A-18 A-5 on the issue of HIV testing in the hospital setting highlighted the legal, ethical, and practical reasons for not recommending removal of mandated informed written consent. The resolution now before the committee, Item 14b, does not resolve those legal, ethical, and practical issues, and further, Item 14b directly contradicts policy just passed by the HOD at A-18. Therefore, CPH advised COL that it had voted to not support Item 14b.

Upon review of this referral, relevant MMS policy, and state law, the Committee on Legislation does not support Item 14b. From a legislative perspective, policy adopted at A-18 substantially addressed the issue in a manner that best balanced providing protections to health care workers with occupational exposures, while not positioning the MMS to engage on advocacy on a highly polarized issue that could jeopardize relationships with the HIV advocacy community, patients, and other stakeholders. In ongoing work with the HIV advocacy community, MMS has come to appreciate that moving for a wholesale removal of consent requirements for HIV testing would be met with vigorous opposition, in potentially high-profile venues. In addition, Item 14b does not necessarily acknowledge the legislative developments from 2012 which lessened HIV-testing barriers by removing written informed consent requirements for testing, and only

maintaining oral written informed consent for HIV testing. (The release of test results to third parties still requires written informed consent.)

Conclusion

The resolution now before the committee, Item 14b, does not resolve those legal, ethical, and practical issues, and further, Item 14b directly contradicts policy just passed by the HOD at A-18. Therefore, CPH advised COL that it had voted to not support Item 14b. COL affirmed CPH's recommendation.

Recommendation:

That the Massachusetts Medical Society not adopt Resolution A-17 A-103 Item 14(b) which reads as follows:

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

Online, each title below is linked — just point, click, or tap. Use bookmark to navigate.
To enable bookmark on a *MacBook using Safari*, open in Preview, go to View and select Table of Contents.

To access bookmark on an *iPad or an iPhone,* open in iBooks and click  or in Adobe Reader click  .
(Full PDF functionality may require downloading a PDF reader app or the latest version of Adobe Reader. Functionality may also be browser- or device-dependent.)

Reference Committee B — Health Care Delivery
Hearing Order

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	1
Code:	Resolution I-18 B-201
Title:	Reauthorizing and Expanding the Conrad Waiver Program
Sponsors:	Mr. Sanjay Raaj Gadi
	Ms. Mugdha Mokashi
	Ms. Dipal Nagda
	Ms. Kavya Pathak
	Mr. Nishant Uppal
	Mr. Rajet Vatsa
	Mr. David Velasquez
Referred to:	Reference Committee B
	Heidi Foley, MD, Chair

Whereas, The Massachusetts Medical Society (MMS) strategic priorities for 2017–2020 include developing a sustainable model of health care delivery and ensuring a sustainable physician workforce; and

Whereas, The MMS strategic priorities for 2017–2018 include meeting the changing needs of physicians across all demographic segments and practice segments; and

Whereas, The MMS currently supports "creating greater opportunities for minorities and immigrants within the medical profession" and the "expansion of educational opportunities in biomedical careers for minority and immigrant populations" (Reaffirmed, MMS House of Delegates, 4/28/18). (See appendix for full relevant policies.);[1] and

Whereas, The MMS currently seeks collaborative opportunities to study and advance initiatives related to the physician workforce and patient access to care and supports advocacy efforts to increase public, legislative, and health plan awareness of the impending shortage in physician staffing and its impact on access to care (Amended and Reaffirmed MMS House of Delegates, 5/7/16). (See appendix.);[2] and

Whereas, The MMS currently supports a decrease in the number of years of American Osteopathic Association (AOA)/Accreditation Council for Graduate Medical Education (ACGME)–approved Graduate Medical Education (GME) training required for international medical graduates (IMGs) to achieve parity with US medical graduates (USMGs) in order to obtain medical licensure;[3] and

[1] Massachusetts Medical Society Policy Compendium, 2018. http://www.massmed.org/policies.
[2] Massachusetts Medical Society Policy Compendium, 2018. pg. 133. http://www.massmed.org/policies.
[3] Massachusetts Medical Society Policy Compendium, 2018. pg. 178. http://www.massmed.org/policies.

Whereas, Federal law (Conrad Amendment to P.L. 103-416) allows IMGs with J1 visas to apply for the Conrad 30 Waiver Program (the "Conrad Amendment"), which allows up to 30 physicians per federal fiscal year to waive the two-year residence requirement following completion of the J1 exchange visitor program;[4] and

Whereas, Expansion of the Conrad Amendment would enable the Massachusetts Department of Public Health to support more than 30 IMGs for a waiver of the two-year residence requirement, many of whom already work in primary care and would be well-equipped to work in federally recognized health professional shortage areas (HPSAs);[5] and

Whereas, Recent tightened immigration regulations have seen a 41% increase in the denial of H-1b visas between July–September 2017 and October–December 2017 and an approval of hundreds of fewer J-1 visa applications, often in regions that are disproportionately reliant on IMGs;[6,7] and

Whereas, Per a report conducted in 2013 by the Robert Graham Center of the American Academy of Family Physicians (AAFP), Massachusetts will need an additional 725 primary care providers (PCPs) by 2030, which represents a 12% increase from the Massachusetts PCP workforce of 5,807 in 2010;[8] and

Whereas, Minnesota, a state facing comparable health challenges in underserved populations, installed the International Medical Graduate (IMG) Assistance Program in 2015, through which legal resident IMGS, who have lived in Minnesota for at least two years and are willing to work in HPSAs, receive assistance in exam and license guidance, financial support, and residency placement;[9,10] and

Whereas, The Health Resources and Services Administration (HRSA) of Massachusetts designates Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P) and makes recommendations for resource allocation;[11] and

Whereas, "S.898 — Conrad State 30 and Physician Access Reauthorization Act" has been introduced in Congress with bipartisan support, and calls for 1) reauthorization of the Conrad Waiver for an additional three years, 2) an increase in the number of Conrad Waivers available for each state, and 3) greater transparency in employment contract terms;[12,13] and

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[4] www.uscis.gov/working-united-states/students-and-exchange-visitors/conrad-30-waiver-program
[5] https://sites.tufts.edu/cmph357/2017/04/09/why-foreign-trained-doctors-are-the-answer-to-americas-doctor-shortage
[6] www.nytimes.com/2018/09/16/us/immigration-family-chain-migration-foreign-born.html
[7] https://whyy.org/segments/pa-hospitals-rely-on-j-1-visas-to-fill-vital-roles-but-fewer-are-applying
[8] Petterson SM, Cai A, Moore M, Bazemore A. State-level projections of primary care workforce, 2010–2030. September 2013. Robert Graham Center, Washington, DC.
[9] www.health.state.mn.us/divs/orhpc/img/documents/2018imgleg.pdf
[10] www.minnpost.com/new-americans/2018/05/could-state-funded-international-medical-graduate-assistance-program-do-more-i
[11] The Federal Shortage Designation Process: Health Professional Shortage Areas (HPSA) Medically Underserved Areas (MUA) Medically Underserved Populations (MUP): A Guide Prepared For: Citizens, Communities, Health Care Organizations, and Providers in Massachusetts. www.mass.gov/files/documents/2016/07/te/shortage-designations-benefits.pdf.
[12] https://www.congress.gov/bill/115th-congress/senate-bill/898/text
[13] https://www.aamc.org/advocacy/washhigh/highlights2017/478874/042117senatorsreintroducebilltoextendandexpandconrad30.html

Whereas, The American Medical Association (AMA) has expressed support for S.898, but the bill has remained stalled in the Senate Committee on the Judiciary for 18 months;[14] and

Whereas, The AMA currently pledges to advocate for the reauthorization, expansion, and improvement of the Conrad Waiver and develop educational and counselling resources for IMGs participating in these programs, but the MMS has not yet adopted similar policy;[15] therefore, be it

RESOLVED, **That the MMS will advocate at the federal and/or state level for the expansion of an existing program (known as the "Conrad 30 Waiver") that waives the two-year residence requirement following completion of a J1 exchange visa for up to thirty (30) physicians per federal fiscal year.** ***(D)***

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

[14] https://searchlf.amaassn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2017-4-26-Sen-Klobuchar-Conrad-30-Program.pdf

[15] See AMA D-255.985 and D-200.980. https://policysearch.ama-assn.org/policyfinder/detail/conrad%2030?uri=%2FAMADoc%2Fdirectives.xml-0-639.xml https://policysearch.ama-assn.org/policyfinder/detail/conrad%2030?uri=%2FAMADoc%2Fdirectives.xml-0-500.xml

Appendix

MINORITIES
Minority and Immigrant Populations
The Massachusetts Medical Society adopts the following policy statement on The Provision of Health Care for 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, Sunset)
Reaffirmed MMS House of Delegates, 4/28/18

PHYSICIANS
Workforce
The Massachusetts Medical Society (MMS) will continue to monitor physician workforce issues through primary and secondary research, including additional relevant measures not explored in the current workforce study. *(D)*

The MMS will develop advocacy efforts to increase public, legislative, and health plan awareness of the impending shortage in physician staffing and its impact on access to care. *(D)*

The MMS will focus further analysis on evaluating the effects of non-patient care activity, such as research, teaching, and biotechnology, on the practicing physician workforce. *(D)*

The MMS will look for collaborative opportunities with physician specialty societies, health care delivery systems, and other appropriate health care organizations to study and advance initiatives related to the physician workforce and patient access to care. *(D)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Amended and Reaffirmed MMS House of Delegates, 5/7/16

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	2
Code:	Resolution I-18 B-202
Title:	Increased Evaluation of Access, Cost, Quality, and Health Outcomes in Direct Primary Care
Sponsors:	Mr. Tonatiuh Liévano Beltrán Mr. Sanjay Gadi Mr. Nicholos Joseph Mr. Rajet Vatsa
Referred to:	Reference Committee B Heidi Foley, MD, Chair

Whereas, An MMS strategic priority is Sustainable Health Care Delivery; and

Whereas, The MMS has approved policy to "advocate for changes in federal law to establish that direct primary care (DPC) membership fees may be paid using pre-tax funds," and to "advocate for state legislation that gives patients the right to seek care from specialists who are contracted under their insurance plan and to have that service covered when referred by a primary care physician who is not contracted with their insurance plan"[1]; and

Whereas, DPC describes an emerging model of primary care delivery in which patients are charged a service fee (average of $77 per month, as of 2018[2]), the charge associated with each patient visit must be less than the monthly service fee they pay,[3] and practices do not bill external third parties (e.g. insurers)[2]; and

Whereas, There are over 720 practices operating under a DPC model in the country[2]; and

Whereas, According to one survey, a majority of DPC practices offer same-day appointments, access to physicians via email, 24-hour physician access, and wholesale labs, while few DPC practices offer inpatient care or obstetric care[4]; and

Whereas, Trends among DPC practices from 2005 to 2015 have shown a decrease in adult annual membership fees and an increase in patient panel size[4]; and

Whereas, Most of the existing understanding surrounding the efficacy of DPC relies on surveys, interviews, anecdotes, and case studies[2,5]; and

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[1] Massachusetts Medical Society. MMS Policy Compendium (1978-2018). 2018. http://www.massmed.org/policies.

[2] Cole ES. Direct Primary Care: Applying Theory to Potential Changes in Delivery and Outcomes. *The Journal of the American Board of Family Medicine.* 2018;31(4):605-611.

[3] Eskew PM, Klink K. Direct primary care: practice distribution and cost across the nation. *The Journal of the American Board of Family Medicine.* 2015;28(6):793-801.

[4] Rowe K, Rowe W, Umbehr J, Dong F, Ablah E. Direct Primary Care in 2015: A Survey with Selected Comparisons to 2005 Survey Data. *Kansas Journal of Medicine.* 2017;10(1):3.

[5] Adashi EY, Clodfelter RP, George P. Direct Primary Care: One Step Forward, Two Steps Back. *JAMA.* 2018;320(7):637-638.

Whereas, There remains a dearth of research among existing literature surrounding the efficacy of DPC across diverse patient populations, as measured by traditional measures of access, cost, quality, and health outcomes[3,6]; and

Whereas, The American College of Physicians (ACP) has cited the lack of evidence surrounding DPC's effects on health care accessibility, cost, and quality for patients at the individual and population levels as a reason for not endorsing the DPC model[6]; and

Whereas, Proponents posit that DPC practices have increased administrative efficiency by eliminating the overhead involved in third-party billing, thereby empowering DPC practices to devote more time to patient care and ameliorate provider burnout[3]; and

Whereas, DPC allows physicians to provide services that the traditional fee-for-service model does not reimburse, including home visits and all-hour availability, which enhance the development of lasting relationships between patients and providers[6]; and

Whereas, DPC practices do not currently possess surveillance modalities that would prevent providers from selecting for healthier patients while excluding more ill patients, which could lead to disparities in health care access[5]; and

Whereas, The monthly retainer fee model of DPC practice may pose a barrier to access for those who are lower-income patients[5]; and

Whereas, There are competing views on whether DPC would exacerbate the existing primary care shortage or increase entry of physicians into primary care due to its appealing emphasis on the patient as an individual and patient-tailored outcomes[7]; and

Whereas, The literature is in disagreement regarding the systemic effects that DPC would have on the care of diverse populations, including lower-income and uninsured populations[2,3]; and

Whereas, Current information about DPC is insufficient to support endorsing or opposing it relative to the predominant fee-for-service model; therefore, be it

RESOLVED, That the MMS work with relevant stakeholders to study (a) the effects of direct primary care (DPC) across diverse patient populations, with regards to health care access, cost, quality, and health outcomes, (b) these effects in comparison to the fee-for-service model, as well as other payment models, and (c) how DPC impacts care utilization in the broader system involving specialty and other non-primary care. *(D)*

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

[6] Rubin R. Is Direct Primary Care a Game Changer? *JAMA.* 2018;319(20):2064-2066

[7] Wu WN, Bliss G, Bliss EB, Green LA. A direct primary care medical home: the Qliance experience. *Health Affairs.* 2010;29(5):959-962.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	3
Code:	Resolution I-18 B-203
Title:	Streamlining the Prior Authorization Process
Sponsor:	Matthew Gold, MD
Referred to:	Reference Committee B Heidi Foley, MD, Chair

Whereas, Strategic priorities of our Massachusetts Medical Society include advocating for practice viability, the fair practice of clinical and economic integration, and an optimal practice environment; and

Whereas, Our MMS has a number of policies acknowledging the burden of prior authorization processes on the practice of medicine, including the following: a) a Principles for Health Plan Coverage Decisions policy that includes "easy access for all stakeholders to information about the health plan's decision-making process in language that is easily comprehensible";[1] b) a Decision-Making Principle that states "it should be the responsibility of the insurer to provide transparency and to facilitate a more satisfying method of preauthorization";[2] and c) Principles for the Use of Prior Authorization Programs, which include affirmation that they should be both "transparent to patients and physicians" as well as :operated in a manner that avoids administrative burdens for physicians and their office staff";[3] and

Whereas, Pharmacy notifications to physicians of the need to request prior authorization generally include a contact number that is valid for pharmacies, but not valid for physicians, and usually fails to identity the pharmacy benefit manager, program, or insurance vendor whom the physician must petition on the patient's behalf for the prescription in question; and

Whereas, Given various layers of processes currently in use by third-party pharmacy benefit managers, the time and effort to discern the identity and process for seeking prior authorization has become excessively opaque, time-consuming, and costly in office resources; and

Whereas, The difficulty in pursuing prior authorization increases the probability of loss of access to medically necessary treatments for the patient; therefore, be it

[1] Massachusetts Medical Society Policy Compendium: "Coverage Decisions," pg. 62. http://www.massmed.org/policies.

[2] Massachusetts Medical Society Policy Compendium: "Preauthorizations/Decision Making," pg. 134. http://www.massmed.org/policies.

[3] Massachusetts Medical Society Policy Compendium: "Principles for the Use of Prior-Authorization Programs," i, #2 and 3, pg. 136. http://www.massmed.org/policies.

RESOLVED, That the Massachusetts Medical Society expand, and, where appropriate, initiate advocacy efforts to regulators and legislators in the Commonwealth of Massachusetts to require pharmacies and other entities responsible for processing and providing patients with prescriptions to provide accurate, complete, and actionable information to prescribing physicians or their agents at the time of notification of prior authorization requirements. Such information must enable Prior Authorization Request submission without further time-consuming and distracting work on the part of the physician or the physician's agents. *(D)*

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	4
Code:	Resolution I-18 B-204
Title:	Elimination by All Massachusetts Health Insurers of All Prior Authorization Requirements When Patients Are Prescribed Buprenorphine/Naloxone
Sponsors:	Ronald Newman, MD Barbara Herbert, MD Michael Medlock, MD
Referred to:	Reference Committee B Heidi Foley, MD, Chair

Whereas, Physician and patient advocacy is a Massachusetts Medical Society strategic priority; and

Whereas, The MMS has the following policy:

PREAUTHORIZATIONS
Pre-Authorizations/Decision-Making
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.
MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

Principles for the Use of Prior Authorization Programs *(for full policy please see appendix)*
Prior authorization programs should be implemented only upon a showing of substantial variation in the targeted practice and good evidence of over utilization among those providers the proposed prior authorization program would affect. Such data should be shared with the physician community well before any action is taken regarding new prior authorization programs in order to allow for appropriate improvement.

Prior authorization requirements should never apply in a medical emergency, or when a patient could be harmed by the delay caused by such programs. If care is required on an urgent basis, prior authorization requirements should be suspended.
MMS House of Delegates, 12/3/05
Amended and Reaffirmed MMS House of Delegates, 5/18/07
Amended and Reaffirmed MMS House of Delegates, 12/6/14

Pre-Authorizations/Decision-Making *(see appendix for full policy)*
The MMS will foster, via regulatory or legislative avenues, elimination of prior authorization requirements for medication approved by the FDA for the specific indication requested and are comparatively cost-effective to alternatives.
MMS House of Delegates, 5/19/12

Whereas, Buprenorphine/naloxone is indicated and approved by the FDA for the treatment of opioid dependence;[1] and

Whereas, Buprenorphine/naloxone has been shown to reduce mortality from opioid overdose[2] and to decrease the incidence of street opioid relapse for patients with opioid use disorder;[2] and

Whereas, Prescriptions for the initiation and continuation of buprenorphine/naloxone usually need to be filled without significant delay to prevent withdrawal and street opioid relapse;[3] and

Whereas, Some Massachusetts third-party payers currently require prior authorization when some patients are prescribed buprenorphine/naloxone; and

Whereas, The 2017 AMA Prior Authorization Physician Survey found that 92% of respondents felt that prior authorization resulted in delayed access to care and adversely affected clinical outcomes;[3] and

Whereas, In 2017, AMA CEO and Executive VP James Madara, MD, urged all attorneys general to take action to secure agreements with insurance companies to end their policies of prior authorization for medication-assisted treatment of opioid use disorder;[4]

Whereas, The American Academy of Family Physicians has also recommended the elimination of prior authorization for medications used to assist in the treatment of opioid use disorder[5];

Whereas, A number of health insurance companies already doing business in Massachusetts currently do not require prior authorization for any buprenorphine medications used to treat opioid use disorder;[6,7] and

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[1] US Food and Drug Administration. Information about Medication-Assisted Treatment (MAT). October 3, 2018. www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm600092.htm. Accessed October 9, 2018.

[2] The American Society of Addiction Medicine, June 2013. Advancing Access to Addiction Medications. www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final. Accessed October 9, 2018.

[3] American Medical Association. 2017 AMA Prior Authorization Physician Survey. 2018. www.ama-assn.org/sites/default/files/media-browser/public/arc/prior-auth-2017.pdf. Accessed October 9, 2018.

[4] Madara JL. Letter to the National Association of Attorneys General. Received by The Honorable George Jepsen; Jim McPherson. February 3 2017. https://wire.ama-assn.org/ama-news/ags-called-help-stop-prior-authorization-mat.

[5] American Medical Association, American Academy of Family Practice. The AMA and AAFP Urge Removing All Barriers to Treatment for Substance Use Disorder. 2018, www.aafp.org/dam/AAFP/documents/advocacy/prevention/risk/BKG-AMA-AAFP-MAT.pdf. Accessed October 9, 2018.

[6] Neighborhood Health Plan Targets Opioid Epidemic by Increasing Access to Life-Saving Treatments. May 18, 2018. https://www.nhp.org/pressreleases1/PressRelease_NHP_Opioid_Initiatives_051818.pdf. Accessed October 9, 2018.

[7] Cigna ends prior authorization policy for opioid addiction treatment. October 21, 2016. https://www.modernhealthcare.com/article/20161021/NEWS/161029981. Accessed October 9, 2018.

Whereas, The Drug Enforcement Agency already requires clinicians to obtain additional training and a Drug Addiction Treatment Act waiver to prescribe buprenorphine/naloxone;[8] and

Whereas, The Massachusetts legislature attempted to prohibit prior authorizations through the passage of Chapter 258 of the Acts of 2014,[9] but this legislation only applies to non-self-insured health insurance plans, and the law only applies to prior authorization for medical necessity, which still allows for prior authorization for dosage, formulation, etc.; and

Whereas, Seven major insurers in Pennsylvania have agreed to end prior authorization for medication-assisted treatment for substance-use disorders;[10] therefore, be it

RESOLVED, That the Massachusetts Medical Society will advocate for the elimination by all Massachusetts health insurers of all prior authorization requirements or other special billing/administrative maneuvers that inhibit patient access to buprenorphine/naloxone. *(D)*

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

FTE: Existing Staff
(Staff Effort to Complete Project)

[8] www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training
[9] https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter258
[10] https://assets.ama-assn.org/sub/advocacy-update/2018-10-18.html#issuespotlight www.media.pa.gov/Pages/Insurance-Details.aspx?newsid=344

Appendix

Principles for the Use of Prior Authorization Programs
The Massachusetts Medical Society adopts as amended the MMS policy on Preauthorizations: Principles for the Use of Prior Authorization Programs adopted at I-05 and reaffirmed at A-07 to read as follows:

Principles for the Use of Prior Authorization Programs
The Massachusetts Medical Society adopts the following Principles for the Use of Prior Authorization Programs:

These principles for the use of prior authorization programs should apply whether the program is administered by a health plan, third party vendor, or provider organization.

1. Prior authorization programs should be implemented only upon a showing of substantial variation in the targeted practice and good evidence of over utilization among those providers the proposed prior authorization program would affect. Such data should be shared with the physician community well before any action is taken regarding new prior authorization programs in order to allow for appropriate improvement.

a. Prior authorization requirements should never apply in a medical emergency, or when a patient could be harmed by the delay caused by such programs. If care is required on an urgent basis, prior authorization requirements should be suspended.
b. The party running a prior authorization program should actively seek input from practicing physicians in development and maintenance of the program.

2. All prior authorization programs should be entirely transparent to patients and physicians. This includes the provision of:

a. A complete list of all procedures subject to any prior authorization, including all relevant codes for providers.
b. Comprehensive clinical criteria and algorithms, as updated based on current medical literature.

3. Prior authorization programs should be operated in a manner that avoids administrative burdens for physicians and their office staff and incremental costs to physicians, other providers, and patients. Data should be reviewed frequently, and physicians who are meeting criteria should be excluded from the program. Proper notice of any change in prior authorization process or criteria should be communicated in a timely fashion. When applicable, electronic methods should be used to streamline any prior authorization processes.

a. Data collected for prior authorization programs should include a minimum number of necessary data elements.
b. Providers should be allowed to transmit required data in a number of different ways, including telephonic, fax, U.S. Postal Service, any web-based platforms, and electronically, in a Health Insurance Portability and Accountability Act (HIPAA) compliant manner.
c. Prior authorization programs should have adequate capacity such that there are no busy signals or delays in transmitting data.
d. Providers should receive immediate proof of submission of prior authorization data. If applicable, this may be achieved electronically.
e. Turnaround time for prior authorization should be less than one business day for non-urgent cases.

f. Appeals rights for patients, families, and providers should be clearly spelled out, and appeals should be readily accessible, if applicable, electronically.
g. Appeals should require the minimum incremental information.
h. Patients, families, or providers should have the right to present appeals information in person at a time and place that is reasonably convenient.
i. Providers should be paid for incremental work effort of prior authorization programs.
j. Providers should receive timely, clear, and actionable reporting on their performance in a prior authorization program.
k. Providers who consistently meet clinical criteria should be exempted from all elements of prior authorization programs.
l. Documentation of a denial should be sent to the clinician to include the date and time of decision, reason for denial and physician making the denial decision. Documentation shall be made available electronically, when applicable.

4. Prior authorization programs should be conducted using up-to-date clinical criteria and appropriate clinical experts.

a. All clinical coverage criteria should be reviewed and updated regularly with evidence-based protocols.
b. Any denials should be issued by a licensed, board certified, actively practicing physician who regularly treats patients in a clinical setting and who would typically manage the medical condition under review. Such a physician should be available whenever a preauthorization is required.
c. Those conducting prior authorization programs should maintain a roster of patients who have been issued denials and plans should track their subsequent care for the problem for which imaging was requested.

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

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

Pre-Authorizations/Decision-Making

The MMS will foster, via regulatory or legislative avenues, elimination of prior authorization requirements for medication approved by the FDA for the specific indication requested and are comparatively cost-effective to alternatives. *(D)*

That the MMS direct the American Medical Association to collaborate with the Centers for Medicare and Medicaid Services in the creation of a CPT code or an equivalent mechanism for professional preauthorization time and related office expenses. *(D)*

That the MMS encourage and facilitate provider reporting of undue delays in accessing the preauthorization process, obtuse denial explanations and undue delays in ultimately approved requests to the Division of Insurance (DOI); and, that the MMS request the DOI to require the health plans to submit their pre-authorization performance data to the DOI them in a common format for public disclosure and share these results with MMS, payers, and other appropriate entities for a collaborative discussion. when known, the clinical consequences of each delay by way of a simple reporting form by whatever medium stored in a database maintained by the MMS and, in turn, periodically reported to appropriate regulatory authorities and MMS membership. *(D)*

MMS House of Delegates, 5/19/12

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	5
Code:	Resolution I-18 B-205
Title:	Elimination of Prior Authorization for Non-opioid Medications and Modalities Prescribed for Pain Management
Sponsor:	Essex South District Medical Society Ronald Newman, MD, President
Referred to:	Reference Committee B Heidi Foley, MD, Chair

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

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

Whereas, There are many non-opioid medications (NSAIDs, muscle relaxers, etc.) and non-pharmacologic strategies (physical therapy/massage therapy, acupuncture, cognitive behavioral therapy, etc.) that are effective in the treatment of painful conditions; and

Whereas, Some of the most effective non-opioid and anti-inflammatory medications and muscle relaxers frequently require prior authorization; and

Whereas, Opioid medications frequently do not require prior authorization and are required as a first-tier prescription before a prior authorization for non-opioid analgesic is approved; and

Whereas, the *New York Times* recently highlighted widespread practice of insurance companies to perversely incent low-cost opioids over alternative evidence-based non-opioid pharmacologic and non-pharmacologic pain management options;[1] and

Whereas, The risks of chronic opioid use are well known; and

Whereas, Opioid and substance-use disorder is at epidemic proportions; and

Whereas, The role of the insurance company is critical in the help with management of the opioid crisis; and

Whereas, The impediment to patients' access to a broad continuum of pain management options is leading physicians to prescribe opioids; therefore, be it

1. **RESOLVED That the Massachusetts Medical Society advocate to expand coverage for evidence-based non-opioid pharmacologic and non-pharmacologic pain management options; and, be it further *(D)***

2. **RESOLVED That the Massachusetts Medical Society advocate for the elimination of prior authorization and other utilization-management obstacles to**

[1] www.nytimes.com/2017/09/17/health/opioid-painkillers-insurance-companies.html

evidence-based non-opioid pharmacologic and non-pharmacologic pain management options. ***(D)***

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	6
Code:	CSPP Report I-18 B-1
Title:	Mitigating the Negative Effects of High-Deductible Health Plans on Patients and Physicians
Sponsor:	Committee on the Sustainability of Private Practice Christopher Garofalo, MD, Chair
Referred to:	Reference Committee B Heidi Foley, MD, Chair

Background

High-deductible health plans disincentivize patients from seeking appropriate heath care. According to a recent Kaiser Family Foundation report,[1] the average deductible for an employee in 2017 was $1,500 per year; in some cases, deductibles can reach $5,000 or more per year. The 2009 Affordable Care Act (ACA) requires that preventive services recommended by the US Preventive Services Task Force (USPSTF) be covered by insurers without a deductible. But, outpatient visits for care of common conditions, such as hypertension, diabetes, hypothyroidism, etc., are not considered preventive, and therefore require that the patient pay in full for these visits, until the deductible is met. As a result, many patients decide not to get appropriate care for their health conditions. Our committee has heard from many physicians who have observed this phenomenon in their practices, particularly in the first few months of the year, when deductibles are unlikely to have been met.

Several studies have found that improved access to a doctor's office to control chronic disease and provide early treatment of medical problems will reduce total health care costs through decreased use of emergency room and in-patient care. (See the February 2016 report of the Patient Centered Primary Care Collaborative's *Annual Review of the Evidence*[2] for 21 separate studies that reach this conclusion.)

In addition to their adverse effect on patients' access to care, high-deductible health plans threaten the economic viability of physician practices. Our committee has found this to be a significant concern among physicians in private practice. While physicians are able to collect copayments at the time of the visit, we are not able to charge for a deductible until a claim for the visit has been submitted to the insurer, and the insurer has responded to the claim. This delay in submitting the claim to the patient inexorably leads to a decrease in the collection rate for this portion of the fee. It is well known among private practice physicians that there is a steady decrease in collection rate as time goes on after the visit. In addition, in the experience of many, physicians are usually not able to ascertain, at the time of service, how much of the patient's deductible has been met; even if a patient will eventually be found to be responsible for payment for the visit, the physician is unable to ask for payment at the time of the visit. For these reasons, high-deductible plans place a financial burden on physician practices.

[1] www.kff.org. Sept. 19, 2017.
[2] Nielsen M, Buett L, Patel K, Nichols L (2016). Patient Centered Medical Home's impact on cost and quality, review of the evidence 2014–15. http://www.pcpcc.org/resources.

Our committee found it interesting to note that the Massachusetts Health Safety Net reimburses eligible hospitals for the deductibles for physician outpatient services provided to low-income patients. This policy holds for patients insured by private insurers. In this setting, it seems, Massachusetts has recognized that the deductibles built into most insurance plans pose an unacceptable burden on the provider.

In summary, high-deductible plans can have a negative effect on patient health, may increase total health care costs, and pose a threat to the economic viability of physician practices. The MMS needs to take steps to address these problems.

Current MMS Policy

The MMS Board of Trustees (as indicated in their report to the HOD, BOT Informational Report A-18-1) recently adopted the following policy related to high-deductible health plans and cost-sharing:

1. *That, in the face of any possible changes in federal laws regarding health insurance coverage, the MMS support and advocate for continuation of the state individual mandate to purchase health insurance, the state's Minimum Creditable Coverage standards, and the state Connector Care Program. (D)*
2. *That the MMS support and advocate for value-based cost sharing measures for high-deductible health plans and patients' out-of-pocket costs. (D)*
3. *That the MMS support and advocate that the Commonwealth assess the impact of cost-sharing on access to care, health outcomes, and medical debt for patients.*
4. *That the MMS support and advocate that the Commonwealth assess the impact of cost sharing on provider's due to patients' inability to pay when there is cost-sharing. (D)*
5. *That the MMS continue to be a strong voice of concern about the adverse effects of cost-sharing on patient health. (HP)*

Relevance to MMS Strategic Priorities

Relevant strategic priorities include:

- Physician and Patient Advocacy
- Membership Value and Engagement
- Professional Knowledge and Satisfaction
- Sustainable Health Care Delivery
- Practice Viability
- Preservation of Professionalism

Discussion

Our committee considered several potential solutions to address the negative effects of high-deductible health plans on patients and physicians. We decided that one change that would provide significant relief to both patients and physicians would be to exempt outpatient physician evaluation and management codes (99201–05 and 99211–15) from the deductible.

As noted in the background section, there is precedent for this policy. The ACA requires that insurance plans exempt preventive services recommended by the USPSTF from deductible payments. In addition, the Massachusetts Health Safety Net reimburses eligible hospitals for the deductible payments associated with outpatient medical visits for insured, low-income patients.

The committee wanted to know how much of the insurers' medical payments would be affected by this exemption. The best data we could find came from the November 2016 report of the Health Care Cost Institute Inc.[3] This report studied health care costs for the population under age 65. In 2015, the average per capita cost of health care for this population was $5,141. Of this, the amount spent on doctors' outpatient visits, excluding preventive care, was $300, or 5.8%. This total includes codes other than 99201–05 and 99211–15; the 5.8% figure is an overestimate of the impact on the insurers.

Deductibles are considered to be a method to control utilization of services by patients; and high-deductible plans usually have a lower premium cost compared to low-deductible plans. We think it is likely that exempting 5.8% of health care costs from the deductible would have a low impact on the health insurance premium.

There would be significant benefits that would accrue due to exempting these codes from payment of the deductible. This policy would improve patient access to needed care, would likely reduce utilization of emergency room and in-patient services, and would help to stabilize the economic viability of physician practices.

Conclusion

The Committee on the Sustainability of Private Practice recommends that the Massachusetts Medical Society advocate for legislative or regulatory policy to specify that codes 99201–05 and 99211–15 for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments, so that insurers will pay the usual fee for these codes without triggering any deductible payment by the patient.

Recommendation:

That the Massachusetts Medical Society advocate for legislation or regulation specifying that codes for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments, so that insurers will pay the entire usual fee for these codes without triggering any deductible payment by the patient. *(D)*

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

[3] https://www.healthcostinstitute.org/images/pdfs/2015-HCCUR-11.22.16.pdf. Nov. 2016.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	7
Code:	Resolution I-18 B-206
Title:	Board of Registration Reporting Practices
Sponsor:	Kimberley O'Sullivan, MD
Referred to:	Reference Committee B Heidi Foley, MD, Chair

Whereas, An MMS strategic priority is Practice Viability; and

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

Whereas, Unsubstantiated allegations are used as a tactic by medical organizations against physicians to exclude doctors from medical staffs in order to reduce competition shielded in the guise of advocating on behalf of patients; and

Whereas, When allegations against a physician are reported to the Board of Registration in Medicine (BORIM), they remain forever on the physician's profile of the BORIM website and on the National Practitioner Data Bank (NPDB), unless a written retraction from the reporting entity to the BORIM is initiated; and

Whereas, The BORIM has no mechanism to allow for amending false allegations to the "facts and findings" at the request of a victimized physician; and

Whereas, Allegations regarding a physician are presumed to be the truth as there is no mechanism for an accused physician to respond on the BORIM Physician Profile website; and

Whereas, The fallout of a false allegation frequently results in a series of events, such as loss of hospital privileges, loss of insurance contracts, loss of malpractice insurance, bankruptcy, etc.; and

Whereas, The BORIM acts on false allegations to find reasons to scrutinize and justify discipline of physicians that would otherwise never have been before the BORIM; and

Whereas, The cost to sue accusers is prohibitive, and the tactic used by accusers in itself both mentally and financially bankrupts the victim physicians; and

Whereas, Such actions can result in the demise of physician's practices and destruction of physician's reputations; and

Whereas, The viability of physician's practices is being severely affected by the takeover of small community hospitals by large hospital systems, and the number of practicing physicians is continuing to fall due to the hostile practice environment; therefore, be it

1. **RESOLVED, That the MMS advocate, when allegations against a physician have been proven to be unsubstantiated, that the Board of Registration in Medicine (BORIM) be required to remove in totality all allegations from a physician's BORIM profile and rescind its reporting of same to the National Practitioner Data Bank at the request of the victimized physician; and, be it further *(D)***

2. **RESOLVED, That the MMS advocate for the Board of Registration in Medicine (BORIM) to remove from the BORIM physician profile and rescind their reporting to the National Practitioner Data Bank all trickle-down events that stemmed from the unsubstantiated allegations, such as loss of hospital privileges, loss of insurance contracts, etc.; and, be it further *(D)***

3. **RESOLVED, That the MMS advocate that any Board of Registration in Medicine (BORIM) discipline that results from the BORIM scrutiny initiated from unsubstantiated allegations must be a stand-alone discipline that does not include any reference to the unsubstantiated allegations or subsequent event that stemmed from the unsubstantiated allegations; and, be it further *(D)***

4. **RESOLVED, That the MMS advocate for the Board of Registration in Medicine (BORIM) to create a narrative section for physicians to make a statement under any and all allegations that are posted to a physician's BORIM profile in order that both parties have equal presence to the matter on the profile. *(D)***

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

FTE: Existing Staff
(Staff Effort to Complete Project)

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	8
Code:	Resolution I-18 B-207
Title:	Better Utilization of NICU Services
Sponsor:	Ihor Bilyk, MD
Referred to:	Reference Committee B Heidi Foley, MD, Chair

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

Whereas, The MMS has the following relevant policy:

HOSPITALS
Neonatal Outcomes and Care
The Massachusetts Medical Society (MMS) will continue to oppose defining levels of neonatal care based on the volume of deliveries at a hospital. (D)

The MMS will continue to work with the Massachusetts Department of Public Health and with the Massachusetts Hospital Association to ensure continued quality surveillance of neonatal outcomes. (D)

MMS House of Delegates, 12/3/05
Reaffirmed MMS House of Delegates, 5/19/12

; and

Whereas, There is substantial variation in the use of services among Neonatal Intensive Care Units (NICUs), which can result in higher costs and in the inappropriate use of intensive care for newborn infants in the United States;[1] and

Whereas, Many infants who were previously transferred from a lower level of care to a higher level of intensive care have had their medical problems stabilized and are ready to be transferred back to the lower level of care that was available at the original referring unit;[2] and

Whereas, Many of the stabilized infants continue to stay at the higher level of NICU care at a higher cost and inconvenience to the families, which in turn "ties up" or eliminates bed space for more acute patients that are unable to be transferred into the higher level of care;[3] and

Whereas, Many higher-level NICUs would prefer to transfer stabilized infants back to the original referring units when appropriate but are unable to do so because of medical insurance obstacles;[4] therefore, be it

[1] Edwards EM, Horbar JD. Variation in use by NICU types in the United States. *Pediatrics.* 2018; 142(5): e20180457.
[2] Ibid.
[3] Ibid.
[4] Ibid.

RESOLVED, That the Massachusetts Medical Society support the wise use of the NICU and advocate to legislators and insurers for regulations that eliminate medical-insurance obstacles that prevent the transport of stabilized infants to a lower level of neonatal care, when appropriate. *(HP)*

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	9
Code:	COL/IMGS Report I-18 B-2 [I-17 B-202]
Title:	Retraining Immigrant Physicians
Sponsors:	Committee on Legislation Theodore Calianos II, MD, FACS, Chair International Graduate Section Mr. Rajendra Trivedi, Chair
Report History:	Resolution I-17 B-202 Original Sponsor: Thomas Murray III, MD
Referred to:	Reference Committee B Heidi Foley, MD, Chair

At I-17, the House of Delegates referred to the Board of Trustees (BOT) for report back at I-18 Resolution I-17 B-202, Retraining Immigrant Physicians. The BOT referred this resolution to the Committees on Legislation and the Diversity in Medicine for a report back with recommendations to the HOD. The resolution states:

That the MMS encourage the AMA, and any appropriate state or federal agency, to investigate starting a program, similar to that of Scotland, in the United States to train immigrant physicians to be able to practice in areas where needed without having to repeat training that may be unnecessary and wasteful of limited resources. *(D)*

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

<u>Reference Committee and HOD Testimony</u>

At I-17, the reference committee recommended that this resolution be referred to the BOT for report back at I-18. The following is the reference committee's rationale:

Your reference committee received testimony in-person and online on the retraining of immigrant physicians to provide patient care in rural areas, with a strong sentiment to refer to the Board for report back due to the complexity of the issue. Complexities arise from the use of the word "immigrant," varying certification requirements, and whether the Scottish model is the best to use or if others exist. Testimony in favor on this resolution stated that allowing foreign medical graduates to practice in rural areas can alleviate some of the access to care issues that currently exist and are expected to worsen over the years. Therefore, your reference committee recommends this resolution be referred to the Board for report back at I-18.

The HOD debated this resolution at I-17. The resolution was extracted because of questions about the terminology, and whether *immigrant physicians* is an appropriate term to use. Debate followed on whether the term *foreign medical graduates* should include students who graduated from the Caribbean. Debate continued on referral to the Board of Trustees for report back.

Current MMS Policy

There is no MMS policy on this topic.

Discussion

International Medical Graduate Section

The International Medical Graduate Section (IMG) discussed this item at an Executive Committee Meeting. Committee members were in favor of adopting this resolution as amended.

Committee on Legislation

The Committee on Legislation (COL) defers to the IMG section on the substance of adopting this resolution. With regards to the legislative and policy mechanisms by which to achieve this aim, the COL recommends looking to the example of Minnesota's International Medical Graduate Program,[1] as Minnesota's legislative landscape bears a closer resemblance to that of Massachusetts than of Scotland.

Minnesota's International Medical Graduate Assistance Program was established in 2015 and is the first program of its kind in the United States.[2] The program was created by state statute and charged the Minnesota Department of Health with:

> 1) Developing a roster of immigrant IMGs (IIMG) in Minnesota, 2) identifying the barriers to residency and taking steps to address them, including funding dedicated residency positions for IIMGs, supporting clinical readiness assessment and preparation programs, and providing career guidance and support, and 3) studying possible licensure changes to allow qualified IIMGs to practice in Minnesota.[3]

Thus far, the program has achieved considerable successes, including the following: developing a roster of IMG physicians in the state, forming grant agreements with nonprofits to provide career support to IMGs, working with residency directors to carve out pathways for IMGs to demonstrate the clinical expertise required to enter into residency programs, funding dedicated residency slots for IMGs, and studying the licensure changes that would be needed to facilitate full IMG integration into the Minnesota physician workforce. The 2018 report to the Minnesota Legislature noted frustrations over the limits to the program's reach, and stakeholders intend to advocate for increased funding to increase the program's efficacy. However, on the whole, the program seems quite successful and beneficial both to IMG physicians and to the Minnesota patient population. The COL therefore concludes that the MMS ought to adopt an amended version of this resolution, as written on the next page.

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[1] www.health.state.mn.us/divs/orhpc/img/

[2] International Medical Graduate Assistance Program: Report to the Minnesota Legislature, August 2018. www.health.state.mn.us/divs/orhpc/img/documents/2018imgleg.pdf

[3] Ibid.

Conclusion

Internationally educated physicians currently account for approximately one quarter of the practicing physician workforce and will continue to play a critical role in the delivery of health care services.[4]

Proposed Amendments

Based on COL and IMG discussions, the committees propose the following amendments to Resolution I-17 B-202 (added text shown as "text" and deleted text shown as "~~text~~"):

That the MMS encourage the AMA, and any appropriate state or federal agency, to ~~investigate starting a~~ support programs, ~~similar to~~ such as that of Minnesota ~~Scotland~~, ~~in~~ throughout the United States to train International Medical Graduate ~~immigrant~~ physicians to be able to practice in areas where needed without having to repeat training that may be unnecessary and wasteful of limited resources. *(D)*

Recommendation:

That the Massachusetts Medical Society adopt as amended Resolution I-17 B-202, to read as follows:

That the MMS encourage the AMA, and any appropriate state or federal agency, to support programs, such as that of Minnesota, throughout the United States to train International Medical Graduate physicians to be able to practice in areas where needed without having to repeat training that may be unnecessary and wasteful of limited resources. *(D)*

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

[4] Pinksy, W. The Importance of International Medical Graduates in the United States. June 6, 2017. Annals of Internal Medicine. http://annals.org/aim/fullarticle/2609645/importance-international-medical-graduates-united-states

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Reference Committee C — MMS Administration

Hearing Order

**(Placed on Speakers' Consent Calendar)*

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	1
Code:	CSP Report I-18 C-1
Title:	MMS Annual Strategic Plan
Sponsor:	Committee on Strategic Planning Maryanne Bombaugh, MD, MSc, MBA, FACOG, Chair
Referred to:	Reference Committee C Mary Lou Ashur, MD

Background

The MMS Committee on Strategic Planning (CSP) — a committee of the Board of Trustees (BOT), with broad-based input from MMS leadership, MMS membership, MMS staff, external experts, and informed by comprehensive primary and secondary research — determines the strategic priorities for the Society. These are presented to the House of Delegates (HOD) annually for endorsement, with a comprehensive report about the health care environment. The following report contains the recommendations for 2019–2020.

The one- and three-year strategic plans (see Appendix A for previous plans) continue to provide guidance to leadership, committees, and staff when assessing the resources and initiatives needed to address day-to-day issues and for planning for the future needs of the Society. While MMS officers and senior management use these strategic priorities to develop tactics that guide the Society's internal and external actions, changes in the environment may require different tactics, scheduling, or focus. Therefore, to be most effective, the strategic planning process must continue to evolve.

Process

As part of the annual strategic planning process, the CSP provides a comprehensive review of the local and national health care environment (see Appendix B), paying specific attention to issues and concerns facing Massachusetts physicians and their patients. To support this process, in September 2018, the chair and vice chair facilitated an overview of the health care environment and a discussion among members of the CSP about the key issues facing physicians in today's health care landscape. The issues raised during that discussion, coupled with the overview of the health care environment, were synthesized into a recommendation for the key strategic priorities for 2019–2020.

In addition, the CSP voted to conduct a review of the Strategic Planning Process to determine if it currently assists in identification of areas of strategic activity, opportunities, and priorities, and to make recommendations for change if warranted. A report on that review and any proposed changes will be presented to the HOD at A-19.

To allow time for this review, the CSP updated the 2019–2020 MMS Strategic Plan, including the Annual Priorities, and is submitting it for approval by the HOD at I-18. Due to this accelerated timeframe, and the fact that the current priorities were approved at A-18, the CSP is not recommending any changes to the Annual Priorities for 2019–2020. Most importantly, the Annual Priorities remain relevant based on the CSP's review of the local and national health care environment in September 2018.

In addition, given the changes in the health care landscape, coupled with equally disruptive changes in the publishing/media business environment, the Committee on Strategic Planning has undertaken an effort to identify the key drivers of change for both the association and the publishing/media areas of the organization and their implications for Massachusetts physicians and the MMS. Successful completion of this effort will result in the submission of a written new strategic plan and process to the HOD at A-19. The proposed plan, if adopted, would be implemented for FY-21.

Conclusion

Both physicians and patients are being forced to continue to manage increasing demands from the government, payers, and the marketplace, while balancing costs, quality, and risk. The attached report (Appendix B) covers a wide range of issues detailing the current pressures on the health care environment. The Massachusetts Medical Society is well-positioned to serve as a strong advocate for physicians and patients, providing the leadership needed to navigate rapid, complex change. By focusing on its strategic priorities (sustainable health care delivery, practice viability, and preservation of professionalism) through its commitment to physician and patient advocacy, membership value and engagement, and professional knowledge and satisfaction, the Society is working toward fulfilling its mission as an organization:

"The purposes of the Massachusetts Medical Society shall be to do all things as may be necessary and appropriate to advance medical knowledge, to develop and maintain the highest professional and ethical standards of medical practice and health care, and to promote medical institutions formed on liberal principles for the health, benefit and welfare of the citizens of the Commonwealth."

Commonwealth of Massachusetts Act of Incorporation,
Chapter 15, Section 2 of the Acts of 1781

One Year Strategic Priorities for Fiscal Year 2019–2020

The Society's strategic priorities for Fiscal Year 2019–2020 include a focus on physician and patient advocacy, membership value and engagement, and professional knowledge and satisfaction. To advance the Society's mission and serve the needs of the physician community and their patients, the goals of our one-year strategic plan will be the following:

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

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

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

Recommendation:

That the Massachusetts Medical Society's strategic priorities for Fiscal Year 2019–2020 are the following: a focus on physician and patient advocacy, membership value and engagement, and professional knowledge and satisfaction. 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

APPENDIX A
Massachusetts Medical Society One-Year (2018–2019)
and Three-Year (2017–2020) Strategic Plans

The one-year strategic plan, adopted at A-18, is as follows:

- *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.

The three-year strategic plan, adopted at A-17, is as follows:

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

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

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

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

MMS House of Delegates, 4/28/2018

Committee on Strategic Planning Report – I-18

APPENDIX B
The Massachusetts Medical Society and the National and Local Health Care Environment

INTRODUCTION AND SUMMARY

As part of the annual strategic planning process, the Committee on Strategic Planning (CSP) provides the following comprehensive review of the local and national health care environment. Since the passage of the Affordable Care Act (ACA), more than 19 million Americans have gained insurance coverage and the uninsured rate in the US has been cut in half from 18% in 2010 to approximately 9% today. Despite this and other achievements that have greatly improved access to health care for Americans under the ACA, health disparities and increasing health care cost pressures persist, threatening the efficiency and viability of an improved health care system. Nationally and at the state level, collaborations across sectors will be essential to address the opioid crisis and social determinants of health, natural disasters, and the rising cost of prescription drugs. The current government partisanship will make health reform efforts more uncertain. New technologies in the form of genomics, disruptive innovations, and new entrants in the health care field will drive further cost increases and uncertainty while providing unprecedented possibilities to improve health and wellness among US patients. Consolidation and increased transparency will also continue unabated, causing a paradigm shift in the practice of medicine. These trends and drivers combine to create a constellation of both opportunities and pressures for physicians, and the physician membership advocacy organizations that represent them, as they face a sea change in the health care landscape. Therefore, in these uncertain times, it will be essential for the MMS to continue its tradition and focus on enhancing and protecting the physician-patient relationship while preserving the physician's ability to make clinical decisions for the benefit of patients.

This report is one aspect of the process the MMS uses to ensure the CSP has a comprehensive understanding of the latest health care trends and information needed by leaders navigating their organizations through complex times. Among the topics addressed in this report include:

- National and state overview of trends in health care spending, access to care, and coverage.
- An overview of health care industry trends.
- Analyses of physician demographics at the national and state levels.
- Physician compensation and workforce data.
- Physician burnout data.
- An overview of MMS activities and services.

As a leadership voice in health care, the MMS is dedicated to educating and advocating for the physicians of Massachusetts and patients locally and nationally. This report reflects the challenges present in today's health care environment and recommends ways in which the MMS can respond to those challenges, by influencing health-related legislation at the state and federal levels, working in support of public health, providing expert advice on physician practice management, and addressing issues of physician well-being.

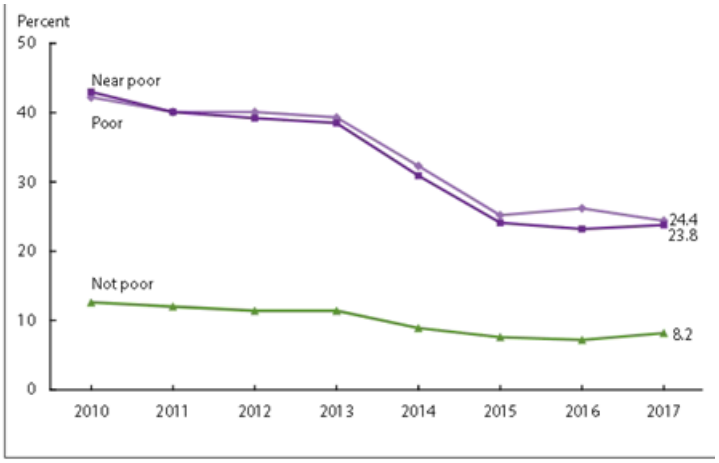
NATIONAL OVERVIEW

The percentage of people of all ages who are uninsured has declined and currently stands at 9.1% (29.3 million), 19.3 million fewer than before passage of the Affordable Care Act (ACA) in 2010.[1] The percentage of adults aged 18–64 who are uninsured in 2017 has decreased to 12.8%. The percentage of adults aged 18–64 with public coverage has increased to 19.3%, while those covered by private insurance stands at 69.3%. The private insurance coverage rate includes 8.5 million people now covered by private health insurance plans available on the Health Insurance Marketplace or state-based exchanges.[2]

Post-ACA, the percentage of adults who were uninsured has declined most dramatically for young adults aged 18–24,[3] which is not surprising given the ACA provision that extended dependent child coverage up to age 26. Five percentage of children aged 0–17 are currently uninsured, which is an all-time low for this population.[4,5] Uninsured rates for poor and racial/ethnic minority groups have also steadily declined since the ACA's passage.

Figure 1:

Percentage of adults aged 18–64 who were uninsured at the time of interview, by poverty status, 2010–2017



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2017, Family Core component.

[1] Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2017. US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics Website. https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf.

[2] Ibid.

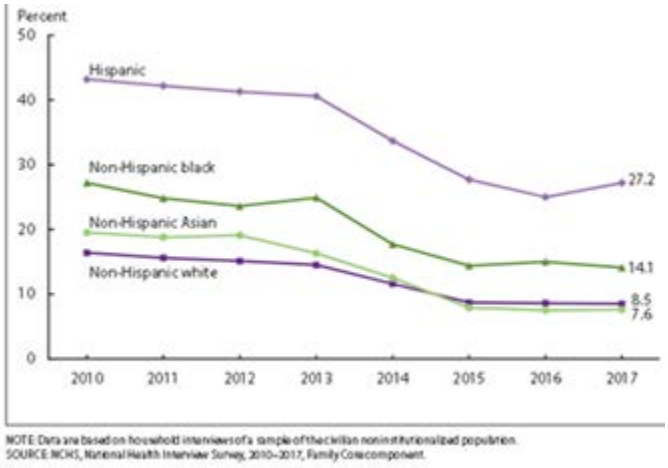
[3] Ibid.

[4] Ibid.

[5] The Henry J. Kaiser Family Foundation. Key Issues in Children's Health Coverage, February 15, 2017. https://www.kff.org/medicaid/issue-brief/key-issues-in-childrens-health-coverage

Figure 2:

Percentage of adults aged 18–64 who were uninsured at the time of interview, by race and ethnicity: United States, 2010–2017



Unfortunately, despite declining uninsured rates among the poor and racial/ethnic minority groups, maternal mortality rates among these groups continue to rise. In fact, "the US ranks a dismal 47th in the world for maternal mortality rates and is the only developed country in which maternal mortality is rising, with women of color and low-income women disproportionately at risk."[6]

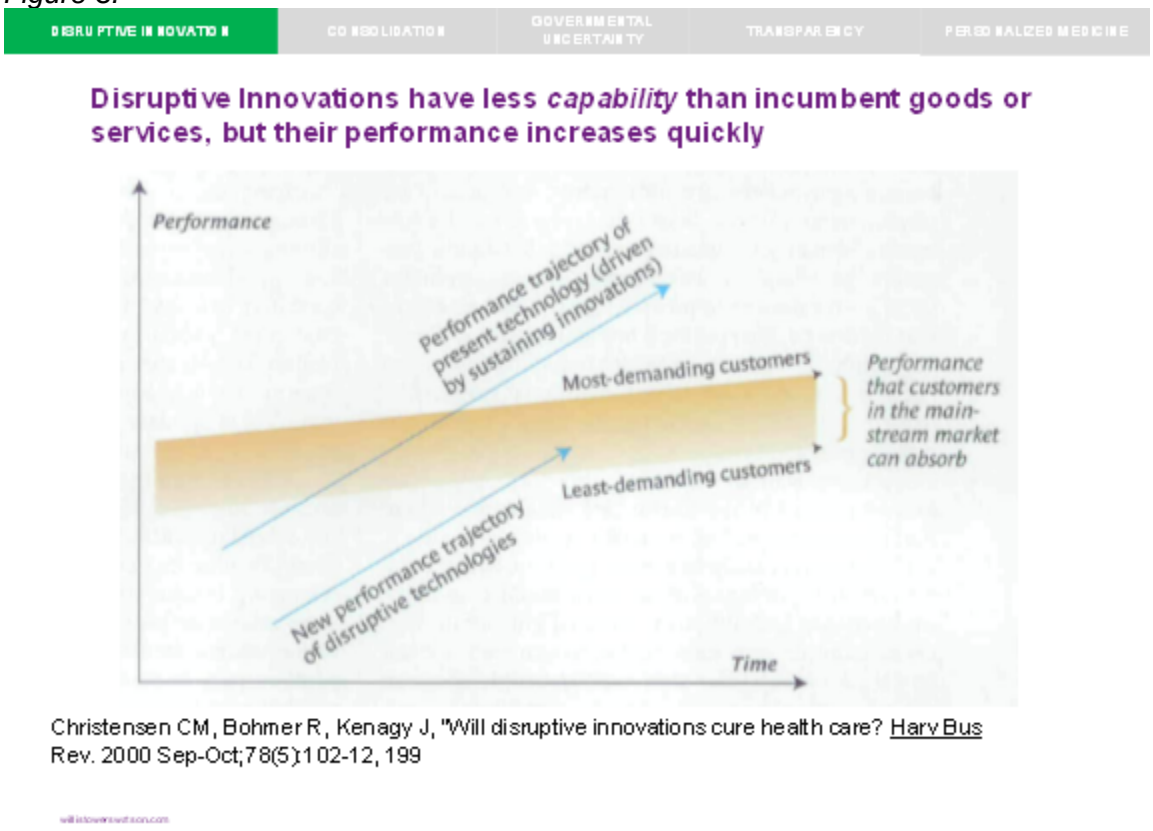
Health Care Industry Trends in 2018: Five Trends that will Profoundly Impact Physicians
Jeff Levin-Scherz, MD, MBA, FACP, Co-Lead at the North American Health Management Practice, Willis Towers Watson and Assistant Professor at Harvard University's TH Chan School of Public Health presented findings to the MMS Committee on Strategic Planning at the Society on September 25, 2018. Dr. Levin-Scherz's presentation focused on five health care trends that will profoundly impact physicians as well as influence and shape the strategic priorities of the MMS in the coming year. These include:

1. Disruptive Innovations and New Entrants
2. Consolidation
3. Government and Regulatory Uncertainty
4. Transparency
5. Genomics/Personalized Medicine

1. Disruptive Innovations and New Entrants
Innovations disrupt the health care system by offering "cheaper, simpler, more convenient products or services aimed at the lower end of the market." But as time passes, these products and services improve to the point where they meet the needs of much of the market they disrupt.[7] Examples in the health care system include nurse practitioners disrupting physicians and generic drugs disrupting brand name drugs.[8]

[6] http://www.massmed.org/News-and-Publications/Vital-Signs/Why-Do-So-Many-US-Women-Die-from-Pregnancy-Related-Causes-/#.W7duw3tKipo
[7] https://hbr.org/2000/09/will-disruptive-innovations-cure-health-care
[8] Jeff Levin-Scherz, MD, MBA, FACP presentation at Committee on Strategic Planning meeting at Massachusetts Medical Society on September 25, 2018.

Figure 3:[9]



The following are examples of clinical areas where disruptive innovation will challenge current health care providers: expert medical opinions, virtual visits, behavioral health, and interventions to address diabetes and metabolic syndrome.

[9] Ibid.

Figure 4:[10]

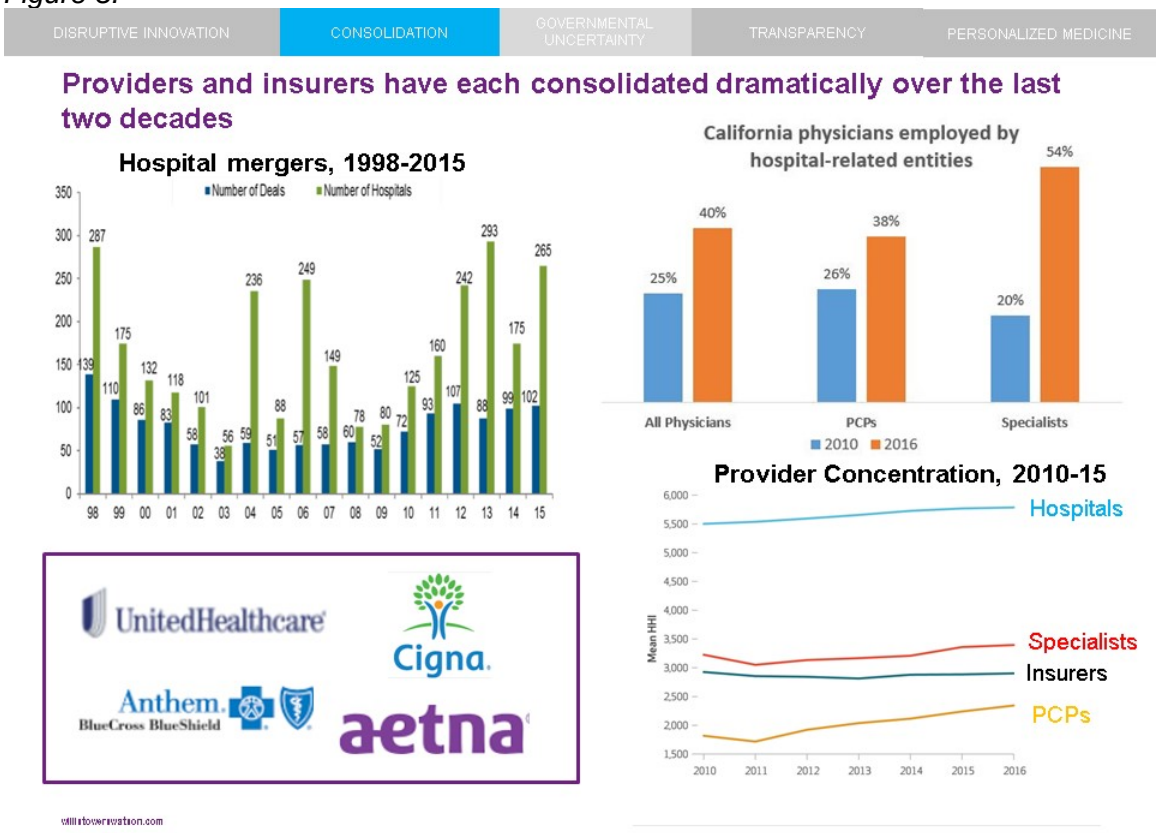
2. Consolidation

Consolidation by providers, insurers, and hospitals has increased dramatically over the last two decades and an increasing proportion of physicians are employed by these consolidated, hospital-related entities. Nationally, a growing number of physicians are employed; a national survey of physicians found that 69% of those surveyed are employed.[11]

[10] Ibid.

[11] https://www.medscape.com/slideshow/2018-compensation-overview-6009667#13

Figure 5:[12]



Note: HHI=Herfindahl-Hirschman Index

"HHI is used in the US Department of Justice and Federal Trade Commission (DOJ/FTC)'s Horizontal Merger Guidelines (US Department of Justice and the Federal Trade Commission 2010) and can range from 0 to 10,000. The measure is calculated by summing the squared market shares of firms)."[13]

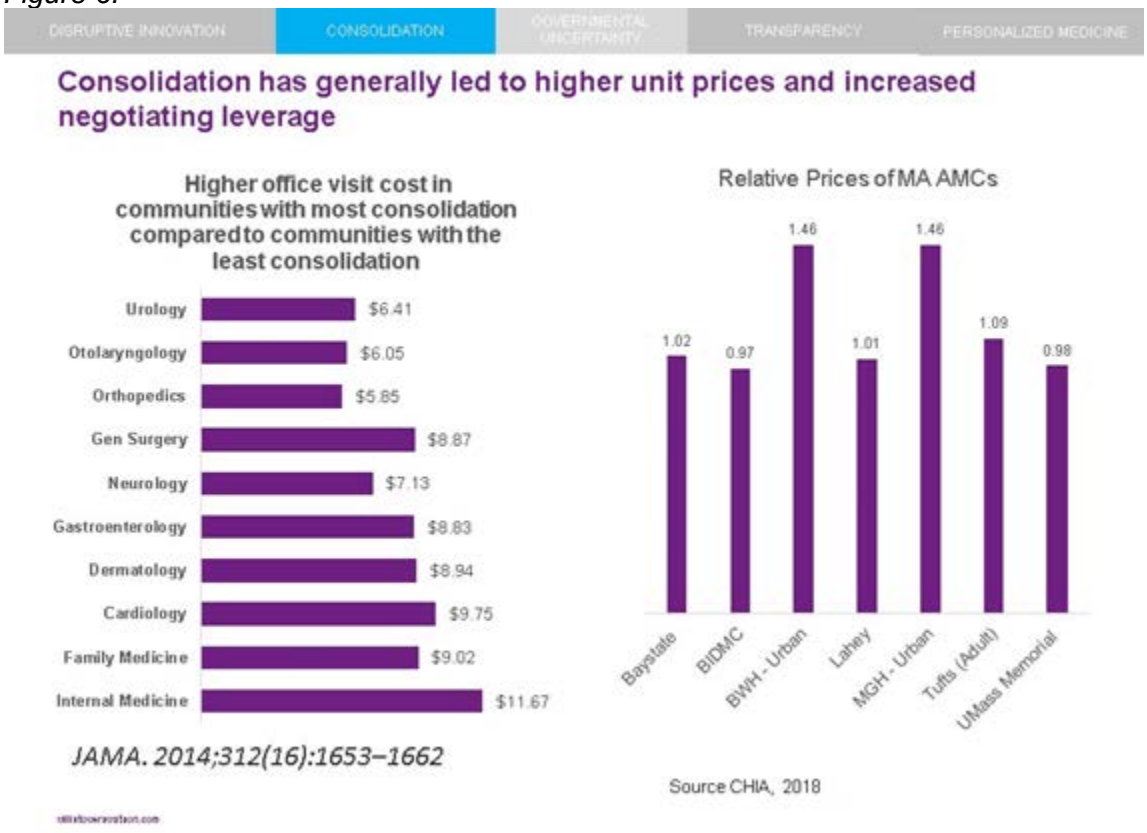
Consolidation of hospital monopolist physicians has led to higher out of plan fees and higher out of pocket costs as well as higher unit prices and increased negotiating leverage.[14]

[12] Jeff Levin-Scherz, MD, MBA, FACP presentation at Committee on Strategic Planning meeting at Massachusetts Medical Society on September 25, 2018.

[13] http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf

[14] Jeff Levin-Scherz, MD, MBA, FACP presentation at Committee on Strategic Planning meeting at Massachusetts Medical Society on September 25, 2018.

Figure 6:[15]

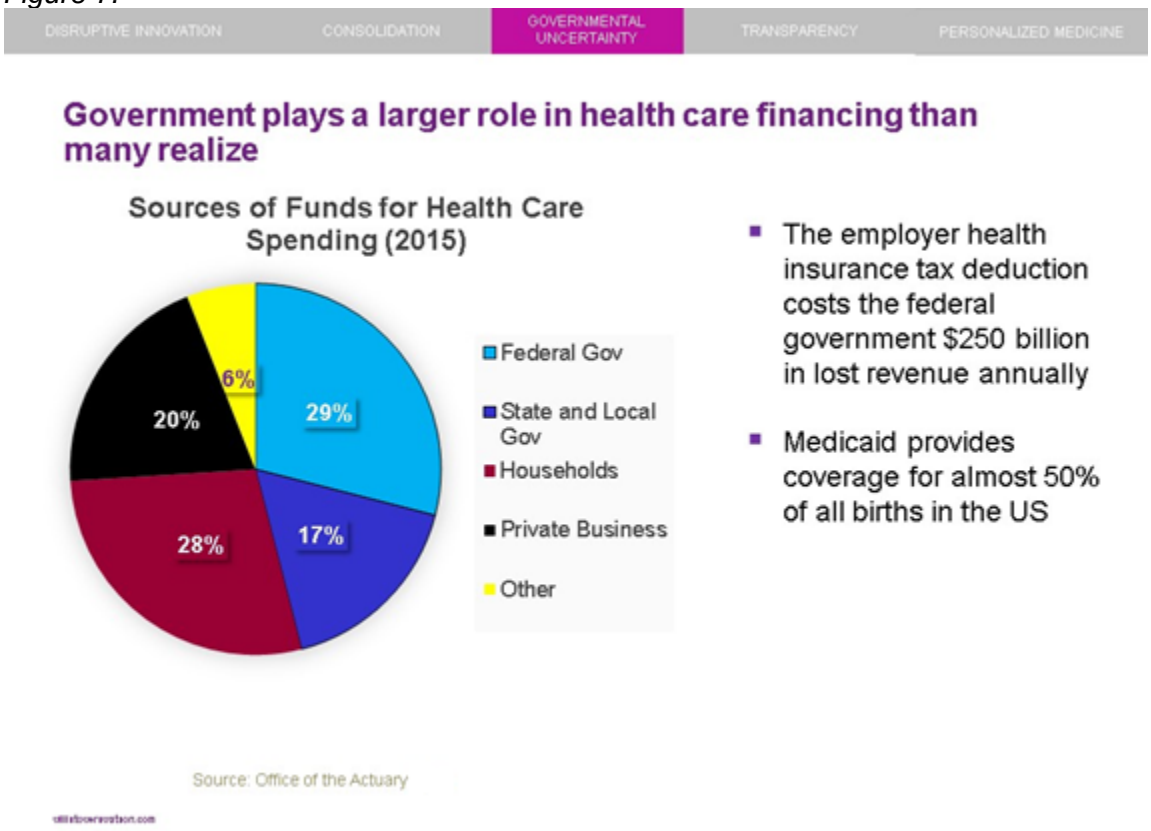


3. Governmental Uncertainty

Government plays a larger role in health care financing than many people realize.

[15] Jeff Levin-Scherz, MD, MBA, FACP presentation at Committee on Strategic Planning meeting at Massachusetts Medical Society on September 25, 2018.

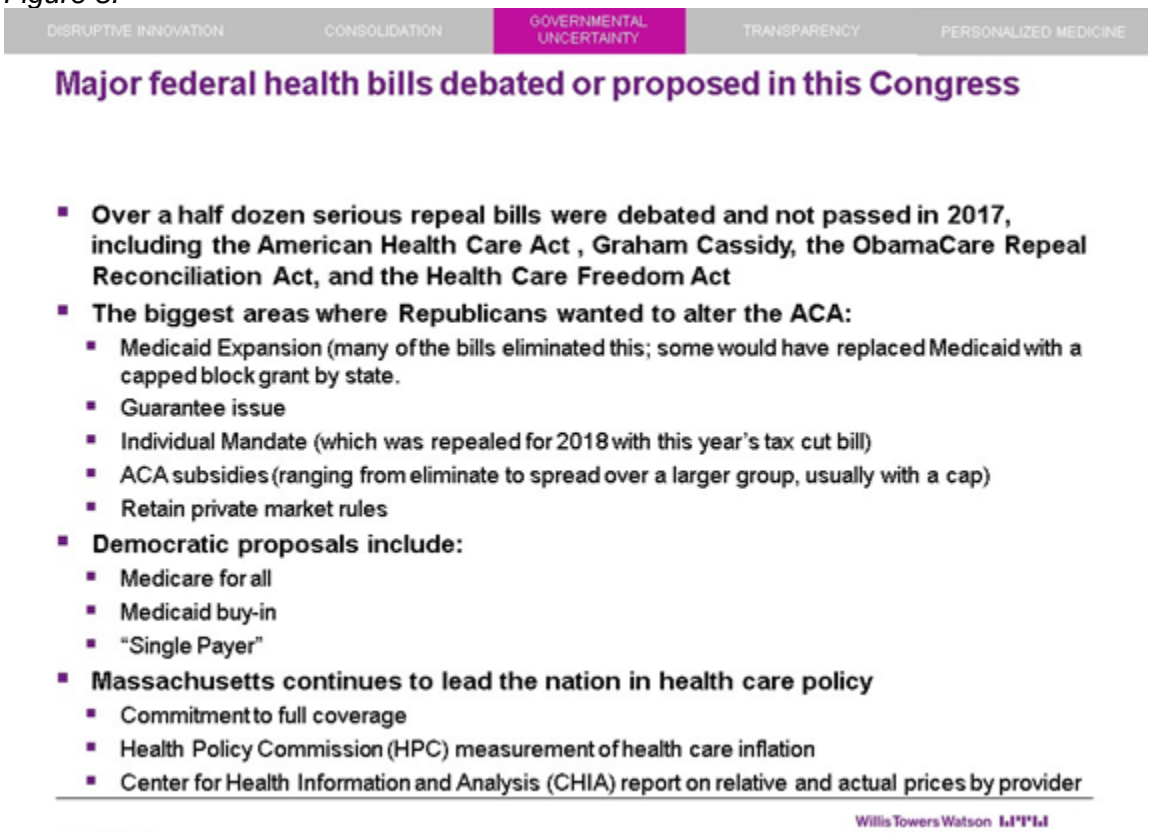
Figure 7:[16]



Unfortunately, there is little bipartisan agreement regarding health policy. Therefore, uncertainty will persist through the midterm elections as major federal health bills continue to be debated by Congress.

[16] Jeff Levin-Scherz, MD, MBA, FACP presentation at Committee on Strategic Planning meeting at Massachusetts Medical Society on September 25, 2018.

Figure 8:[17]



4. Transparency

Transparency trends will continue in the coming years, including reporting on patient outcome data and provider payments.

[17] Ibid.

Figure 9:[18]

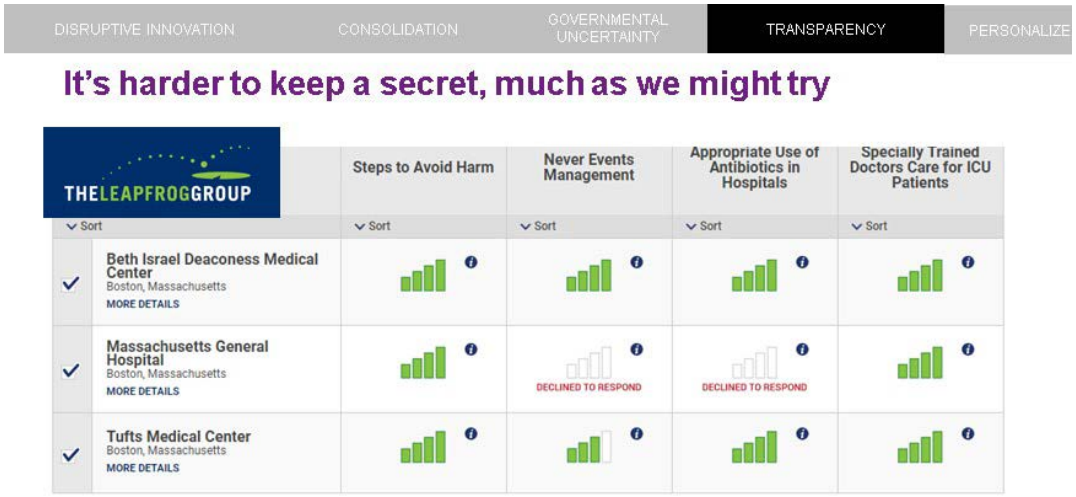


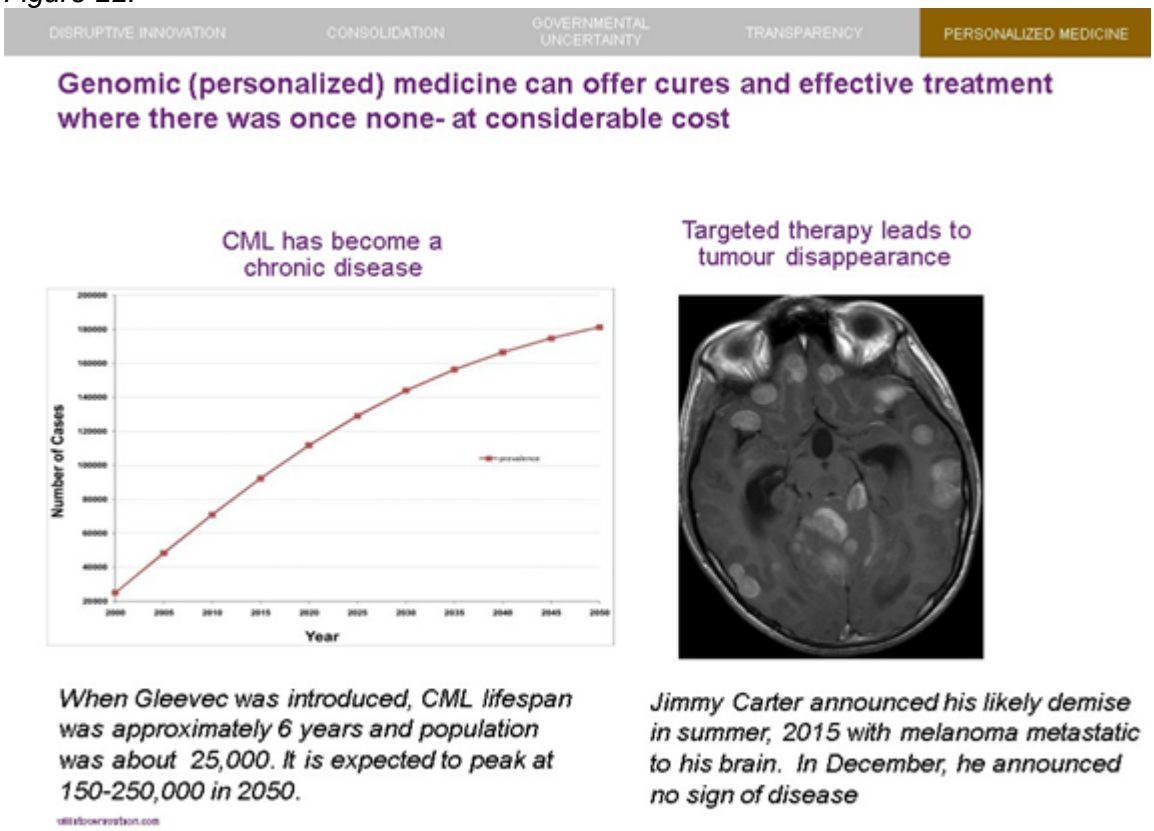
Figure 10:[19]

[18] Ibid.
[19] Ibid.

5. Genomics (Precision Medicine)

Ground-breaking genomic treatments are now available to treat diseases that were once incurable.

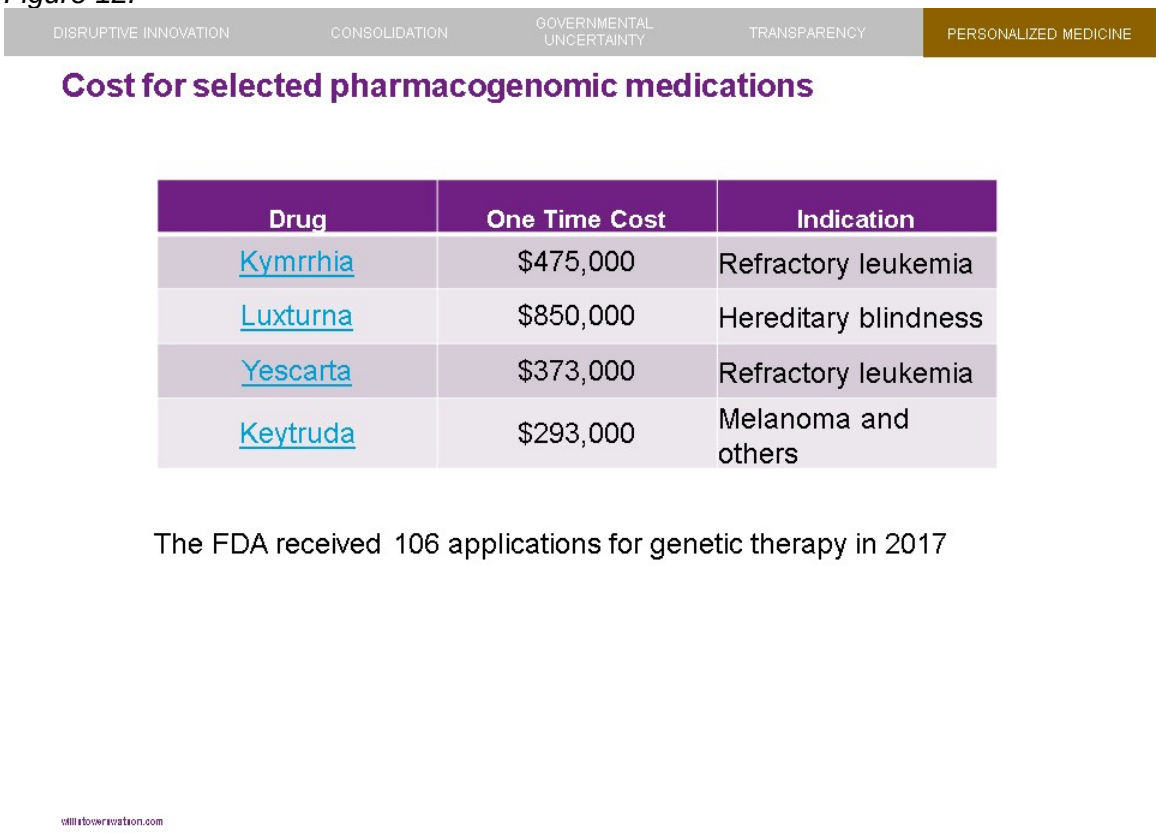
Figure 11:[20]



However, these treatments are expensive and could lead to de-skilling, and situations where treatment can be optimized even without the most learned and experienced physicians.

[20] Ibid.

Figure 12:[21]



In conclusion, these five trends demonstrate that:

- Change will be constant
- Physicians are likely to be disrupted, and might disrupt other stakeholders in health care delivery
- Regulatory uncertainty likely to persist until 2020 or beyond
- Pressure will increase to rein in utilization of high cost services and products
- Pressure will mount for providers with high unit costs to demonstrate their incremental value

Health Care Spending and Costs

The Cost of Insurance Coverage

According to a 2018 benchmark Kaiser Family Foundation Employer Health Benefits Survey, premiums for employer-sponsored family health coverage rose 5% to an average of $19,616,and single premiums rose 3% to an average of $6,896.[22] Overall, the growth in premiums since last year has been modest. However, deductible costs for covered workers have tripled over the past decade, growing at a pace eight times faster

[21] Ibid.
[22] http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018

than wages. Currently, more than one in four (29%) covered workers are enrolled in high-deductible health plans.

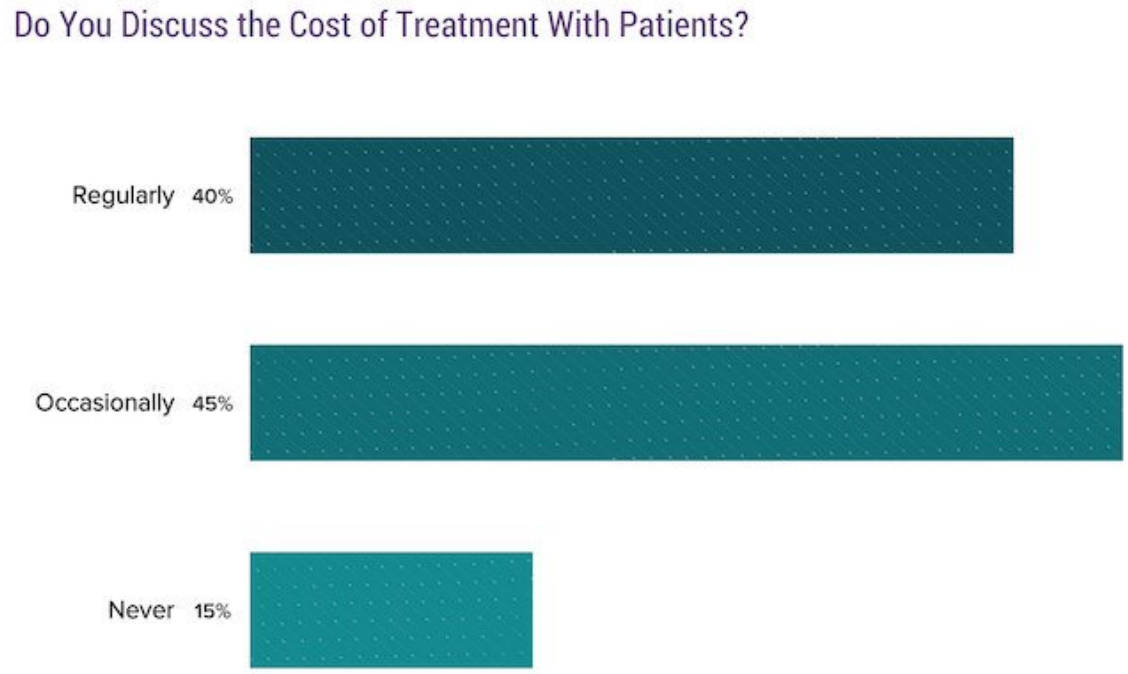
Large employers also provided data on wearable technology, telemedicine, and retail health clinics.[23] Findings show:

- About 20% of large employers gather data from their employees from wearable device technology.
- About three quarters of large firms offering health insurance coverage to their employees cover services provided via telemedicine and retail health clinics.
- The rate of coverage for telemedicine services among large firms is increasing rapidly, up from 63 % last year and 27% in 2015. However, survey estimates show that very few workers are using these services.

Given that cost concerns continue to grow among the public, it is encouraging to note that, according to a recent Medscape survey, 85% of physicians indicate that they are talking with their patients about health care costs. As outlined in the national survey, 40% of respondents indicated that they regularly speak to their patients about costs (up from 1/3 last year), while an additional 45% speak to their patients about cost occasionally (up from 40% last year).[24]

[23] https://www.kff.org/health-costs/press-release/employer-sponsored-family-coverage-premiums-rise-5-percent-in-2018/
[24] https://www.medscape.com/slideshow/2018-compensation-overview-6009667#28

Figure 13:



Source: Medscape Physician Compensation Report 2018.

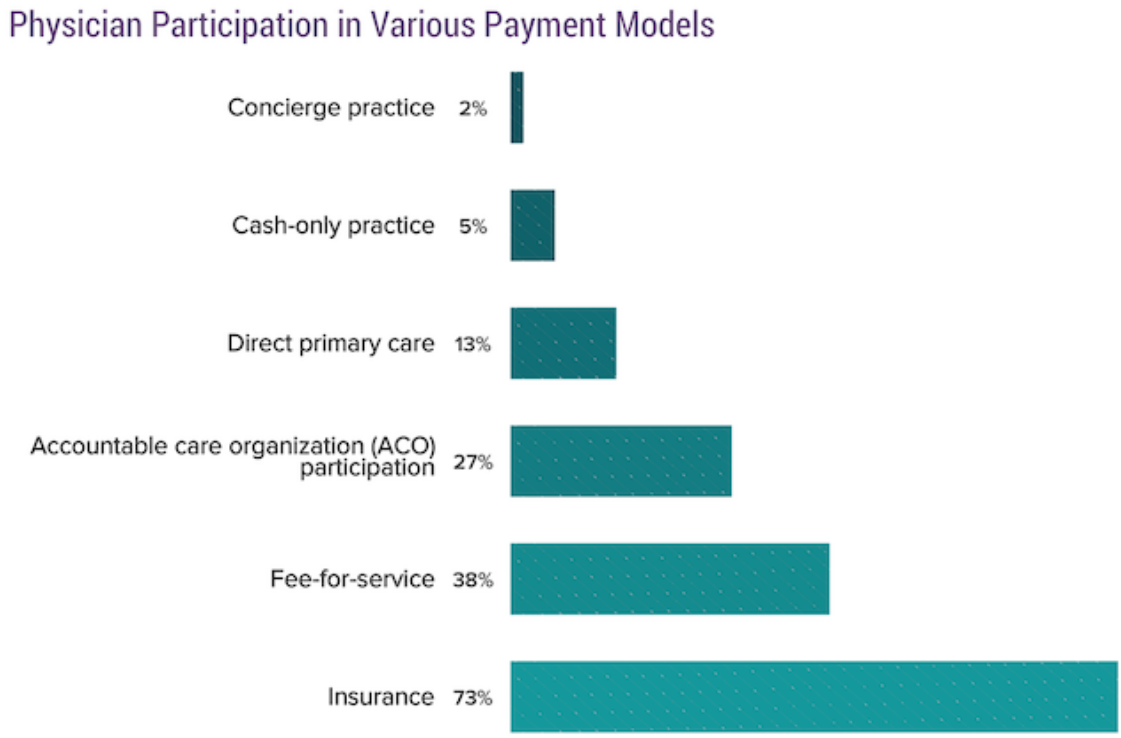
MACRA

The MMS commented on the extensive notice of proposed rulemaking which proposed changes to both the QPP program and Medicare Fee schedule. In developing our comments, the MMS worked closely with a number of MMS Committees, state and national medical societies and the AMA. Of note, our comments supported the agencies interested in reducing paperwork and addressing physician burnout. However, we opposed the collapsing of payments for levels 2–5 into one level on a number of groups, including the implicit undervaluing of decision-making for medical care for complex patients and the negative impact on patients' access to both primary and specialty care. The MMS continued to support additional exemptions for physicians in small practices and other changes which would reduce the complexity of the Merit-Based Incentive Payment System (MIPS) program.

Accountable Care Organizations (ACOs)

Findings from the 2018 Medscape Physician Compensation Survery indicate that more than one in four physicians (27%) are participating in accountable care organizations (ACOs), down from one-third of physicians surveyed last year.[25]

Figure 14:



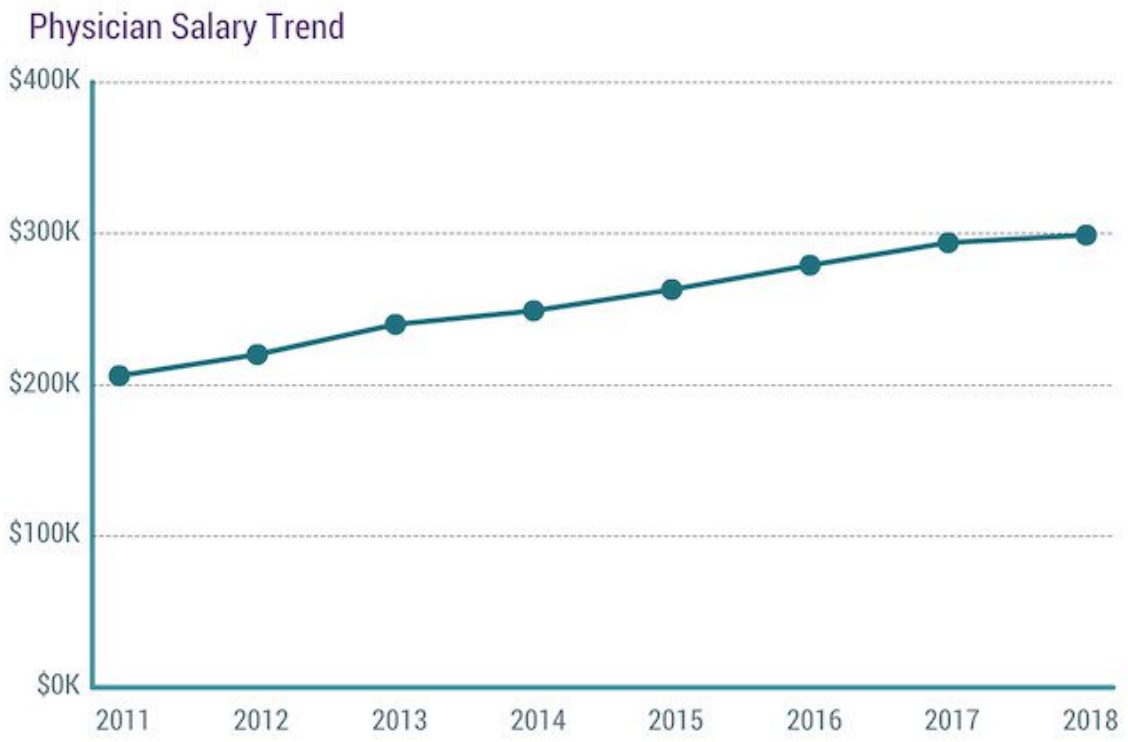
Source: Medscape Physician Compensation Report 2018.

Physician Compensation

Nationally, physician salaries are on the rise, according to the Medscape Physician Compensation Survey. According to recruitment specialists at Merritt Hawkins, salaries have risen steadily over the past seven years as starting salaries, the amount needed to persuade physicians to move from one setting to another, are consistently rising.[26,27]

[25] Medscape Physician Compensation Report 2017. Medscape Website, April 11, 2018. https://www.medscape.com/slideshow/2018-compensation-overview-6009667. https://www.medscape.com/slideshow/2018-compensation-overview-6009667#3
[26] Ibid.
[27] Ibid.

Figure 15:

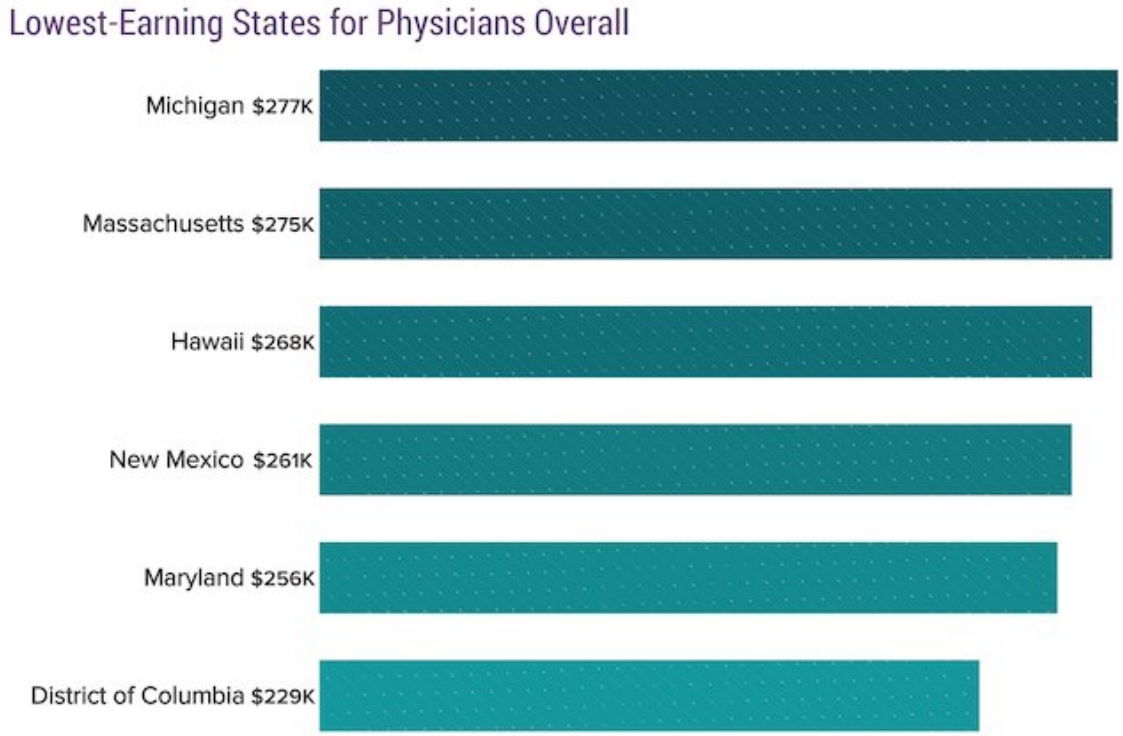


Source: Medscape Physician Compensation Report 2018.

Massachusetts is ranked as one of the lowest-earning states for physicians.[28]

[28] Ibid.

Figure 16:



Source: Medscape Physician Compensation Report 2018.

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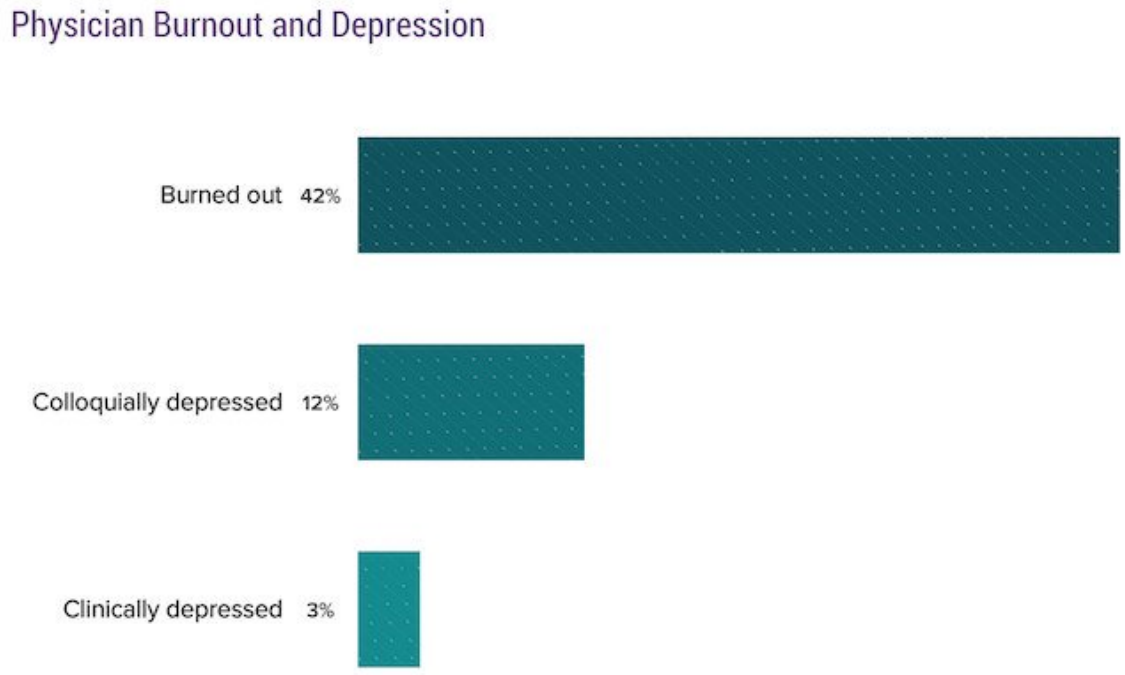
Physician Burnout

Burnout and administrative burdens continue to plague physicians. The Medscape Lifestyle Report 2018 found that burnout continues to be significant among US physicians. The report defined burnout as "a loss of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment."[29] In 2018, 42% of US physicians surveyed by Medscape reported burnout, down from 51% in 2017.[30]

Figure 17:

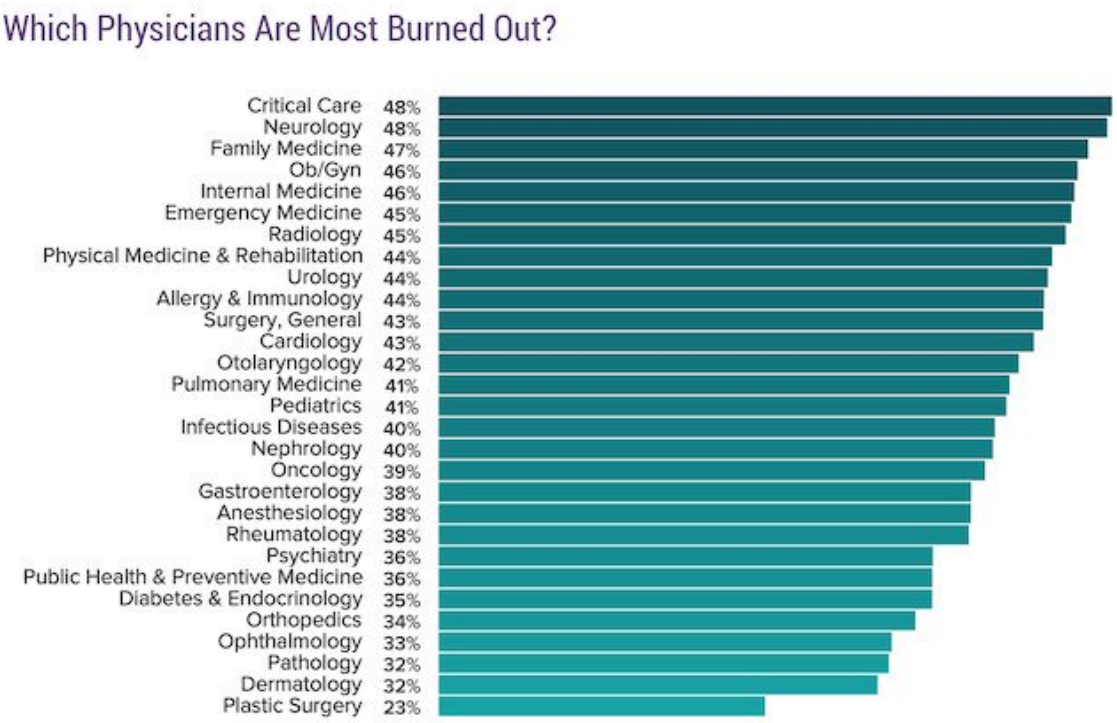


Source: Medscape National Physician Burnout & Depression Report 2018.

Specialties experiencing the highest rates of burnout nationally were critical care medicine and neurology (both at 48%), family medicine (47%) followed by OB/GYN and internal medicine (both at 46%).[31]

[29] Medscape Lifestyle Report 2017: Race and Ethnicity, Bias and Burnout. January 11, 2017. https://www.medscape.com/features/slideshow/lifestyle/2017/overview#page=2.
[30] Medscape National Physician Burnout & Depression Report 2018. Retrieved on October 19, 2018, from https://www.medscape.com/slideshow/2018-lifestyle-burnout-depression-6009235#2.
[31] Ibid.

Figure 18:

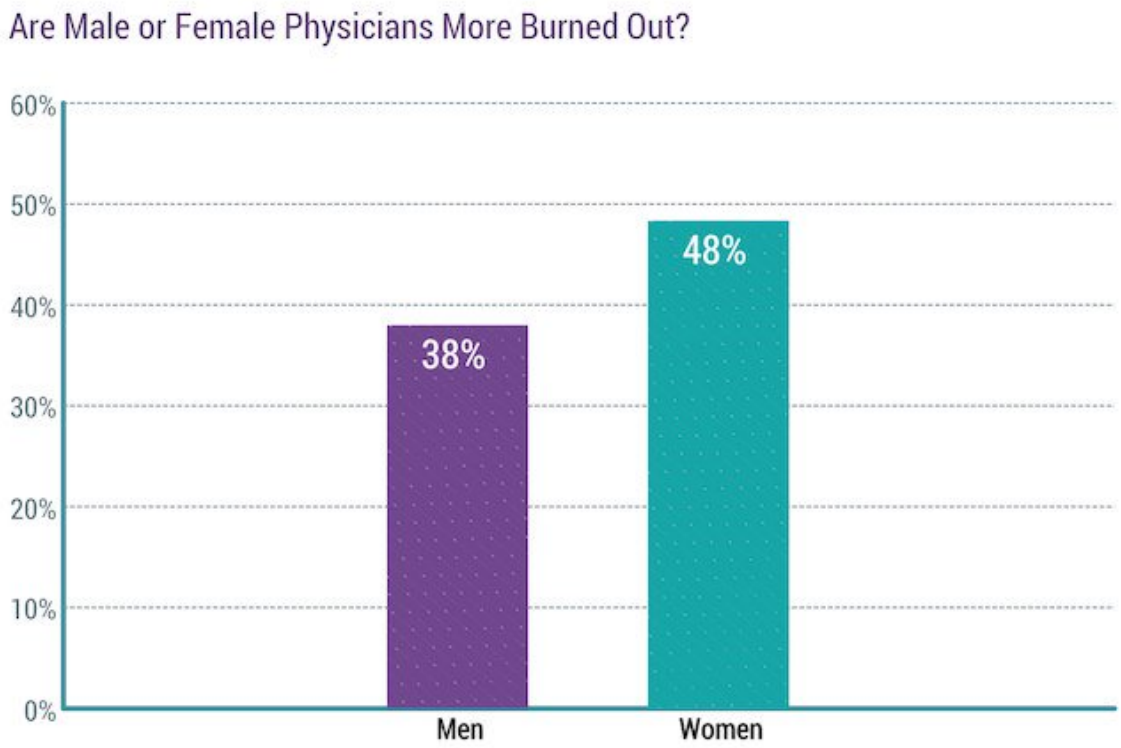


Source: Medscape National Physician Burnout & Depression Report 2018.

Women reported more burnout than men.[32]

[32] Ibid.

Figure 19:

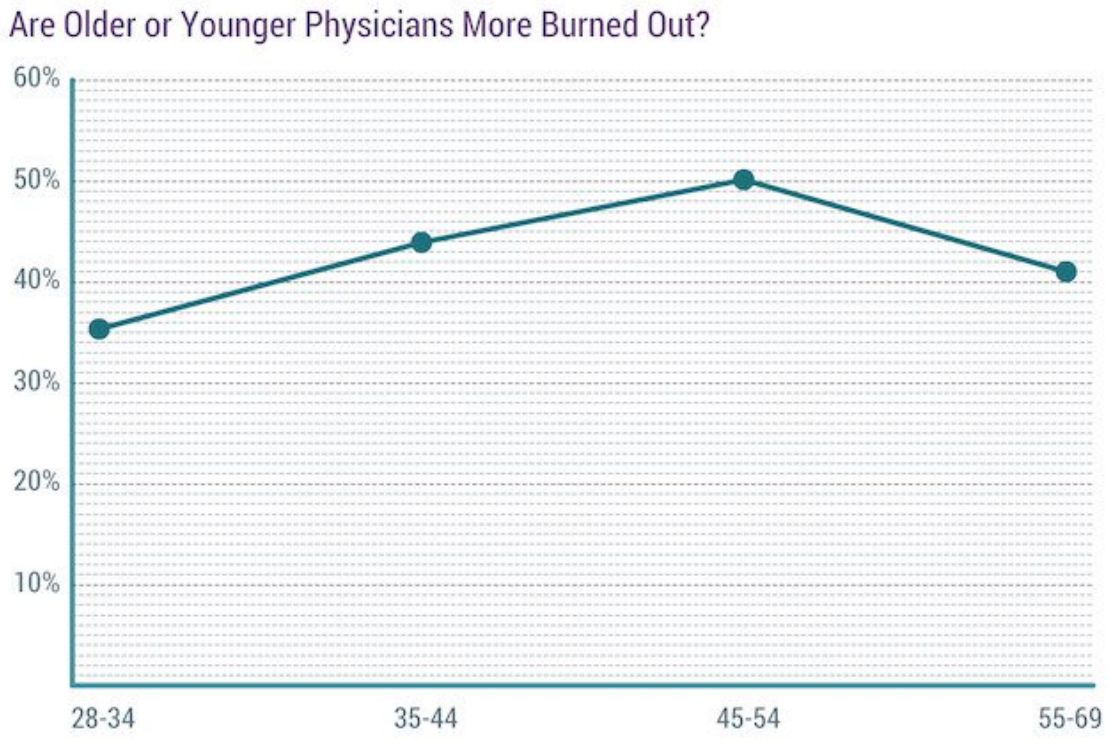


Source: Medscape National Physician Burnout & Depression Report 2018.

Burnout also varies by age, peaking between the ages of 45–54.[33]

[33] Ibid.

Figure 20:

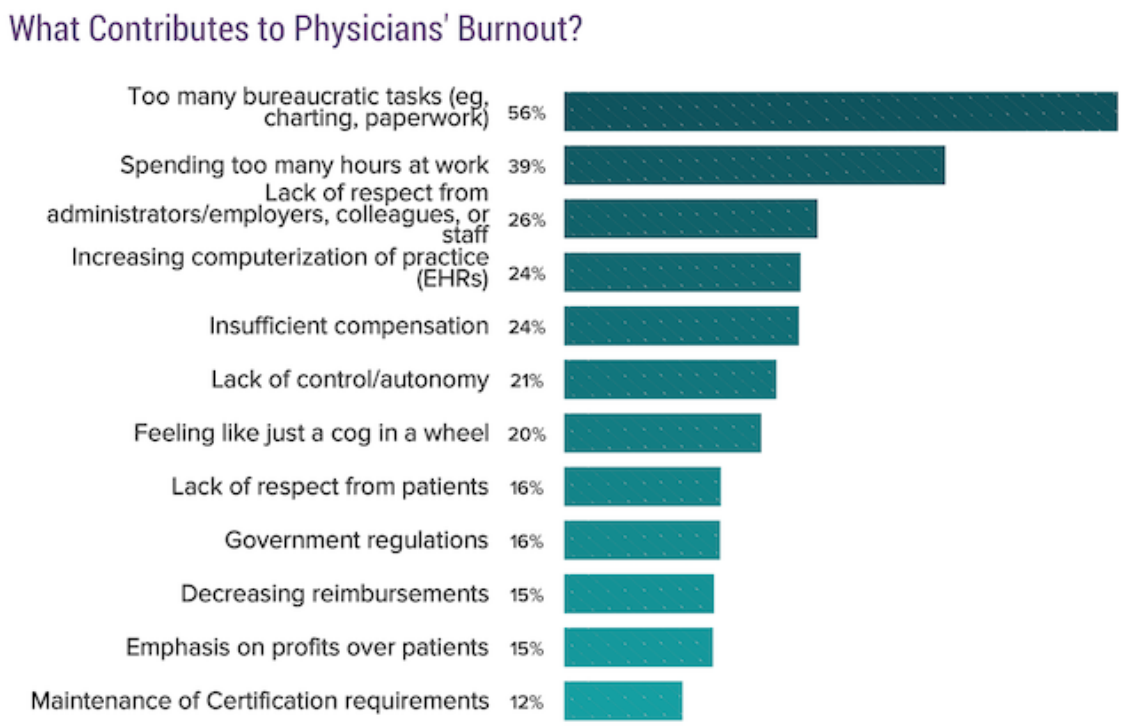


Source: Medscape National Physician Burnout & Depression Report 2018.

However, burnout does not vary between employed and self-employed physicians; 42% report burnout in each category.[34] The following overview demonstrates physician self-reported data on burnout. The top contributors to burnout cited by physicians include too many bureaucratic tasks, spending too many hours at work, and lack of respect from colleagues.[35]

[34] Ibid.
[35] Ibid.

Figure 21:

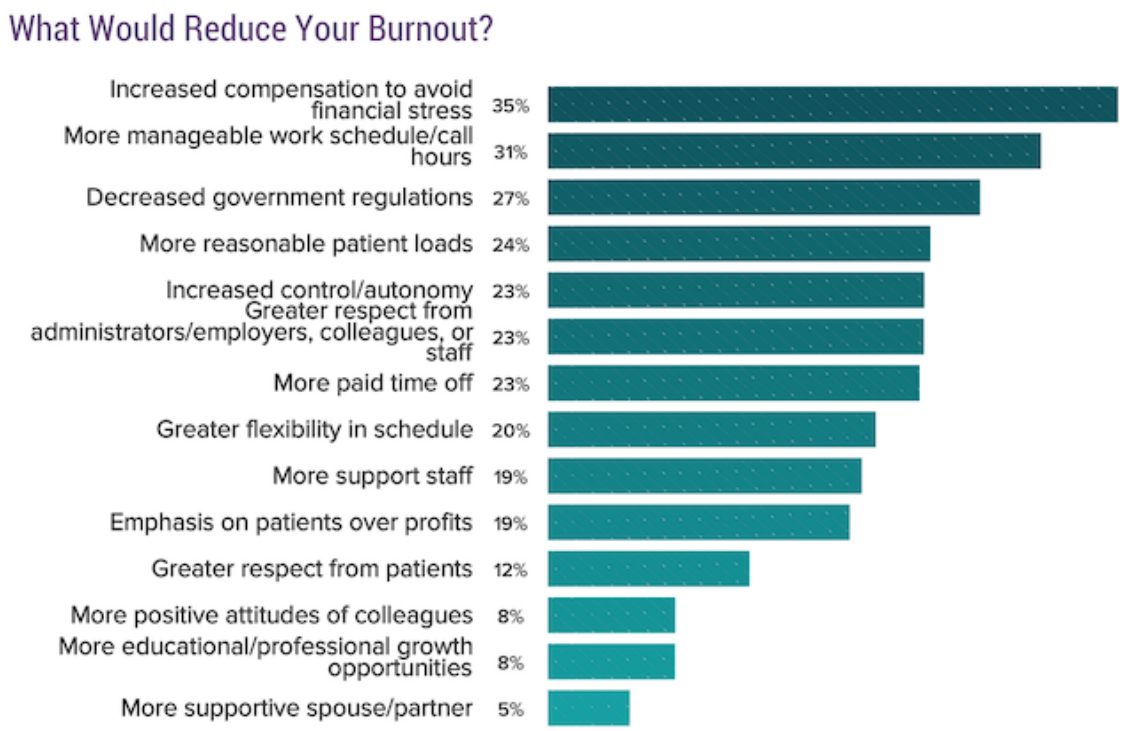


Source: Medscape National Physician Burnout & Depression Report 2018.

Increased compensation, more manageable work schedules, and decreased government regulations were frequently cited by physician respondents as ways to reduce their burnout.[36]

[36] Ibid.

Figure 22:

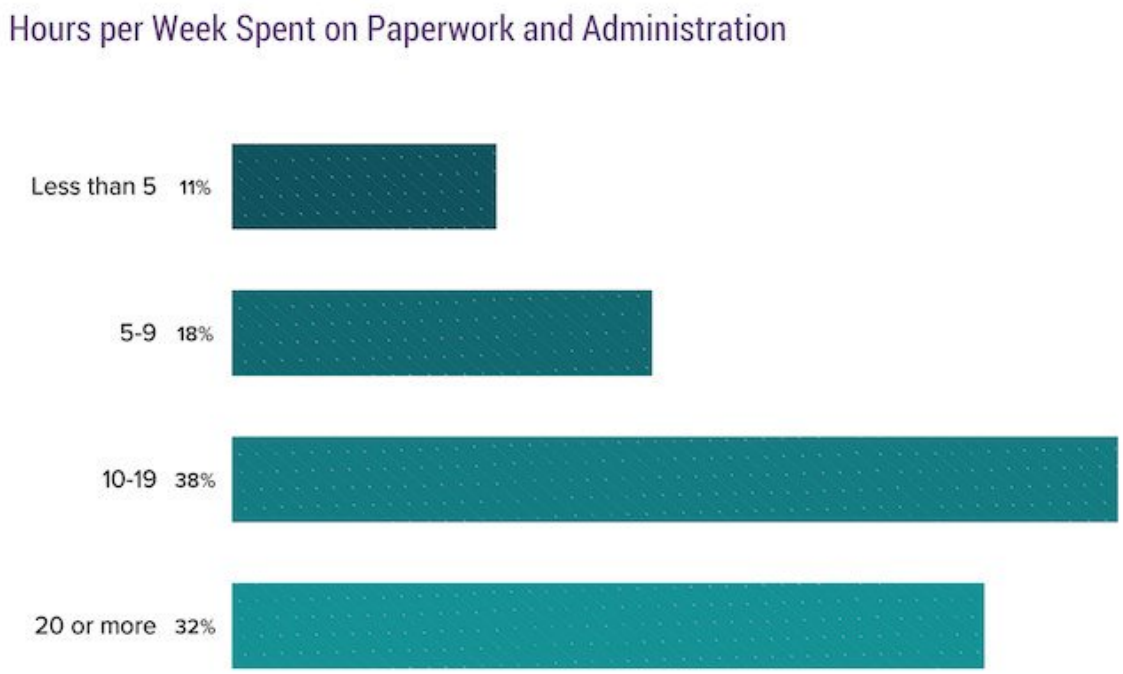


Source: Medscape National Physician Burnout & Depression Report 2018.

Likely contributing to burnout are the number of hours physicians spend on paperwork and administration. As indicated by the results from the *2018 Medscape Physician Compensation Report*, nearly one in three physicians (32%) say they are spending 20 or more hours per week on paperwork and administrative tasks, up from 20% last year.[37]

[37] Ibid.

Figure 23:



Source: Medscape Physician Compensation Report 2018.

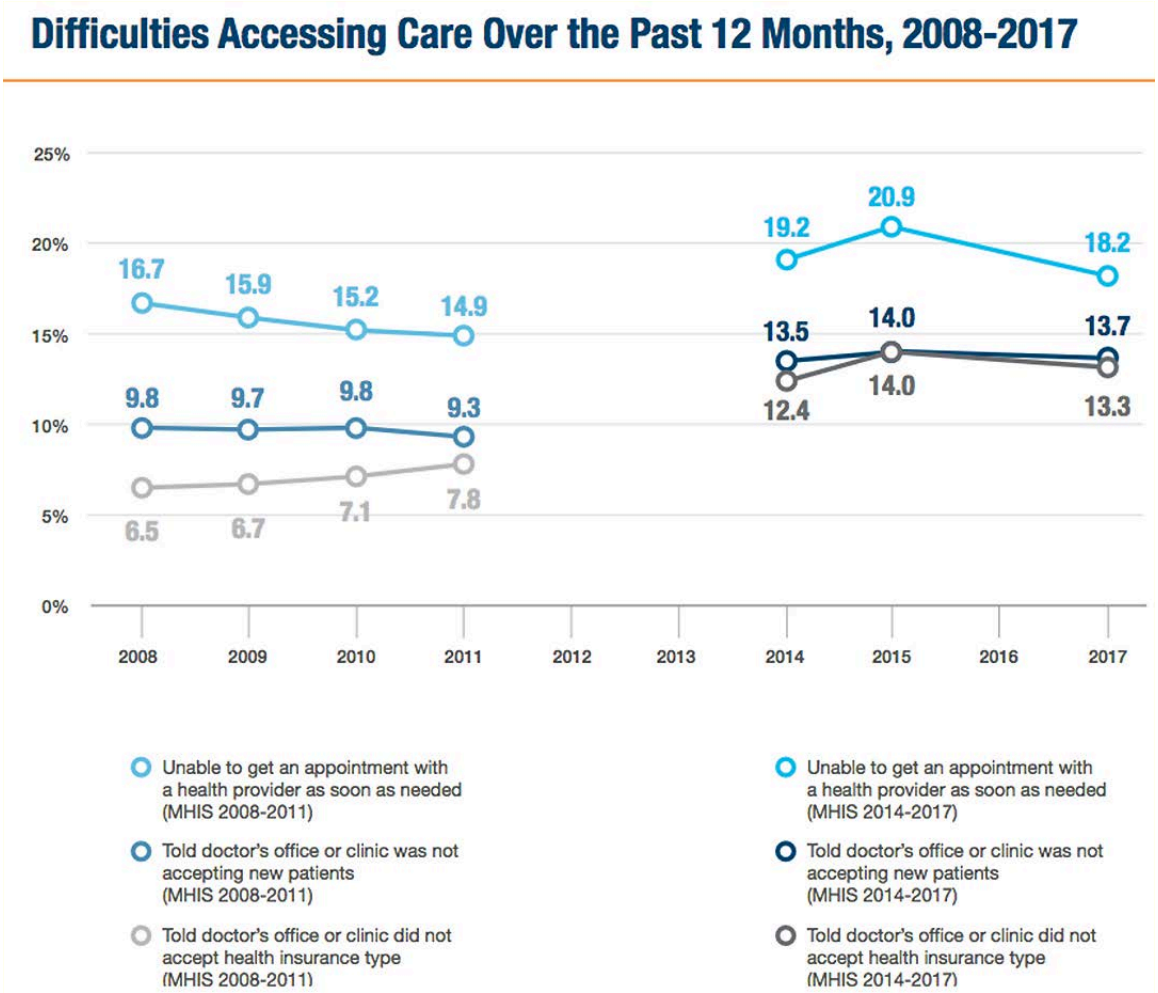
MASSACHUSETTS OVERVIEW

Access to Health Care

Based on the latest available data, Massachusetts continues to lead the nation in health insurance coverage, with an uninsured rate of 4%, compared to the national uninsured rate of 9%.[38] Uninsured Massachusetts residents are more likely to be male, single, without children, Hispanic, and low-income.[39] The majority (53%) of Massachusetts residents with coverage have employer-sponsored coverage.[40] Access to care is strong in Massachusetts, with 89% reporting a usual source of care and 82% indicating they had visited a doctor during the previous year. However, 18% of patients reported difficulty getting an appointment as soon as needed. Trend data for specific difficulties patients have had in accessing care over the past 12 months shows the following:[41]

[38] Health Insurance Coverage of the Total Population. Kaiser Family Foundation Website, 2016. http://kff.org/other/state-indicator/total-population/.
[39] Findings from the 2017 Massachusetts Health Insurance Survey. Center for Health Information and Analysis Website. CHIA, December 2017. Findings from the 2017 Massachusetts Health Insurance Survey.
[40] Ibid.
[41] Ibid.

Figure 24:



Source: Center for Health Information and Analysis (CHIA), 2017 Massachusetts Health Insurance Survey.[42]

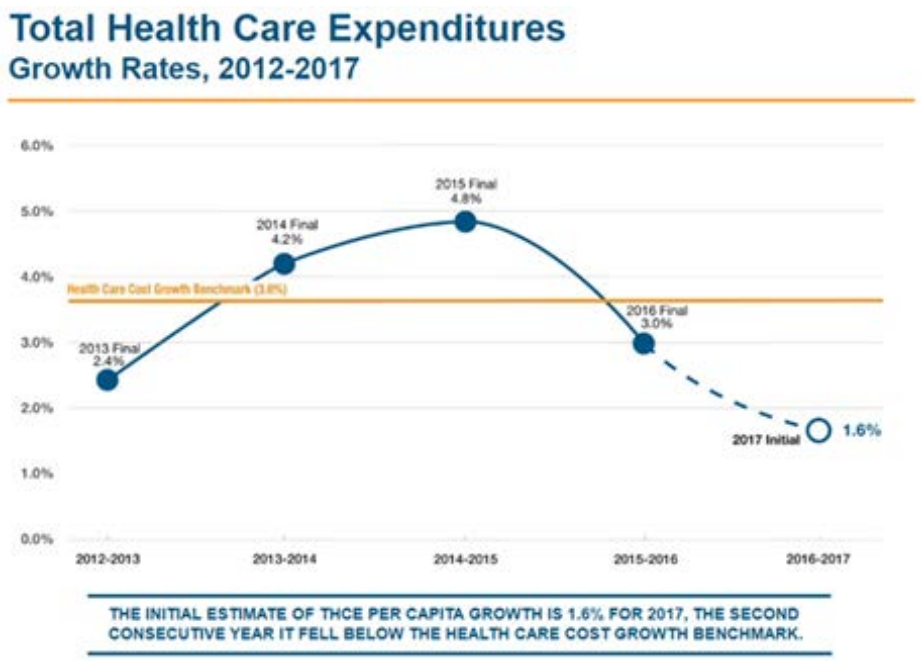
A portion of non-emergency care issues may be tied to access difficulties. For example, more than one in three emergency department visits in the Commonwealth are for non-emergency conditions. Of those Massachusetts residents reporting a non-emergent emergency department visit, 58% said the reason for the visit was because they were unable to get an appointment at a doctor's office or clinic as soon as needed. More than two-thirds (68%) indicated that they needed care after normal operating hours at a doctor's office or clinic.[43] However, cost is also an important access barrier. Specifically, about one in four (26%) of Massachusetts residents had unmet medical or dental care needs due to cost, while 78% of families with medical debt incurred that debt while insured.[44]

[42] Ibid.
[43] Ibid.
[44] Ibid.

Cost Trends in Massachusetts

Total health expenditures (THE) is a measure of total statewide health care spending in the Commonwealth. Massachusetts is finding success in bending the cost curve, as evidenced by a steady decline since 2014–2015. Below are the initial findings for 2017 and may be adjusted slightly by the state as more information is verified. THE grew by 1.6% from 2016–2017, well below the 3.6% statewide target for THE growth rate for the year, and also below the 3.0% growth for 2015–2016.[45]

Figure 25:

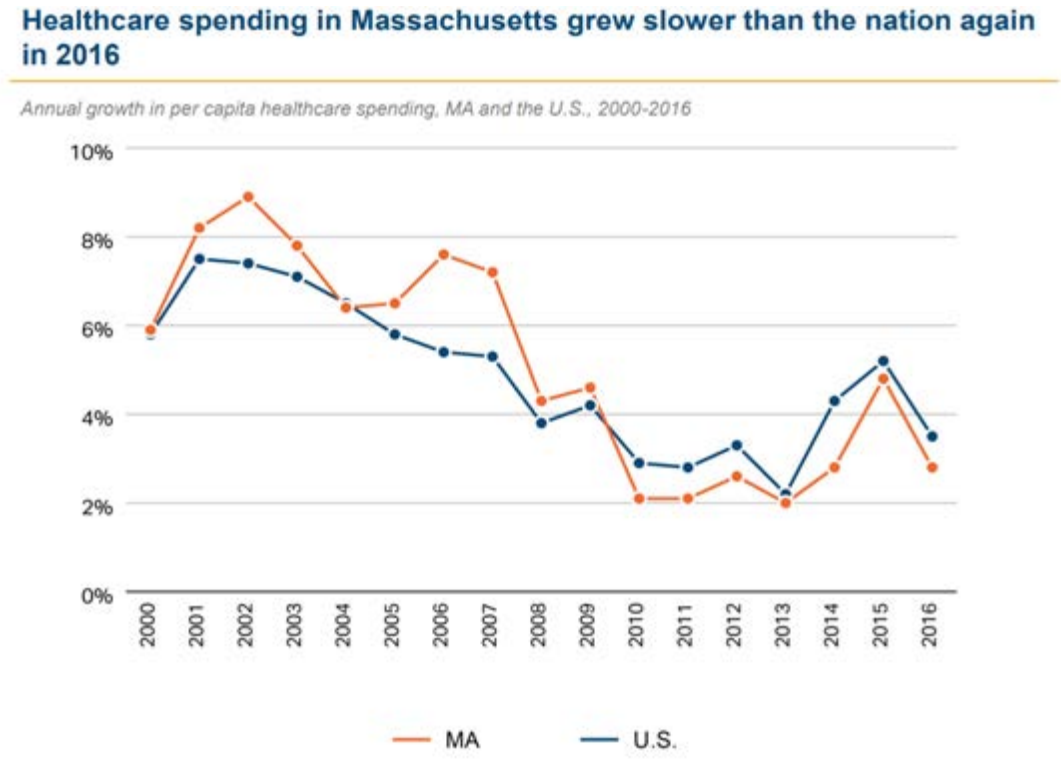


Source: Center for Health Information and Analysis (CHIA). *Performance of the Massachusetts Health Care System: Annual Report* (September 2018).[46]

Health care spending in Massachusetts continued a trend begun in 2010, where annual growth in per capita health spending remains below the US growth rate as outlined below.[47]

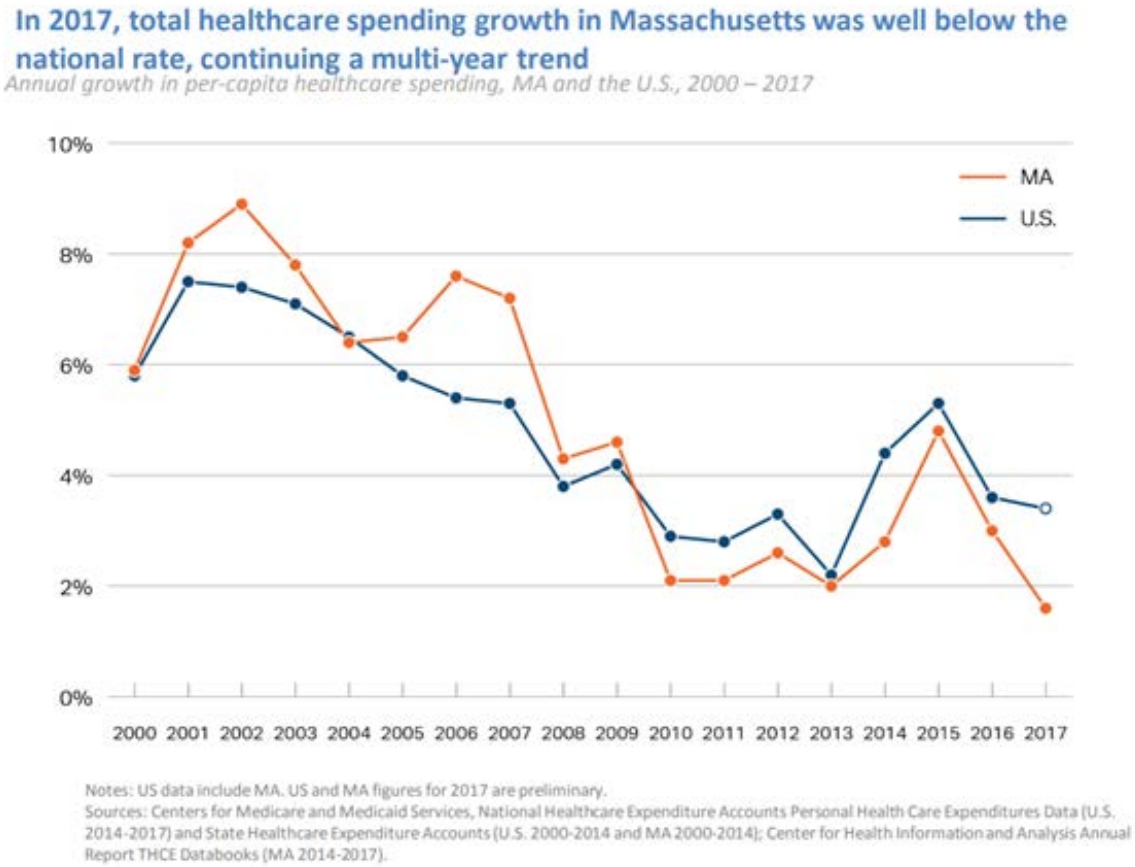
[45] Center for Health Information and Analysis (CHIA). *Performance of the Massachusetts Health Care System: Annual Report* (September 2018) retrieved on September 25, 2018, from http://www.chiamass.gov/assets/2018-annual-report/2018-Annual-Report.pdf.
[46] Ibid.
[47] Ibid.

Figure 26:



Source: Health Policy Commission Board Meeting. December 12, 2017.[48]

[48] Health Policy Commission Board Meeting. December 12, 2017. Retrieved on September 25, 2018, from https://www.mass.gov/files/documents/2017/12/20/20171212-commission-document-presentation.pdf.



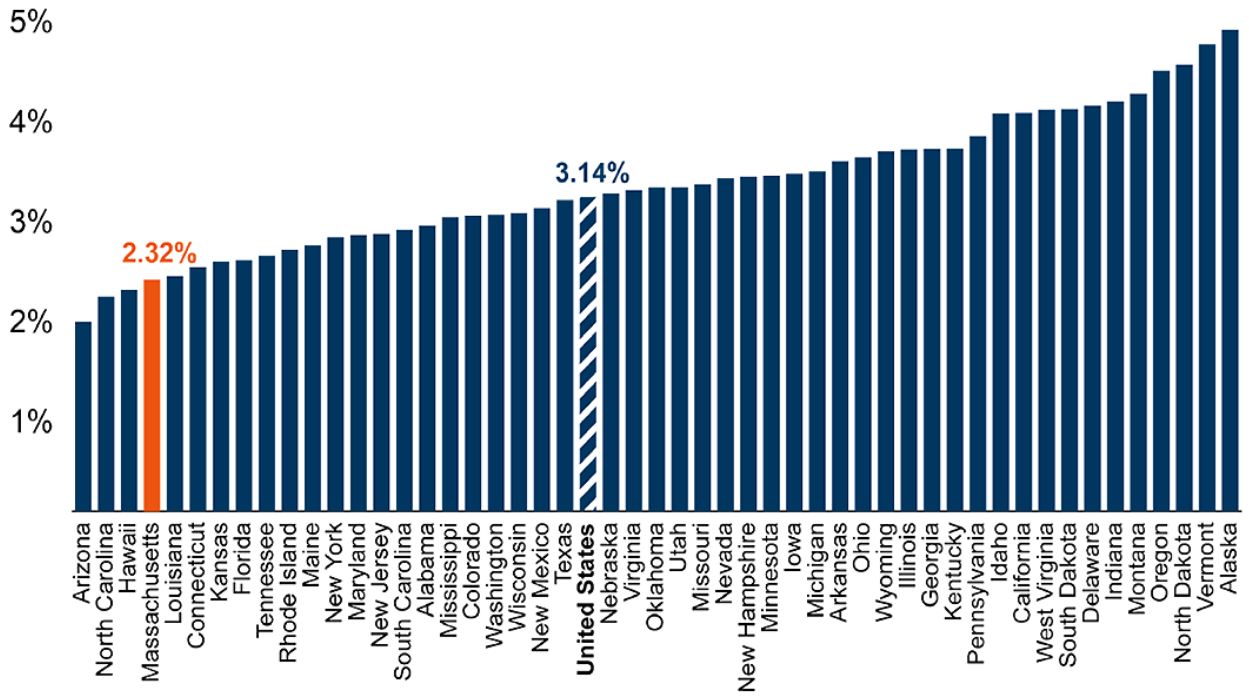
Source: Dr. David Auerbach Director of Research and Cost Trends, Massachusetts Health Policy Commission. *State Perspective on Health Care Cost Trends.* Retrieved on October 19, 2018 from https://www.mass.gov/files/documents/2018/10/16/HPC-CHIA.pdf.

Nationally, Massachusetts's efforts to control costs have resulted in a health care spending growth rate lower than all but three states.[49]

[49] Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2009-2014.

Figure 27:

Average Annual Health Spending Growth, Per Capita, By State, 2009–2014

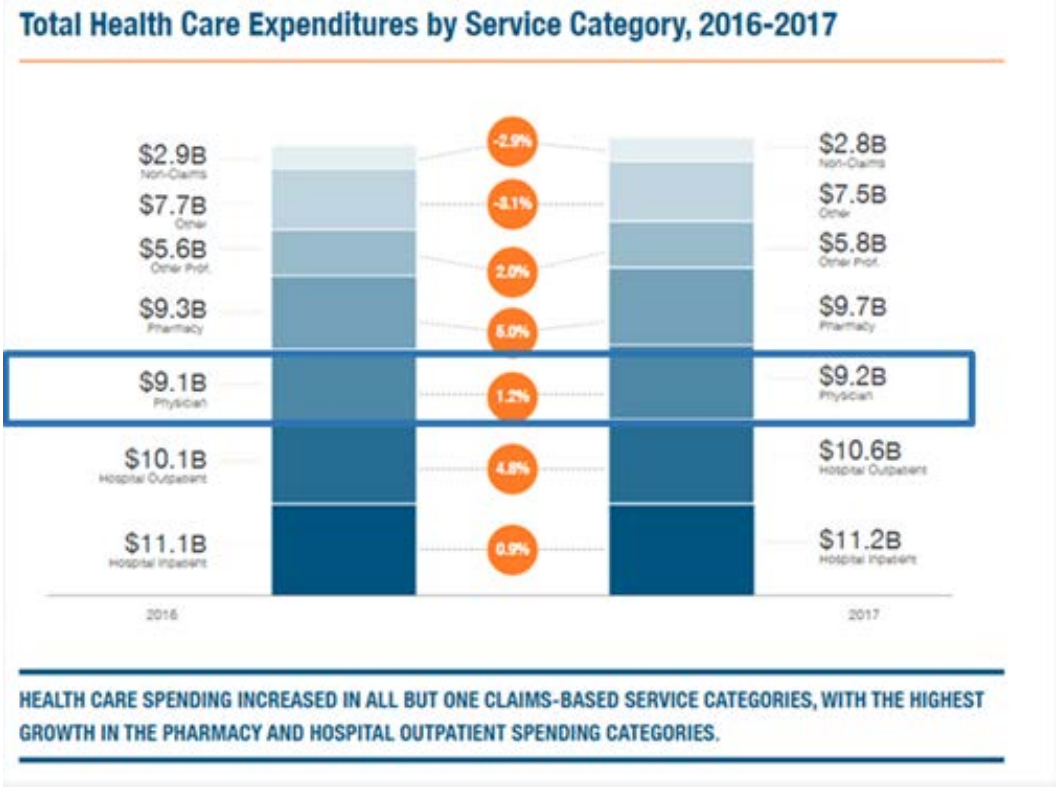


Source: Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2009 and 2014

Physicians in Massachusetts play a central role in the state's efforts to contain costs and are demonstrating an ability to successfully manage and contain total medical costs.[50] Specifically, physician costs in Massachusetts are rising very slowly over time; they rose 1.2% in 2017, according to data from the Center for Health Information and Analysis (CHIA). The physician cost growth rate is lower than most of the other claims categories, including pharmacy, hospital, and other professional service category expenditures.

[50] *Holding the Line: How Massachusetts Physicians Are Containing Costs.* Massachusetts Medical Society Website, 2017. http://www.massmed.org/costreport2017/.

Figure 28:

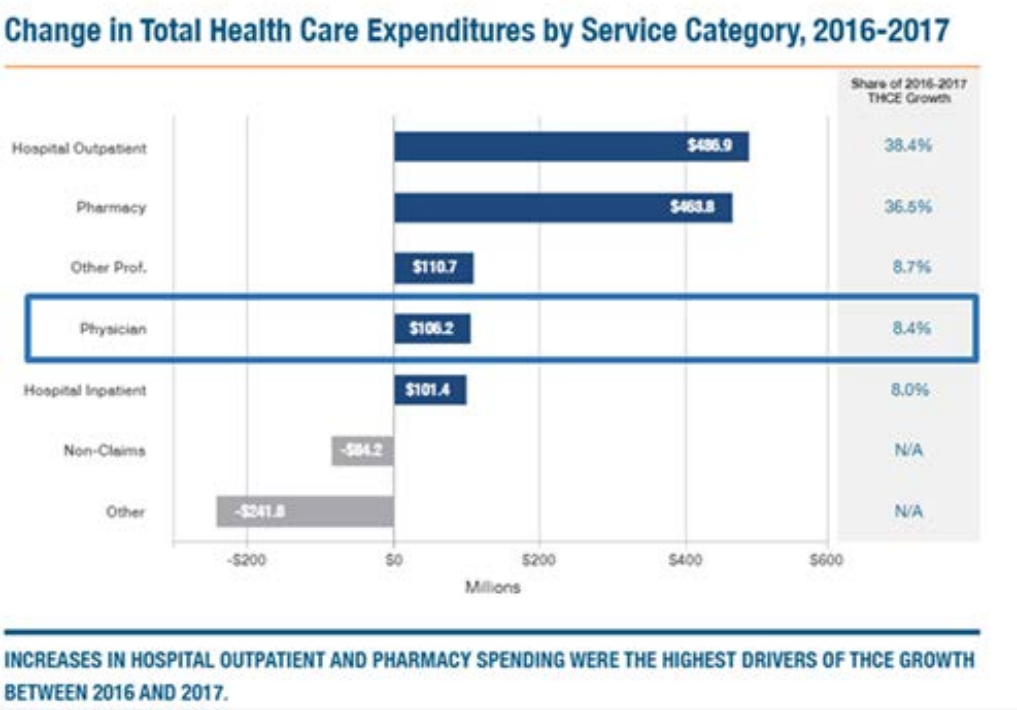


Source: Center for Health Information and Analysis (CHIA). *Performance of the Massachusetts Health Care System: Annual Report* (September 2018).[51]

Increases in hospital outpatient and pharmacy spending were the highest drivers of total health care expenditures (THCE) growth, each accounting for more than 1/3 of the growth; physicians as a spending category account for 8.4% of the growth.

[51] Source: Center for Health Information and Analysis (CHIA). *Performance of the Massachusetts Health Care System: Annual Report* (September 2018). Retrieved on September 25, 2018, from http://www.chiamass.gov/assets/2018-annual-report/2018-Annual-Report.pdf.

Figure 29:



Source: Center for Health Information and Analysis (CHIA). *Performance of the Massachusetts Health Care System: Annual Report* (September 2018).[52]

While MMS has a fair policy argument for the state government, particularly the legislature, to have a more hands-off approach with physicians than they have in the past, government officials' constituents, both patients and employers, continue to be negatively impacted by cost, specifically in the form of increases in premiums, cost sharing, and high-deductible health plans. In addition, the Massachusetts Association of Health Plans warned that, under a proposed law that would mandate nurse staff ratios, projected spending increases of $900 million would "likely result in increased premiums for employers and consumers, and based on these findings, will threaten our state's ability to meet the health care cost growth benchmark."[53]

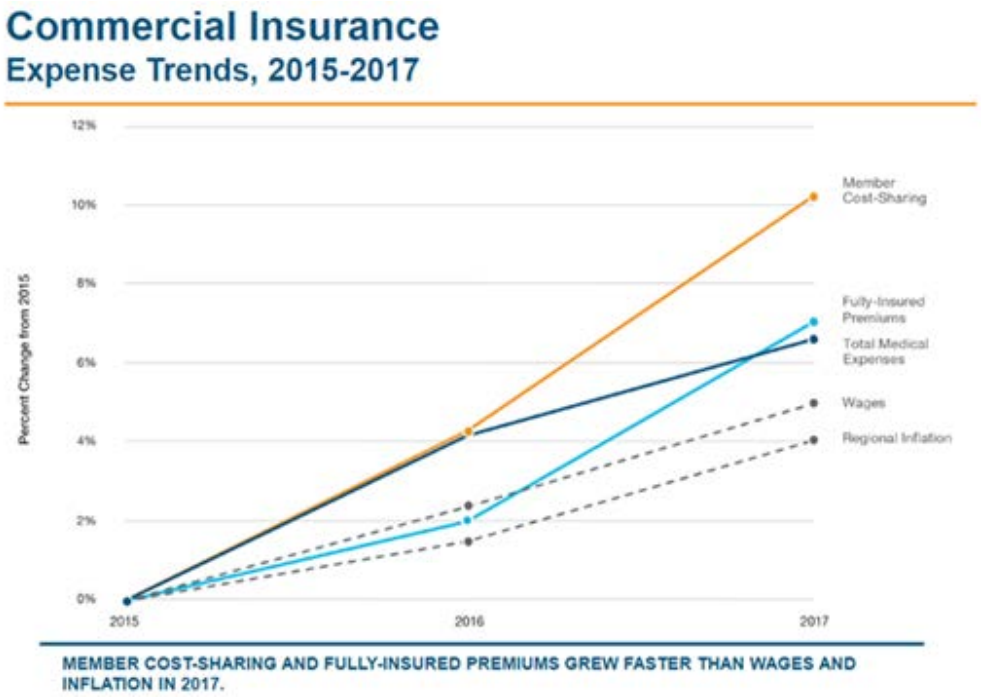
[52] Ibid.

[53] https://www.protectpatientsafety.com/2018/10/05/insurers-premiums-to-rise-if-question-1-passes-state-house-news/

Figure 30:

Source: Center for Health Information and Analysis (CHIA). *Performance of the Massachusetts Health Care System: Annual Report* (September 2018).[54]

Figure 31:



Source: Center for Health Information and Analysis. Presentation to the Health Policy Commission: CHIA's Annual Report. 2018 Cost Trends Hearing.[55]

And despite the state's successful efforts to control cost growth rates, the cost of premiums in Massachusetts remains high compared to US premiums, except for those on the state's exchange.[56]

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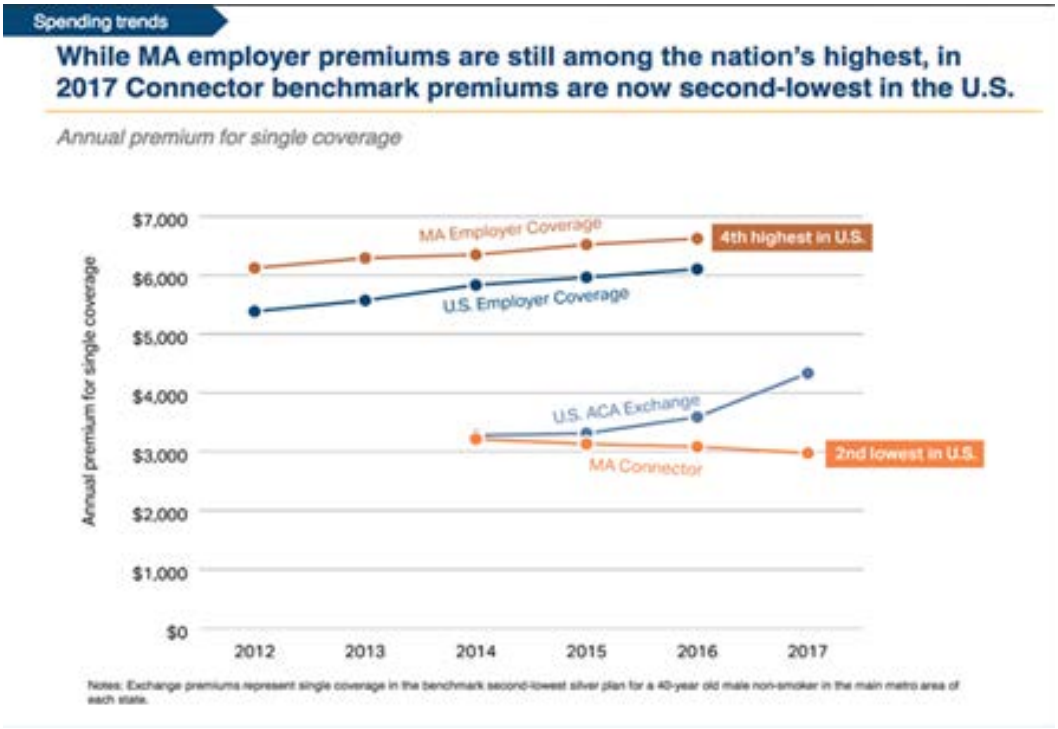
[54] Source: Center for Health Information and Analysis (CHIA). *Performance of the Massachusetts Health Care System: Annual Report* (September 2018). Retrieved on September 25, 2018, from http://www.chiamass.gov/assets/2018-annual-report/2018-Annual-Report.pdf.

[55] https://www.mass.gov/files/documents/2018/10/16/HPC-CHIA.pdf

[56] https://www.mass.gov/files/documents/2017/12/20/20171212-commission-document-presentation.pdf

Figure 32:

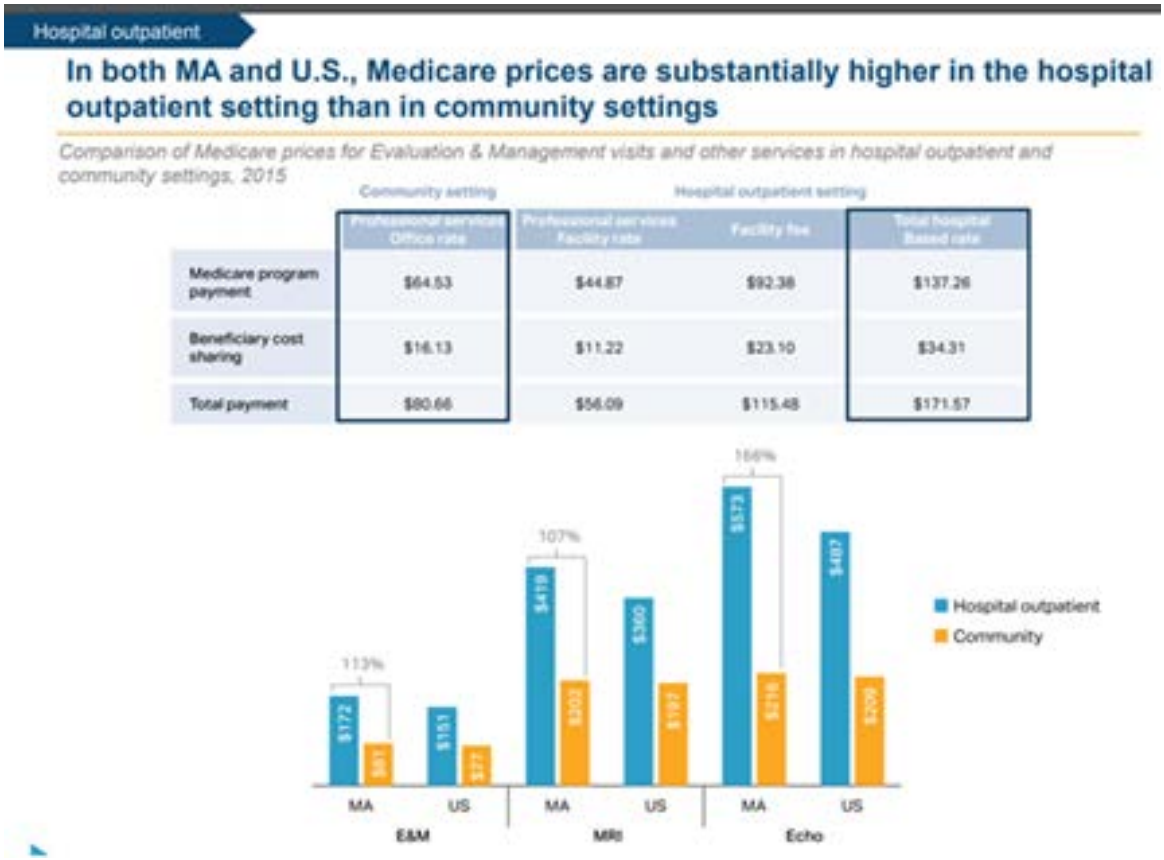


Source: Health Policy Commission Board Meeting. December 12, 2017.[57]

In Massachusetts, cost varies considerably by setting.

[57] https://www.mass.gov/files/documents/2017/12/20/20171212-commission-document-presentation.pdf

Figure 33:

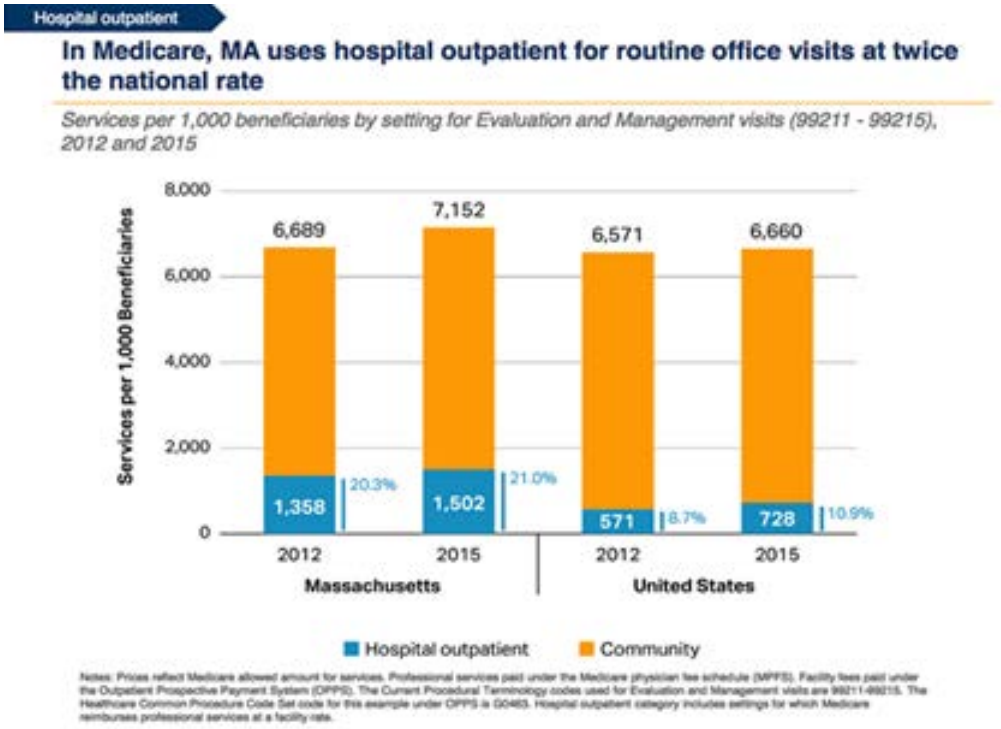


Source: Health Policy Commission Board Meeting. December 12, 2017.[58]

Further driving costs is the fact that for Medicare, Massachusetts uses hospital outpatient settings for routine visits at twice the national rate.

[58] Ibid.

Figure 34:



Source: Health Policy Commission Board Meeting. December 12, 2017.[59]

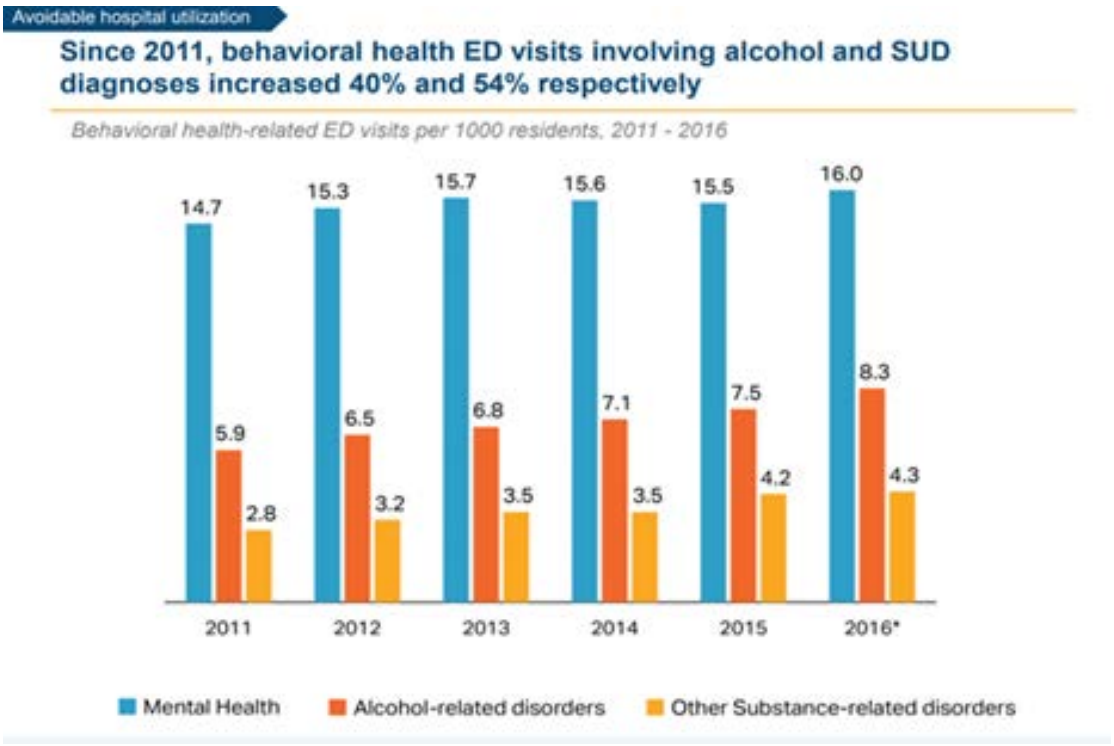
Given the remaining cost challenges the Commonwealth faces, we will need to remain vigilant as an advocacy organization as there will likely be a continued appetite for government interventions to control cost, particularly from the state legislature.

Access and Utilization

Emergency department utilization remains an issue in Massachusetts. In fact, employer groups representing thousands of businesses across the state said in May 2018 that they plan to reduce avoidable emergency room visits by 20% over the next two years, saving $100 million. The following illustrates the impact that substance use disorder, including the opioid epidemic, has had on ED visits.

[59] Ibid.

Figure 35:

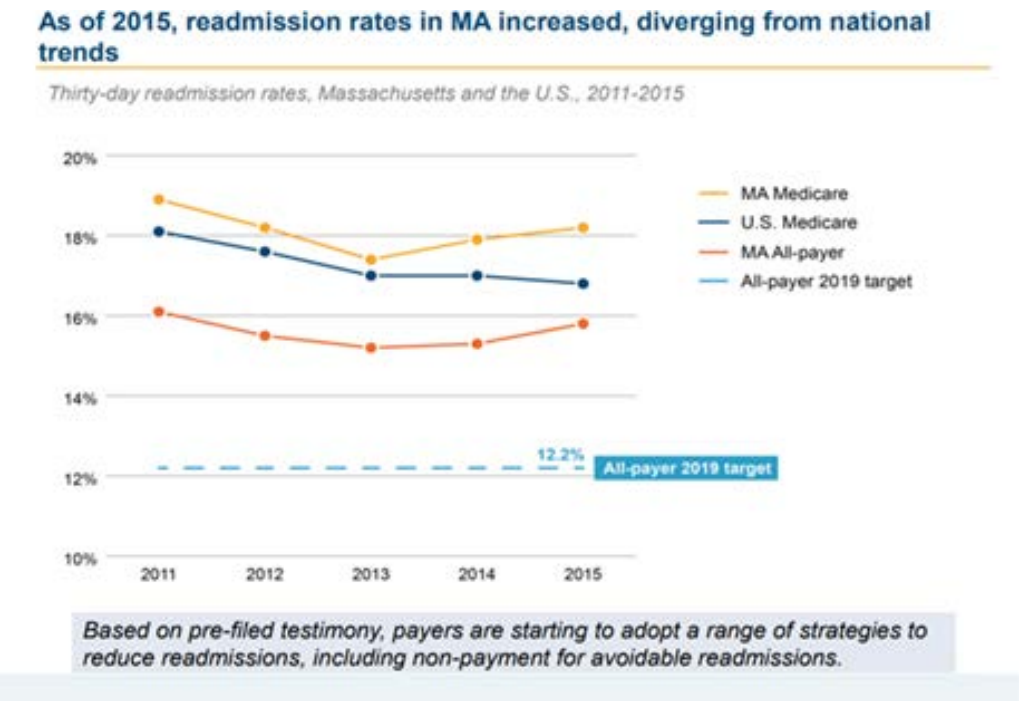


Source: Health Policy Commission Board Meeting. December 12, 2017.[60]

High 30-day re-admission rates can be important cost drivers. In Massachusetts, these rates were declining but have now started to increase, diverging from national trends. Specifically, while Massachusetts had been making strides in addressing high re-admission rates for Medicare patients, that momentum has slowed, and rates are now on the rise again according to the following data.

[60] Ibid.

Figure 36:



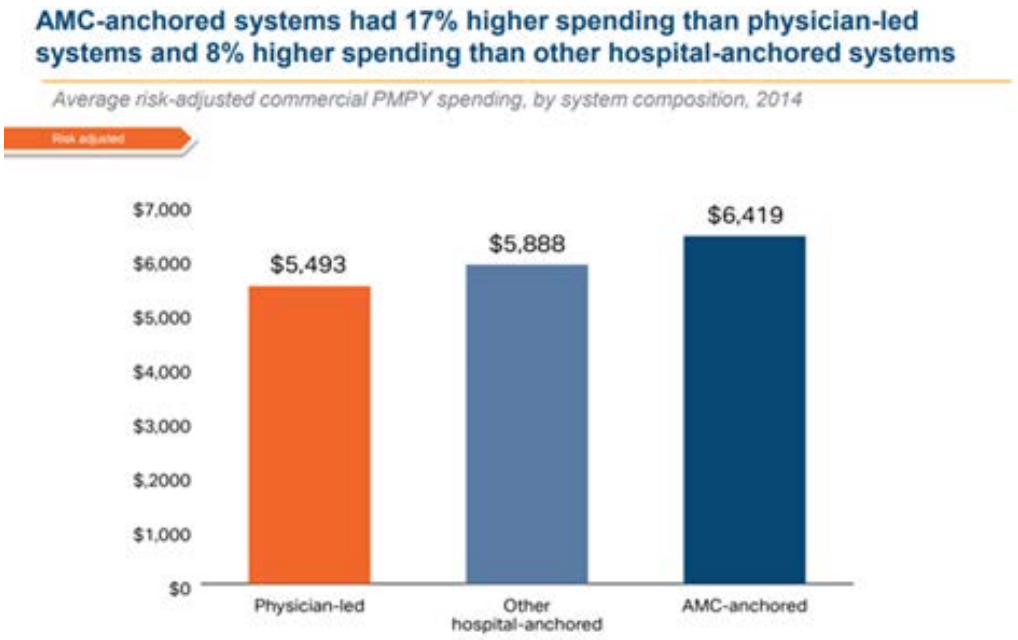
Source: Health Policy Commission Board Meeting. December 12, 2017.[61]

Performance of Physician-Led Teams

The Massachusetts HPC conducted an analysis of physician-led system cost and utilization compared to cost and utilization for systems anchored by academic or other hospital-based systems. Findings demonstrated that physician-led systems demonstrate lower spending than non-physician-led systems. As this report outlines, physician-led systems demonstrated 17% lower spending than academic medical center (AMC) anchored systems, and 7% lower spending than other hospital-anchored systems.[62]

[61] Ibid.
[62] Ibid.

Figure 37:

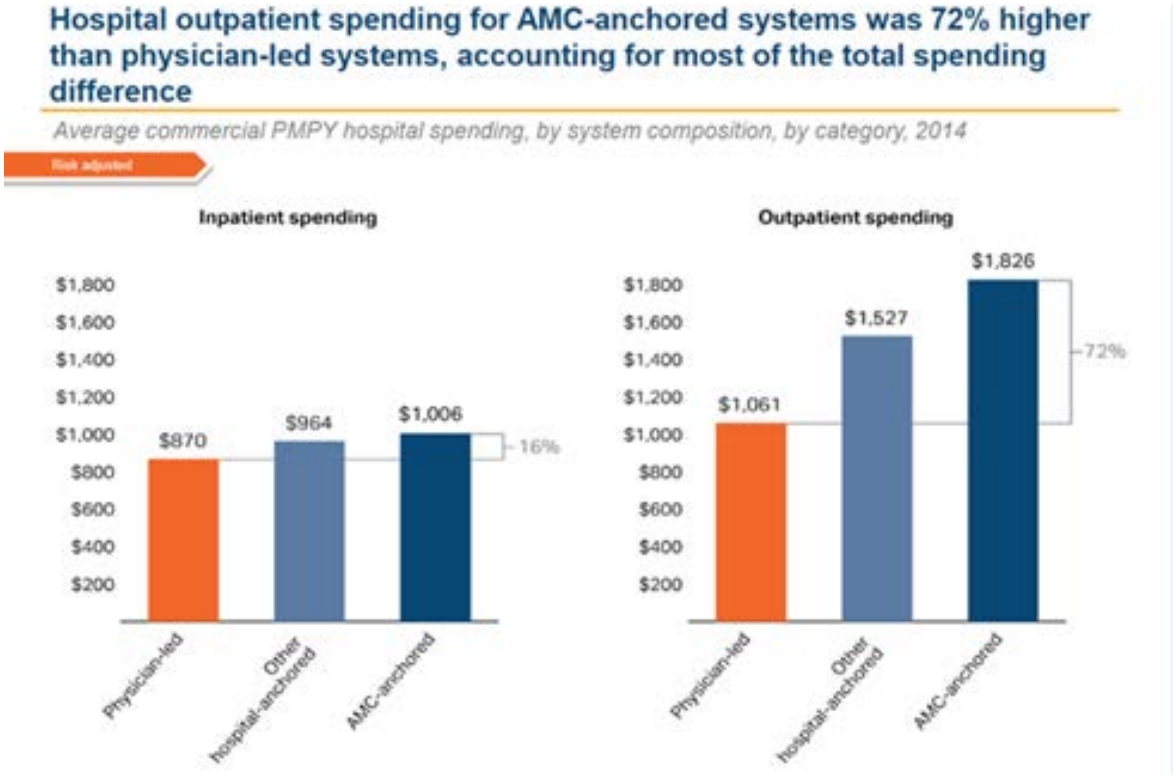


Source: Health Policy Commission Board Meeting. December 12, 2017.[63]

Physician-led teams did better controlling inpatient and outpatient hospital spending as well.

[63] Ibid.

Figure 38:

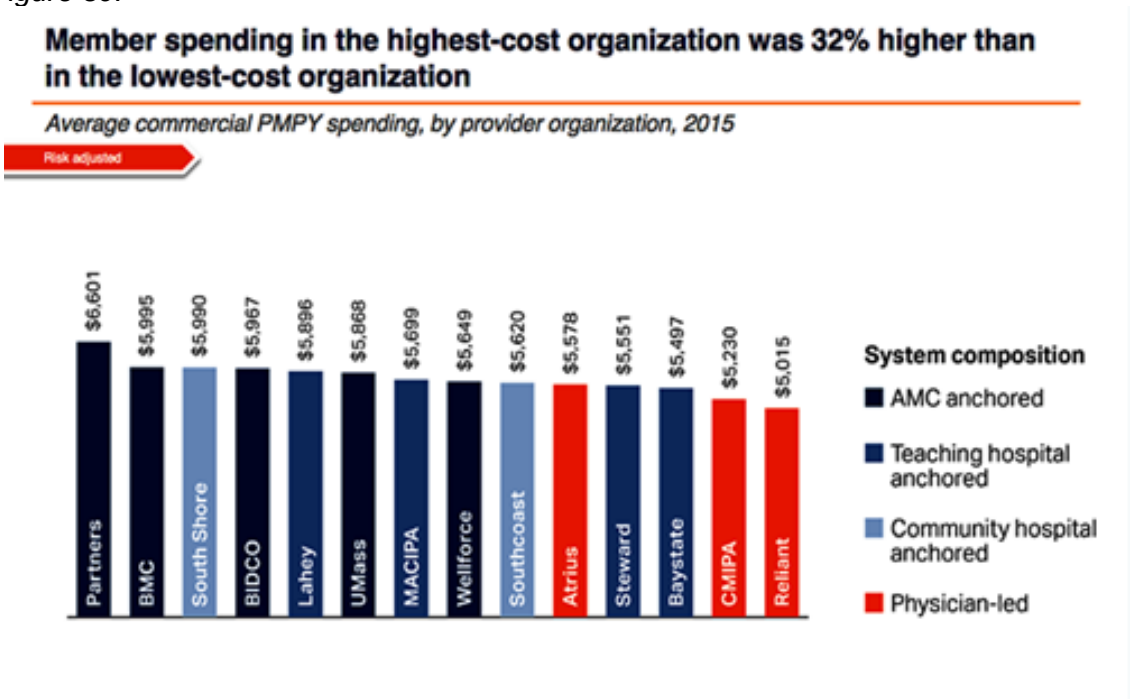


Source: Health Policy Commission Board Meeting. December 12, 2017.[64]

Average commercial per-member, per-year (PMPY) spending data also demonstrates the success of physician-led provider organizations in controlling costs.

[64] Ibid.

Figure 39:



Source: HPC DataPoints, Issue 6: Provider Organization Performance Variation: Patient Characteristics and Spending.[65]

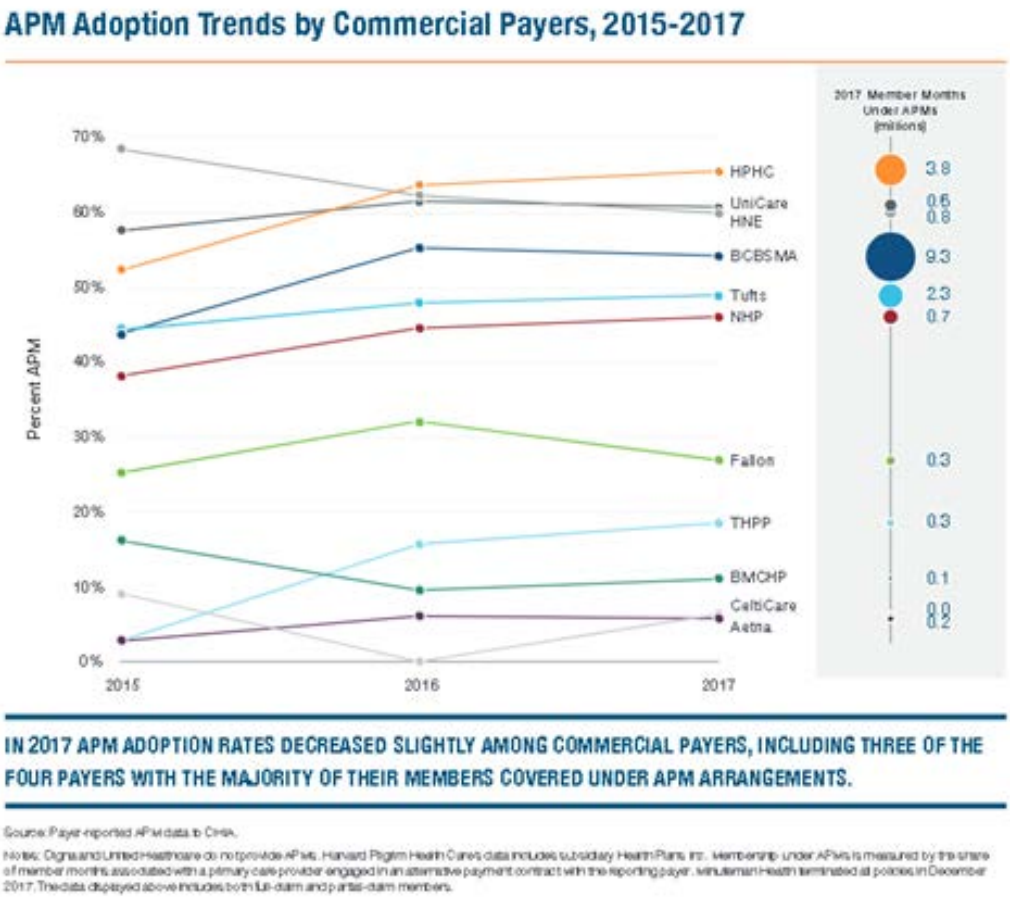
Alternative Payment Methodologies (APMs)

Adoption of APMs decreased by 1.3% in the commercial market in 2017, driven largely by a decline in HMO members covered under an APM.[66]

[65] https://www.mass.gov/service-details/hpc-datapoints-issue-6-provider-organization-performance-variation

[66] http://www.chiamass.gov/assets/2018-annual-report/2018-Annual-Report.pdf

Figure 40:



Source: Center for Health Information and Analysis (CHIA). *Performance of the Massachusetts Health Care System: Annual Report* (September 2018).[67]

Health Insurance Enrollment Trends

The following are the key findings from the August 2018 Enrollment Trends report from Massachusetts Center for Health Information and Analysis:

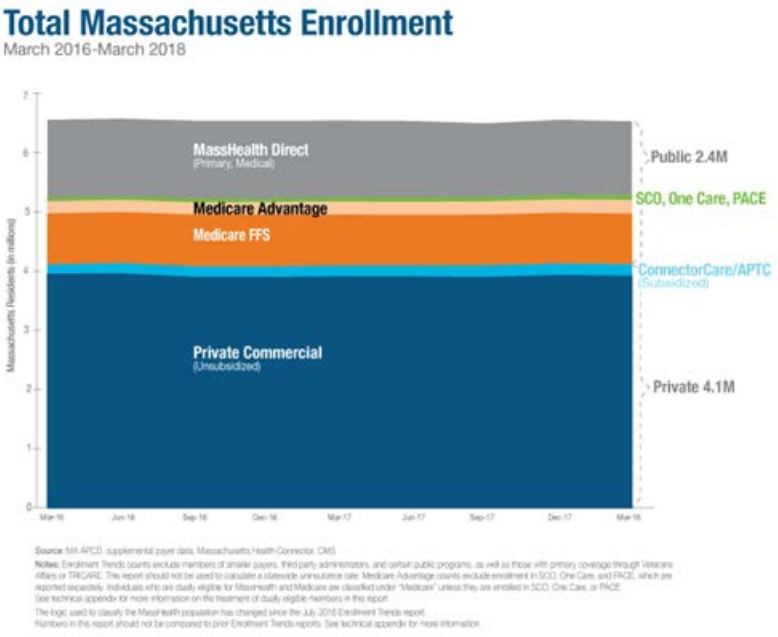
- Over four million Massachusetts residents received their primary medical health insurance coverage through private commercial insurance between March 2016 and March 2018.

- In March 2018, MassHealth shifted approximately two-thirds of its Managed Care Organization (MCO) and Primary Care Clinician (PCC) plan enrollees to Accountable Care Organization (ACO) plans.

[67] Center for Health Information and Analysis (CHIA). *Performance of the Massachusetts Health Care System: Annual Report* (September 2018) retrieved on September 25, 2018, from http://www.chiamass.gov/assets/2018-annual-report/2018-Annual-Report.pdf.

- Unsubsidized Qualified Health Plan (QHP) enrollment decreased by 14.4% (-7,000 members) from March 2017 to March 2018, while subsidized QHP enrollment increased by 55.0% (+5,000 members) over the same time period."[68]

Figure 41:



Source: Center for Health Information and Analysis. August 2018. Enrollment Trends.[69]

Conclusions:

The following is a list of future and continuing trends impacting the health care system in Massachusetts that MMS should keep in mind as they plan their strategic priorities for the coming year(s):

- Continued consolidation/mergers
- More momentum toward direct employer/system contracting for chronic and other services — self-insured programs
- Slow but steady increase in price transparency, patient engagement, and quality measurement
- Drug cost issues
- Use of artificial intelligence (to address burnout, EHR, population management, predicative analytics) and increased use of wearables and patient monitoring systems at home reduces office visits and improves the patient experience
- Reimbursement alternatives away from fee-for-service toward bundled, value-based, global payments

[68] http://www.chiamass.gov/enrollment-in-health-insurance

[69] Center for Health Information and Analysis. August 2018. Enrollment Trends. http://www.chiamass.gov/assets/Uploads/enrollment/2018-august/EnrollmentTrends-Aug2018-Report.pdf

- "Hospital Home" expands to reduce hospital stays and costs and increase patient satisfaction. Reduced reliance on post-acute institutions — driven to Home Care which is directed from a single/central control center (via monitors w/medical providers)
- Telemedicine
- Increase pressure on scope of practice and service provider expansion from MD/DO to Nurse Practitioners, Physicians Assistants
- Slow but consistence growth of Direct Primary Care, Concierge, Hybrid, Practice w/o walls
    - Expansion in Service Center footprints (locations):
    - Pharmacy Mini-Clinics; Neighborhood Urgent Care Centers/Clinics; Office-based Ambulatory Surgical Centers; Standalone — Radiology Provider(s); Standalone — Laboratory Stations

MMS's Potential Competitors

A scan of the Massachusetts landscape for provider advocacy organizations found the following potential MMS competitors:

- The physician's employer
  National specialty societies
    - American College of Physicians
- Massachusetts Health and Hospitals Association (MHA)
- Conference and education companies
- Independent physician health organizations
- Minority physician organizations
- Professional "Health Care" Associations
    - American College of Healthcare Executive
    - Healthcare Financial Management Association (HFMA)
    - Medical Group Management Association (MGMA)
    - Council of Accountable Physician Practices
    - American College of Private Physicians (Concierge)
    - American Association of Physician Leadership (physician leadership education and training)

MMS ACTIVITIES, SERVICES, AND MEMBER SURVEYS

The MMS continues to address the key issues facing Massachusetts physicians. As a foundation for understanding these topics, the MMS conducted surveys, interviews, and secondary research, as well as participated in a large number of local and national meetings with the administration, payers, policy experts, physician-leaders of large medical groups and ACOs, and practicing physicians in the community to gather critical input. Understanding key topics — and how they affect the way physicians deliver care — is critical.

Analysis of Massachusetts Physician Demographics

MMS merged and analyzed data from the Massachusetts Board of Registration in Medicine July 2018 file, July 2018 MMS Membership data, and 2017 Massachusetts Health Policy Commission HPC-RPO data. The MA-RPO (Registration of Provider Organization) Program was established through Chapter 224 of the Acts of 2012, An Act

Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation. The HPC-RPO dataset only contains data on provider or provider organizations with a patient panel of more than 15,000 or which represents providers who collectively receive more than $25,000,000 in annual net patient service revenue or is a risk-bearing provider organization. [70] The following provides an overview of these findings.

The Massachusetts physician population is aging; one-third of physicians graduated from medical school more than 30 years ago.

Figure 42:

MA Physician Age = Years since graduation

- Age of MA physicians (DOB no longer available from the BRM file)
  - Number of years since graduation from medical school as a proxy:
  - Mean = 24 years
  - Median = 23 years

Years since graduation	% of MA Physicians
0 to 5 years	6.3%
6 to 10 years	14.5%
11 to 20 years	24.6%
21 to 30 years	22.0%
more than 30 years	32.7%

Massachusetts physicians are 43% female, and 62% are specialists compared to 38% who engage in primary care. The findings on age stratified by gender show that Massachusetts physicians are increasingly female; older Massachusetts physicians are overwhelmingly male, while the majority of younger physicians are female.

Figure 43:

MA Physician Years since graduation by Gender

Years Since Graduation from Medical School	Female	Male
0 to 5 years	52.5%	47.5%
6 to 10 years	52.5%	47.5%
11 to 20 years	51.0%	49.0%
21 to 30 years	45.7%	54.3%
more than 30 years	27.2%	72.8%

[70] https://www.mass.gov/service-details/registration-of-provider-organizations

The following findings are concentrated on those Massachusetts physicians included in the HPC-RPO dataset. Although the HPC-RPO data set does not represent all of the physicians practicing within the state it does include a vast number of full and active licensed physicians. Nearly 2/3 of physicians in this file are listed as employed. More than 1/3 (38%) of the employed physicians in this file are MMS members while 47% of those listed as not employed in the data file are MMS members.

MMS Survey of Massachusetts Physicians — 2018

MMS contracted with Denneen & Company, a growth strategy consulting firm, to conduct a survey of Massachusetts physicians' opinions on MMS.

Project Background

In an effort to better understand physicians in MA, including both current members and non-members, and identify opportunities to grow their membership going forward, the Massachusetts Medical Society (MMS) engaged Denneen & Company to design, field, and analyze a quantitative research study.

- From February 7–February 20, 2018, 220 physicians with awareness of MMS completed a 15-minute online survey.
- To ensure non-biased responses and a representative distribution of physicians in MA, the survey was distributed blindly (MMS was not identified in the survey invitation) to a large and diverse panel of MA physicians.
- While the survey target was 200 responses, we received 20 additional completions prior to closing the survey.
- No quotas were used, but age, gender, practice type, ethnicity, and geography were all tracked.
- As part of their participation in the panel, respondents were paid a fee for their response.

Respondent Profile

- 220 total respondents, all with awareness of MMS
- 113 Members, 107 Non-Members
  - Non-Member breakdown: 72 former members, 25 considerers, 10 only aware of MMS
- 140 Men, 77 Women
- 89 Hospital based, 99 in Group or Private Practice
- 82% from Massachusetts
- 84% clinical physicians
- Broad mix of specialties, with 24% in internal medicine

Findings from the Executive Summary

Research results indicate that MMS has opportunities to better serve and satisfy current members, while increasing the perceived value of membership to non-members.

- Members largely indicate that MMS is the leading professional organization for physicians in MA, that MMS strives to serve all physicians across MA, and is a welcoming and inclusive organization.
- MMS enjoys high levels of awareness; however, the majority of non-members are previous members who have chosen to leave.

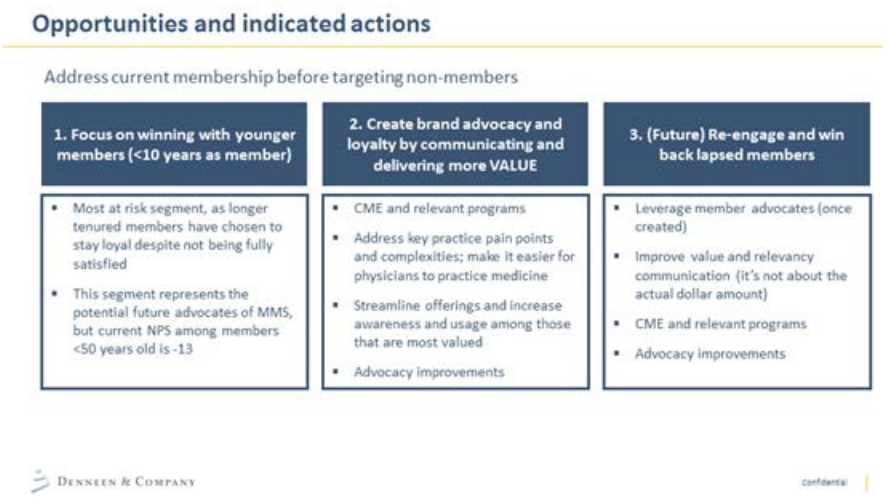
- Current members are only somewhat satisfied with MMS, while net promoter scores[71] are negative, reflecting a lack of member advocacy.
- Non-members are unlikely to join within the next 1–3 years based on the current state of MMS, and cite cost and lack of benefit as the reason they're not members.
- MMS does not appear to be addressing advocacy and policy agenda topics to the level expected by physicians (both members and non-members), especially the topics they find most important.
- Both members and non-members indicate that MMS should focus on improving CME offerings and developing new programs and benefits that are relevant to MA physicians (e.g., improving practice conditions/making it easier to practice).

Emerging Conclusions:

To maintain and grow membership going forward, it's recommended that MMS:

1. Target membership efforts and ensure loyalty among less tenured members (<10-year members).
2. Communicate and deliver more value via CME offerings and more relevant programs and benefits.
3. Create advocates to drive current member loyalty and potential membership among non-members in the long-term.

Figure 44:



Membership Activities

The annual membership survey will be conducted in January 2019.

Data on membership totals demonstrate that the Society remains a relevant, influential physician membership organization closing FY18 with another all-time high of 25,672 total members. The Society's Community Health Center program has recruited 41 facilities and 711 members, demonstrating that the Society's focus on meeting the needs

[71] "Net Promoter Score®, or NPS®, measures customer experience and predicts business growth." For more information go to https://www.netpromoter.com/know/.

of the community-based physicians and organizations should continue to be a focus in the coming years. The success of the Society's Physician Networking Events, which brought together members and non-members at networking event in Boston, Fitchburg and on the Cape, demonstrates that networking is an essential priority for MMS and its members across the Commonwealth.

Continuing Education

Data show that access to care continues to be an important priority for continuing education, given that more than 350 live and online participants engaged with faculty in learning about the current structure of our health system, single-payer and other models for the future, and the potential impact on the upcoming 2018 and 2020 elections.

The recent mandates from the MA Board of Registration in Medicine (BORM), which reduced the number of required CME/CPD credits for physicians from 100 to 50 for a two-year licensing period and required a one-time training on patients with cognitive impairments including Alzheimer's Disease and Dementia, demonstrate the need for the Society to remain vigilant in its strategic priorities to advocate for these important issues impacting physicians.

Practice Research and Resources

Physician Practice Resource Center (PPRC)

Data from the Society's PPRC demonstrates the ongoing importance of the Society's focus on practice viability. Specifically, between June 1, 2018, and August 31, 2018, PPRC received 297 emails or calls. This data includes 197 requests for scheduling for the Independent Claims Consultants that occurred in three locations — Springfield, Waltham, and Lakeville. Each physician practice could make up to 6–9 meetings per day with the variety of health plans and payors.

Of the remaining 100 calls/emails — Based on prior data, the range of topics that the other calls occupy are about seeking help with — in no particular order:

1- Starting a practice
2- Medical records
3- Closing a practice
4- Credentialing/Licensure
5- Human Resources
6- Payment issue with health plans
7- CME courses
8- A variety of other questions

Physician Burnout

The results of the Taskforce on Physician and Medical Student Burnout Polling Project demonstrate the importance of a continued focus by the Society on physician wellness and addressing physician burnout.

The Taskforce developed lists of root causes of burnout specific to:

- medical students;

- residents/fellows;
- early-career physicians (physicians younger than 40 years of age or in their first eight years of medical practice);
- private practice physicians; and
- employed physicians.

The Taskforce on Burnout requested that MMS research staff conduct a poll to determine if these five lists resonated with other committees and leaders within the MMS as well as key stakeholders at MHA.

Polling Project Analysis

- The poll resulted in a ranking of the root causes based on the popularity of the answers chosen by poll respondents.
- The report ranks the root causes for all respondent groups and separately for each constituent group ranking.

Polling Project Findings

Figure 45:

Top Three Root Causes of Burnout by Physician Type (August 2018)*				
Medical Student Burnout	**Residents and Fellows**	**Early-career Physicians**	**Private Practice Physicians**	**Employed Physicians**
Pressure to succeed	Work-life balance issues	Overwhelmed by work-life balance resulting in not feeling fully engaged with work Overworked — expected to see too many patients	EHRs	EHR burden
Perceived high-stakes game on each rotation: fear that inadequate performance may eliminate the potential to match and the specialty of choice	Non-physician tasks expected by physicians	Ideal vision of what starting a career should be isn't always the "reality" experienced	Clerical/ administrative burden	System feels broken
Fear of inadequate performance	Inefficiency in the healthcare system resulting in lack of time for direct patient care	Lack of mentoring	Frustration with quality measurement requirements	Extra hours of work at night

*Based on MMS-MHA Task Force on Physician Burnout root cause listing. The listing was then vetted by polling: MMS Sections: Medical Students and Resident/Fellows, the Committee on Early Career Physicians, and representatives from MHA's Physician Integration Council and MHA's Chief Medical Officers group.

Per a recent poll, physician burnout and wellness is being identified as a major area of focus for the Interspecialty Committee as well.

Federal and State Government Relations and Advocacy

At the federal level, the MMS continued to distinguish itself as a state medical society with national standing, advocating consistently for patients and our physicians who serve them. Highlights from our Congressional advocacy demonstrate the importance of a continued focus on physicians and patient advocacy at the federal level. Given the need for the following key Congressional advocacy activities over the past year, specific areas of focus should include:

- Reauthorization of the SCHIP and Community Health Centers
- Opioid legislation
- Opposition to continued efforts to repeal the ACA, including Graham-Cassidy bill
- Support for DACA
- Support for legislation allowing federal research into the causes and prevention of gun violence
- Support for Prescription Drug reform, including such measures allowing Medicare to negotiate for the price of drugs, requiring the AWP of drugs being included in advertising of drugs, greater transparency across the board regarding the cost of drugs, to name a few
- Support for comprehensive legislation to address mental health, substance use disorder and mental health parity
- Support for legislative changes to the *Sunshine Act*

Given the federal regulatory advocacy efforts of the past year, specific areas of focus should continue to include the following:

- Opposition to short-term insurance plans and association health plans exempt from the basic ACA patient protections
- Opposition to proposed Title X rules which would prohibit physicians and other health care professionals in Title X funded clinics from knowingly referring patients to abortion providers, the so-called “gag rule”
- Opposition to proposed rules which would allow physicians and other health care providers to refuse treatment to patients based on any perceived “moral or ethical” issues endemic to the patient, such as sexual orientation, or other issues
- Comments to the Medicare Physicians Payment Rules and proposed changes to the Quality Payment Program

At the federal level, the MMS should continue to voice its opposition to ill-advised Administrative actions such as the separation of refugee children from their parents at the borders.

State Government Advocacy

MMS will need to continue its focus on physician and patient advocacy by monitoring and intervening on legislative and regulatory initiatives that intrude on the practice of medicine, and on the patient-physician relationship. Specific examples of continued

focus should consist of the following areas based on key advocacy issues surfacing and addressed over the past year:

- There continues to be strong pressure in state government to address rising health care costs. While Massachusetts has done well constraining the rate of grown in the US over the past several years (including a remarkably low 1.6% rate of grown from 2017–2018), health insurance premiums and total cost sharing continues to rise significantly, including at a nearly 6% clip last year.[72] In addition, there continues to be large variation in health care costs between hospitals, even after controls for quality and patient acuity. We therefore expect the state legislature to continue to consider significant intervention to address health care costs. Last session, proposals included increases on physician licenses, and taxes on ambulatory surgery, office-based surgery, and urgent care to subsidize community hospitals. MMS successfully opposed those provisions but expects similar issues to be on the table in subsequent legislative sessions.

- MMS expects to see other related issues such as Out-of-Network billing to be on the legislature's agenda. MMS will continue to play a lead role, weighing-in on various proposals, and serving as a leader among state medical specialties, national specialties, and other interested stakeholders.

- MMS will need to continue to monitor and intervene on legislative and regulatory initiatives that intrude on the practice of medicine, and on the patient-physician relationship. For example, MMS negotiated to vastly improve a bill aimed at addressing care for persons with Alzheimer's disease, as well as regulations put forward by the Board of Registration in Medicine and MassHealth. MMS expects a continuation of these problematic bills that require MMS advocacy to improve or oppose.

- MMS will also need to continue to be a key player overseeing the implementation of many policies passed to address the opioid crisis. There will be multiple state special commissions, and a continued need to partner with state government to promote balanced policy that allows for comprehensive pain management.

Public Health

Given the importance and success of the Society's public health initiatives in the following areas, the MMS should continue its focus on the following topics:

1. Social determinants of health, a key area of focus for health policy and public health professionals and a priority for the state's Health Policy Commission (HPC);
2. Transmissible disease, a key area of focus for health policy and public health officials;
3. Substance use and misuse, given the ongoing national and state opioid crisis;
4. The patient-physician relationship, given the ongoing efforts by government officials to cut costs and increase administrative burdens that may erode the patient-physician relationship;

[72] Center for Health Information and Analysis. Presentation to the Health Policy Commission: CHIA's Annual Report. 2018 Cost Trends Hearing.

5. Access to prescription medication (October 25, 2018, Public Health Leadership Forum topic), given the rising costs of prescription drugs and the focus on controlling cost of prescription drugs by national and state government officials (e.g., the MA Health Policy Commission (HPC); and
6. Disaster preparedness, as evidenced by results from a global health survey of medical students indicating that disaster preparedness/humanitarian response was the top area of interest for MMS upcoming global health conferences.

CONCLUSION

As a leadership voice in health care, the Massachusetts Medical Society is dedicated to educating and advocating for the physicians of Massachusetts and patients locally and nationally. This report reflects the challenges present in today's health care environment and recommends the ways in which the MMS can continue to respond to those challenges, by influencing health-related legislation at the state and federal levels, working in support of public health, providing expert advice on physician practice management, and addressing issues of physician well-being.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	2
Code:	Resolution I-18 C-301
Title:	Clarification on Specificity and Flexibility of Investment Policy on Fossil Fuels, Climate Change, and Socially Responsible Investments
Sponsors:	Joseph Heyman, MD Essex North District Medical Society Joshua St. Louis, MD, President
Referred to:	Reference Committee C Mary Lou Ashur, MD, Chair

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

Whereas, The MMS has adopted this related policy from the American Medical Association:

ENVIRONMENTAL HEALTH
Fossil Fuels

a) The MMS concurs with the findings of the Intergovernmental panel on Climate Change's fifth assessment report that "human influence on the climate system is clear, and recent anthropogenic emissions of greenhouse gases are the highest in history"; that "recent climate changes have had widespread impacts on human and natural systems"; that "climate change will amplify existing risks and create new risks for natural and human systems"; and "that risks are unevenly distributed and are generally greater for disadvantaged people and communities in countries at all levels of development."

b) The MMS recognizes the importance of physician involvement in policymaking at the state, national, and global levels and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect human health;

c) The MMS encourages physicians to consider and promote environmentally responsible policies and practices in the health care setting

(MMS House of Delegates, 12/3/16)

Whereas, The MMS has adopted this related policy: "That the MMS will pursue a suitable way to invest a portion of its Portfolio in an appropriate alternative ("clean") energy fund and report back on progress and status to the HOD at I-17" (MMS House of Delegates, 12/3/16); and

Whereas, The MMS has adopted this related policy: "The MMS consider and report back on a shift of non-pension investments into socially responsible investments" (MMS House of Delegates, 12/3/16); and

Whereas, The Committee on Finance, in its response in COF Informational report I-17-04, has indicated only that it will retain the proxy voting services of the Institutional Shareholders Services, Inc. (ISS) using the customized MMS, US, and Institutional

guidelines to vote the shares held in the MMS portfolio (at an annual cost of $14,000), and continue to pursue appropriate investment of its portfolio in investments with high environmental, social, and governance (ESG) ratings; and

Whereas, The will of the MMS House of Delegates seemed to desire a more concerted effort to divest fossil fuel investments when fiscally responsible, and consistent with a shift of non-pension investments into socially responsible investments and appropriate alternative ("clean") energy funds; and

Whereas, As noted by the 65th World Medical Assembly in Durban in 2014,[1] physicians around the world are aware that fossil fuel air pollution reduces quality of life for millions of people worldwide, causing a substantial burden of disease, economic loss, and costs to health care systems; and

Whereas, According to World Health Organization data, in 2012, approximately "7 million people died, one in eight of total global deaths, as a result of air pollution" (WHO, 2014);[2] and

Whereas, The United Nations' Intergovernmental Panel on Climate Change (IPCC) notes that global economic and population growth, relying on an increased use of coal, continues to be the most important driver of increases in carbon dioxide emissions. These emissions are the major component of accelerating the amount of human fossil fuel greenhouse gas (GHG) emissions despite the adoption of climate change mitigation policies (IPCC, 2014);[3] and

Whereas, The burden of disease arising from climate change will be differentially distributed across the globe and, while it will affect everyone, the most marginal populations will be the most vulnerable to the impacts of climate change and have the least capacity for adaptation; and

Whereas, In many densely settled populated cities around the world, the fine dust measurable in the air is up to 50 times higher than the WHO recommendations. A high volume of transport, power generated from coal, and pollution caused by construction equipment are among the contributing factors (World Medical Association [WMA], SMAC 197, Air Pollution, WMA Statement on the Prevention of Air pollution due to Vehicle Emissions, 2014);[4] and

Whereas, Evidence from around the world shows that the effects of climate change and its extreme weather are having significant and sometimes devastating impacts on human health. Fourteen of the 15 warmest years on record have occurred in the first 15 years of this century (World Meteorological Organization, 2014).[5] The vulnerable among us—including children, older adults, people with heart or lung disease, and people living in poverty—are most at risk from these changes; and

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[1] www.wma.net/policies-post/wma-statement-on-divestment-from-fossil-fuels/
[2] www.who.int/mediacentre/news/releases/2014/air-pollution/en/
[3] www.ipcc.ch/
[4] www.wma.net/policies-post/wma-statement-on-the-prevention-of-air-pollution-due-to-vehicle-emissions/
[5] https://public.wmo.int/en/media/press-release/2015-hottest-year-record

Whereas, The Lancet Commission describes climate change as "the greatest threat to human health of the 21st century";[6] and

Whereas, The Paris agreement at COP21 on Climate calls upon governments "when taking action on climate change" to "respect, promote and consider their respective obligations on human rights (and) the right to health";[7] and

Whereas, "Although governments and international organizations have the main responsibility for creating regulations and legislation to mitigate the effects of climate change and to help their populations adapt to it, the World Medical Association (WMA), on behalf of … its physician members, feels an obligation to highlight the health consequences of climate change and to suggest solutions. … The WMA and National Medical Associations (NMAs) should develop concrete actionable plans/practical steps" to both mitigate and adapt to climate change (WMA, 2009);[8] and

Whereas, The WMA recommends that its national medical associations and all health organizations:

1. *Continue to educate health scientists, businesses, civil society, and governments concerning the benefits to health of reducing greenhouse gas emissions and advocate for the incorporation of health impact assessments into economic policy.*
2. *Encourage governments to adopt strategies that emphasize strict environmental regulations and standards that encourage energy companies to move toward renewable fuel sources.*
3. *Begin a process of transferring their investments, when feasible without damage, from energy companies whose primary business relies upon extraction of, or energy generation from, fossil fuels to those generating energy from renewable energy sources.*
4. *Strive to invest in companies upholding the environmental principles consistent with the United Nations Global Compact (www.unglobalcompact.org), and refrain from investing in companies that do not adhere to applicable legislation and conventions regarding environmental responsibility; and*

Whereas, The American Medical Association (AMA) hired an independent agency that had not done business with the AMA before, Mercer Investments, a subsidiary of March & McLennon Companies ($13.2 billion in revenue), and a global leader in providing institutional investment services, to analyze 1) an overview of fossil fuel divestment among large institutional investors; 2) back tests over the last twenty years, evaluating the impact of fossil fuel divestment on both the actual AMA portfolio and market index portfolios with respect to return and risk; and (3) future return and risk projections utilizing Mercer's capital market assumptions, comparing a portfolio of no constraints with a portfolio implementing fossil fuel divestment; and

Whereas, 1) Mercer found that most large institutions, especially those with retirement plans with fiduciary responsibility for the finance of their pensioners, have yet to divest. Of the 100 largest endowment and foundations, six have committed to divest with the most common focus limited to divestment of investments in coal mining companies; 2) analysis

[6] www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(09)60935-1.pdf
[7] www.un.org/ga/search/view_doc.asp?symbol=FCCC/CP/2015/L.9/Rev.1&Lang=E
[8] https://www.wma.net/policies-post/wma-statement-on-divestment-from-fossil-fuels/

of a 20-year period ending December 2017, found that a divestment of fossil fuels from the AMA Reserve Portfolio is unlikely to result in a material change to risk or return, with an increase in total risk of 15 basis points as expected by a more constrained portfolio, and a partial offset by 7 basis points in expected return; 3) while a divested portfolio would have delivered a slightly higher return on a prospective basis, it would do so with higher risk or volatility resulting in the same return for risk measurement as the current portfolio;[9] and

Whereas, The tobacco sector represents 1% of the MSCI (formerly Morgan Stanley Capital International and MSCI Barra) All World Index and fossil fuels represent 6%; and

Whereas, The AMA House of Delegates adopted this policy after the Mercer study at Annual 2018 (and this is used as the template for the first three resolves listed below):

1. *That our AMA, AMA Foundation, and any affiliated corporations work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels;*
2. *That our AMA choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption;*
3. *That our AMA support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers; and*

Whereas, In a recent New Energy Outlook Report this past summer, the 65 international analysts of Bloomberg New Energy Finance Limited finds cheap renewables and batteries remake the world's power systems, with wind and solar producing nearly half of world electricity by 2050;[10] and

Whereas, The Bloomberg report further describes that the price of photovoltaic modules has dropped 83% since 2010, on an exponential curve that has shown a cost reduction of 28.5% for every doubling of photovoltaic capacity;[11] and

Whereas, Our investment advisor, Meketa Investment Group (Meketa), has stated that divestment of fossil energy investments is not effective; and

Whereas, Meketa will continue pursuing appropriate investment of its portfolio in investments with high ESG ratings, in spite of Meketa not finding any alternative energy funds that meet its standards; and

Whereas, If this were tobacco, no matter what the impact, we would divest; and

Whereas, If this were apartheid, no matter what the impact, we would divest; and

Whereas, Fossil fuels and climate change have a much higher impact on the health and welfare of human beings than either tobacco or apartheid; therefore, be it

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[9] http://www.massmed.org/AMAreport/
[10] https://about.bnef.com/new-energy-outlook/
[11] Ibid.

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

1. **That the MMS, the MMS and Alliance Foundation, and any affiliated corporations or subsidiaries work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels. *(D)***

2. **That the MMS choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption. *(D)***

3. **That the MMS support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers. *(D)***

4. **That the MMS shall report annually to the HOD, for a period of seven years, on progress toward divestment of fossil fuel investments. *(D)***

5. **That the MMS shall report annually to the HOD, for a period of seven years, on the voting decisions made in proxy voting services of the Institutional Shareholders, Services, Inc. (ISS) using the customized MMS, US, and International guidelines to vote the shares held in the MMS Portfolio. *(D)***

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	3
Code:	Resolution I-18 C-302
Title:	Advancing Gender Equity in Medicine
Sponsors:	Julie K. Silver, MD Michael S. Sinha, MD, JD, MPH
Referred to:	Reference Committee C Mary Lou Ashur, MD, Chair

Diversity and Progress

Whereas, Workforce Diversity is defined as the presence of people from many different backgrounds, and Workforce Inclusion[1] represents how these individuals are able to equitably be promoted, compensated, and supported in their careers; and

Whereas, Women physicians have documented gaps in compensation and career advancement at all levels, and these gaps widen over their career trajectory;[2] and

Whereas, The published literature has documented that progress for women physicians has been slower than would be anticipated given the growing numbers of women in medicine;[3] and

Whereas, Traditional justifications for the lack of or slow progress for women in medicine have been refuted[4] and there has been a shift away from focusing on the women themselves and towards addressing institutional and structural bias and other barriers;[5] and

Whereas, There is a continuum of documented disparities for women in medicine, from micro- to macro-inequities, and it is theorized that a culture which supports pervasive micro-inequities provides opportunities for macro-inequities to flourish;[6] and

Whereas, Workforce disparities for women physicians may negatively impact a patient's ability to receive services and the quality of the services provided;[7] and

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[1] Silver JK, Slocum CS, Bank AM, et al. Where Are the Women? The Underrepresentation of Women Physicians Among Recognition Award Recipients From Medical Specialty Societies. *PM R.* 2017;9(8):804-815.

[2] Carr PL, Gunn CM, Kaplan SA, Raj A, Freund KM. Inadequate progress for women in academic medicine: findings from the National Faculty Study. *J Womens Health (Larchmt).* 2015;24(3):190-199.

[3] Helitzer DL, Newbill SL, Cardinali G, Morahan PS, Chang S, Magrane D. Changing the Culture of Academic Medicine: Critical Mass or Critical Actors? *J Womens Health (Larchmt).* 2017;26(5):540-548.

[4] Carnes M, Morrissey C, Geller SE. Women's health and women's leadership in academic medicine: hitting the same glass ceiling? *J Womens Health (Larchmt).* 2008;17(9):1453-1462.

[5] Lillemoe KD. Surgical Mentorship: A Great Tradition, But Can We Do Better for the Next Generation? *Ann Surg.* 2017;266(3):401-410.

[6] Silver JK, Rowe M, Sinha MS, Molinares DM, Spector ND, Mukherjee D. Microinequities in Medicine. *PM R*. 2018 Oct;10(10):1106-1114.

[7] Myers CG, Sutcliffe KM. How Discrimination Against Female Doctors Hurts Patients. *Harvard Business Review.* August 30, 2018. Available at: https://hbr.org/2018/08/how-discrimination-against-female-doctors-hurts-patients.

Whereas, Reports in the published literature have documented gaps in medical societies' efforts to tackle workforce and patient health disparities[8] and have called on them to more critically assess their efforts through metrics, outcomes, and reporting methodology that is consistent with that used in evidence-based medicine;[1] and

Whereas, Physicians are working together in a grass roots effort to encourage their organizations to be better allies (e.g., national campaigns such as the Societies As Allies Campaign[9] and the Be Ethical Campaign);[10] and

Unequal Pay

Whereas, Recent studies have demonstrated that there are persistent pay disparities for women physicians that begin early in their careers and across practice settings, specialties, and positions — with the gaps more pronounced for mid- and late-career women;[11,12,13,14] and

Whereas, Gender pay disparities exist even when other factors are accounted for, including differences in age, years of experience, specialty, reported work hours, clinical productivity, research productivity, and faculty rank;[12,14,15] and

Whereas, Gaps in compensation between men and women physicians widen over the physician's career trajectory, particularly for women with intersectionality (those who also identify with other underrepresented groups);[16] and

Whereas, A recently published analysis of salary differences at 24 US public medical schools found that the annual salaries of female physicians were $19,879 (8%) lower than the salaries of male physicians; this difference persisted through all faculty ranks;[9] and

Whereas, The 2018 Medscape Physician Compensation Report found that male primary care physicians earned almost 18% more than their female counterparts, and among specialists, that gap widened to about 36%;[17] and

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[8] Peek ME, Wilson SC, Bussey-Jones J, et al. A study of national physician organizations' efforts to reduce racial and ethnic health disparities in the United States. *Acad Med.* 2012;87(6):694-700.

[9] #SocietiesAsAllies - Twitter Search. 2018; Available at https://twitter.com/search?q=%23SocietiesAsAllies&src=typd.

[10] Silver JK. Be Ethical: A Call to Healthcare Leaders: Ending Workforce Disparities is an Ethical Imperative. Sept 2018. Available at http://sheleadshealthcare.com/wp-content/uploads/2018/09/Be-Ethical-Campaign.pdf.

[11] Jena AB, Olenski AR, Blumenthal DM. Sex Differences in Physician Salary in US Public Medical Schools. *JAMA Intern Med*. 2016 Sep 1;176(9):1294-304.

[12] Sanfey H, Crandall M, Shaughnessy E, Stein SL, Cochran A, Parangi S, Laronga C. Strategies for Identifying and Closing the Gender Salary Gap in Surgery. *J Am Coll Surg*. 2017 Aug;225(2):333-338.

[13] Willett LL, Halvorsen AJ, McDonald FS, Chaudhry SI, Arora VM. Gender differences in salary of internal medicine residency directors: a national survey. *Am J Med.* 2015 Jun;128(6):659-65.

[14] Jagsi R, Griffith KA, Stewart A, et al. Gender differences in the salaries of physician researchers. *JAMA*. 2012;307: 2410e2417.

[15] Ly DP, Seabury SA, Jena AB. Differences in incomes of physicians in the United States by race and sex: observational study. *BMJ.* 2016;353:i2923.

[16] Carr PL, Gunn CM, Kaplan SA, Raj A, Freund KM. Inadequate progress for women in academic medicine: findings from the National Faculty Study. *J Womens Health (Larchmt)*. 2015;24(3):190-199.

[17] Kane L. Medscape Physician Compensation Report 2018. Available at: https://www.medscape.com/slideshow/2018-compensation-overview-6009667.

Whereas, The city of Chicago can no longer ask about salary history on employment applications, part of a growing effort nationwide to improve pay equality between men and women;[18] and

Whereas, Studies have historically found a payment disparity gap among male and female physicians within the same specialty,[19,20] and this payment disparity continues to exist in all specialties of medicine in 2018;[21,22] and

Whereas, Among cohorts of equal training and experience, adjusting for variables including work hours, calls, vacation, gender, academic versus non-academic practice, women held less advanced academic positions, earning significantly less compensation ten years after graduation;[23] and

Whereas, Significant differences in salary also exist among male and female physicians with faculty appointments at US public medical schools, even after accounting for age, experience, specialty faculty rank, and measures of research productivity and clinical revenue;[11] and

Whereas, The Lilly Ledbetter Fair Pay Act took effect in 2009, restoring protection against pay discrimination that had been undermined by a recent US Supreme Court decision;[24] and

Whereas, The Massachusetts Equal Pay Act took effect July 1, 2018, requiring, among other things, equal pay for comparable work, non-prohibition of voluntary wage disclosure to others; prohibitions on asking about salary history; and prohibitions on retaliating against employees who exercise their rights under the Act;[25] and

Organizational Efforts

Whereas, The National Institutes of Health (NIH) has speaker guidelines that focus on the inclusion of women in medicine at scientific conferences[26] and publishes workforce inclusion metrics for women in medicine such as grant funding;[27] and

Whereas, Literature searches reveal there have been few studies published focusing on medical society metrics; and

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[18] *Chicago Tribune*: "Emanuel moves to boost gender pay equity." April 12, 2018.
[19] MEDSCAPE 2016 Physician Compensation Report. https://www.medscape.com/features/slideshow/compensation/2016/public/overview.
[20] MEDSCAPE 2017 Physician Compensation Report. www.medscape.com/slideshow/compensation-2017-overview-6008547.
[21] MEDSCAPE 2018 Physician Compensation Report. https://www.medscape.com/slideshow/2018-compensation-overview-6009667.
[22] Doximity: Second Annual Physician Compensation Report. March 2018. https://www.doximity.com/press_releases/national_research_study_finds_large_gaps_in_us_physician_compensation.
[23] Singh A, Sastri S, Burke C. Do Gender Disparities Persist in Gastroenterology after Ten Years of Practice? *Am J Gastroenterol*. Vol. 103, pages1589–1595 (2008).
[24] https://nwlc.org/resources/lilly-ledbetter-fair-pay-act/.
[25] https://www.mass.gov/service-details/learn-more-about-the-massachusetts-equal-pay-act.
[26] National Institutes of Health. *Guidelines for Inclusion of Women, Minorities, and Persons with Disabilities in NIH-Supported Conference Grants.* 2003. NOT-OD-03-066.
[27] Ginther DK, Kahn S, Schaffer WT. Gender, Race/Ethnicity, and National Institutes of Health. R01 Research Awards: Is There Evidence of a Double Bind for Women of Color? *Acad Med.* 2016;91(8):1098-1107.

Whereas, In 2018, the Association of Academic Physiatrists (AAP) was the first (and to date the only) medical society to report in a medical journal its gender inclusion metrics and provide a plan to achieve equitable inclusion in the future;[28] and

Whereas, The American College of Physicians (ACP) recently published a position paper titled "Achieving Gender Equity in Physician Compensation and Career Advancement," clarifying the organization's positions and recommendations regarding gender equity in medicine[29]; and

Whereas, The Association of Women Surgeons (AWS) recently published a position paper[10] titled "Strategies for Identifying and Closing the Gender Salary Gap in Surgery"; and

Whereas, Recently the American Surgical Association (ASA) Equity, Inclusion, and Diversity task force published a white paper stating that "surgery must identify areas for improvement and work iteratively to address and correct past deficiencies" with "honest and ongoing identification and correction of implicit and explicit biases" that aim to "increas[e] diversity in [surgical] departments, residencies, and universities" in an effort to improve patient care;[30] and

Whereas, The National Academies of Science, Engineering, and Medicine (NASEM) published a report in 2004, *Achieving XXcellence in Science: Role of Professional Societies in Advancing Women in Science*;[31] and

Whereas, The NASEM published a report in 2018, *Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine*;[32] and

Whereas, Salesforce, an American cloud computing company, recently undertook regular assessments and adjusted salaries accordingly in order to close pay gaps among employees based on gender and ethnicity,[33] with companies like Adobe, Apple, Facebook, Intel, and Starbucks following suit;[34] and

Whereas, Medical societies have unique opportunities to support underrepresented physician members with career-enhancing opportunities;[35] and

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[28] Silver JK, Cuccurullo S, Ambrose AF, et al. Association of Academic Physiatrists women's task force report. *Am J Phys Med Rehabil.* 2018;(accepted and in press).

[29] Butkus R, Serchen J, Moyer DV, Bornstein SS, Hingle ST. Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians. *Ann Int Med.* 2018.

[30] West MA et al. Ensuring Equity, Diversity, and Inclusion in Academic Surgery: An American Surgical Association White Paper. *Ann Surg*. 2018 Sep;268(3):403-407.

[31] https://www.nap.edu/catalog/10964/achieving-xxcellence-in-science-role-of-professional-societies-in-advancing.

[32] http://sites.nationalacademies.org/shstudy/index.htm.

[33] Salesforce Is Focused on Erasing the Gender Pay Gap. Available at http://fortune.com/video/2018/04/13/salesforce-is-focused-on-erasing-the-gender-pay-gap/.

[34] How These Major Companies Are Getting Equal Pay Right. Available at http://fortune.com/2018/04/09/equal-pay-companies-starbucks-apple/.

[35] National Research Council. *Achieving XXcellence in Science: Role of Professional Societies in Advancing Women in Science: Proceedings of a Workshop.* Washington, DC: The National Academies Press; 2004.

Whereas, Women physicians have been underrepresented for medical society-affiliated career-enhancing opportunities, including, but not limited to, journal editorial boards,[36] journal authorship,[37,38] conference speakers,[39] and recognition awards[40,41,42,43], which are directly linked to promotion and part of the formal criteria for promotion at most academic institutions; and

American Medical Association (AMA) Efforts

Whereas, The AMA and AMA's Women Physicians Section have made concerted efforts to highlight the disparity of physician payment by gender in the United States today, and to increase the influence of women physicians in leadership roles in medicine;[44] and

Whereas, The AMA Women Physicians Section supports a number of important initiatives, including Women in Medicine Month, the Women in Medicine Symposium, and the Joan F. Giambalvo Fund for the Advancement of Women; and

Whereas, AMA policy H-525.992 supports "the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine"; and AMA policy D-200.981 notes that the organization "will collect and publicize information on best practices in academic medicine and non-academic medicine that foster gender parity in the profession";

Whereas, Our AMA had strong existing policy on equal pay in medicine prior to June 2018,[45] which has been endorsed by the Massachusetts Medical Society, stating that "Our AMA: (1) encourages 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) supports 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) urges medical schools, hospitals, group practices and other

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[36] Amrein K, Langmann A, Fahrleitner-Pammer A, Pieber TR, Zollner-Schwetz I. Women underrepresented on editorial boards of 60 major medical journals. *Gend Med.* 2011;8(6):378-387.

[37] Silver JK, Poorman JA, Reilly JM, Spector ND, Goldstein R, Zafonte RD. Assessment of Women Physicians Among Authors of Perspective-Type Articles Published in High-Impact Pediatric Journals. *JAMA Netw Open*. 2018;1(3):e180802.

[38] Hengel E. Publishing While Female: Are Women Held to Higher Standards? Evidence from Peer Review. Available at: https://www.repository.cam.ac.uk/bitstream/handle/1810/270621/cwpe1753.pdf.

[39] Johnson CS, Smith PK, Wang C. Sage on the Stage: Women's Representation at an Academic Conference. Pers Soc Psychol Bull. 2017;43(4):493-507.

[40] Silver JK, Blauwet CA, Bhatnagar S, Slocum CS, Tenforde AS, Schneider JC, Zafonte RD, Goldstein R, Gallegos-Kearin V, Reilly JM, Mazwi NL. Women physicians are underrepresented in recognition awards from the Association of Academic Physiatrists. *Am J Phys Med Rehabil*. 2018. Jan;97(1):34-40.

[41] Silver JK, Bank AM, Slocum CS, Blauwet CA, Bhatnagar S, Poorman JA, Goldstein R, Reilly JM, Zafonte RD. Women physicians underrepresented in American Academy of Neurology recognition awards. *Neurology.* 2018 Aug 14;91(7):e603-e614.

[42] Silver JK, Blauwet CA, Bhatnagar S, Slocum CS, Tenforde AS, Schneider JC, Zafonte RD, Goldstein R, Gallegos-Kearin V, Reilly JM, Mazwi NL. Women physicians are underrepresented in recognition awards from the Association of Academic Physiatrists. *Am J Phys Med Rehabil*. 2018. Jan;97(1):34-40.

[43] Silver JK, Slocum CS, Bank AM, Bhatnagar S, Blauwet CA, Poorman JA, Villablanca A, Parangi S. Where are the women? The underrepresentation of women physicians among recognition award recipients from medical specialty societies. *PM R*. 2017. Aug;9(8):804-815.

[44] American Medical Association. https://www.ama-assn.org/about/women-physicians-section-wps.

[45] AMA Policy Finder. Gender Disparities in Physician Income and Advancement, D-200.981.

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) will collect and publicize information on best practices in academic medicine and non-academic medicine that foster gender parity in the profession; and (5) will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit"; and

Whereas, The AMA in June 2018 passed the most comprehensive gender equity policy to date, "Advancing Gender Equity in Medicine" (D-65.989), which states that:

"(1) Our AMA will draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting;

(2) Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement;

(3) Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits;

(4) Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity"; and

(5) Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work"; and

Massachusetts Medical Society (MMS) Efforts

Whereas, The MMS has the following policies:

MMS ADMINISTRATION AND MANAGEMENT
House of Delegates
The MMS will request that the districts work toward selecting delegates that better reflect the composition of practicing physicians in the Commonwealth (as registered with the Board of Registration in Medicine) by considering such factors as gender, specialty, age, and other demographics. *(D)*

MMS House of Delegates, 11/3/07
(Item 2 and 3 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/17/14

Leadership and Development
The Massachusetts Medical Society will promote representation in its leadership and committees that reflects the Society's membership diversity, demographics, and gender. *(D)*

MMS House of Delegates, 12/3/16

PHYSICIANS
Gender Parity
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
Reaffirmed MMS House of Delegates, 4/28/18

; and

Whereas, The MMS in April 2018 established a Women Physician's Section and hosts annual Women's Leadership and Health Forums, most recently in October 2018; and

Whereas, The MMS does not have comparable policies to the AMA on the following im portant topics; therefore, be it

RESOLVED, That the MMS adopt the following, which is adapted from American Medical Association policy/directives:

1. **That the MMS draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers, and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting. *(D)***

2. **That the MMS:**
   (a) Promote institutional, departmental, and practice policies, consistent with federal and Massachusetts law, that offer transparent criteria for initial and subsequent physician compensation;
   (b) Continue to advocate for pay structures based on objective, gender-neutral criteria;
   (c) Promote existing Attorney General guidance related to the Massachusetts

Equal Pay Act, which offers a framework for to identifying gender pay disparities and guidance regarding appropriate compensation models and metrics for all Massachusetts employees; and
(d) Advocate for training to identify and mitigate implicit bias in compensation decision making for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement. *(D)*

3. **That the MMS recommend as immediate actions to reduce gender bias to:**
(a) Inform physicians about their rights under the: (i) Lilly Ledbetter Fair Pay Act, which restores protection against pay discrimination; and the (ii) Equal Pay Act, requiring, among other things, equal pay for comparable work, non-prohibition of voluntary wage disclosure to others, prohibitions on asking about salary history, and prohibitions on retaliating against employees who exercise their rights under the Act; and (iii) disseminate educational materials informing physicians about their rights under the Massachusetts Equal Pay Act;
(b) Promote educational programs to help empower physicians of all genders to negotiate equitable compensation; and
(c) Work with relevant stakeholders to develop and host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings. *(D)*

4. **That the MMS collect and analyze comprehensive demographic data and produce a study on gender equity, including, but not limited to, membership; representation in the House of Delegates; reference committee makeup; and leadership positions within our MMS, including the Board of Trustees, Councils and Section governance, plenary speaker invitations (including, but not limited to, the Annual Meeting Education Program, the Annual Oration, and the Public Health Leadership Forum), recognition awards, and grant funding (including, but not limited to, grants from the MMS and Alliance Charitable Foundation); and disseminate such findings in regular reports to the House of Delegates, beginning at A-19 and continuing yearly thereafter, with recommendations to support ongoing gender equity efforts. *(D)***

5. **That MMS commit to the principles of pay equity across the organization and take steps aligned with this commitment. *(D)***

Fiscal Note: (Out-of-Pocket Expenses)	One-Time Expense of $3,000
FTE: (Staff Effort to Complete Project)	Existing Staff

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	4
Code:	Resolution I-18 C-303
Title:	Facilitating the Community of Medicine
Sponsor:	Matthew Gold, MD
Referred to:	Reference Committee C Mary Lou Ashur, MD, Chair

Whereas, MMS strategic priorities include Professional Knowledge and Satisfaction, to build and promote a sense of community, professional satisfaction, and meaning in practice through support, networking, mentoring, education and physician wellness programs; and Membership Value and Engagement, to create a clear membership value proposition; and

Whereas, The advent of new models of health care has diminished the personal, physical interaction of medical staff members on a day-to-day basis, with separation of physicians primarily working within versus outside of the hospital setting, and attenuation of the sense of community of physicians in a time when the profession, as well as individuals within the profession, is beset by many outside challenges; and

Whereas, Fostering a sense of community is arguably one of the best ways to inoculate individuals in a community against the enervating sense of isolation when facing common external stressors; and

Whereas, One of the less-acknowledged satisfactions in the practice of medicine is sharing interests with fellow practitioners, both within the field of medicine and extending to outside interests and shared experiences; and

Whereas, Professional organizations of various derivations (e.g., hospital medical staffs, professional organizations) are increasingly attempting to engage their members in collegial activities to enhance a sense of community and professional satisfaction by offering group activities (including those with non-medical themes); and

Whereas, Our MMS fosters some interest-centered communities such as those in the arts through the Arts, History, Humanism, and Culture Member Interest Network; and

Whereas, Existing activities already consummated along with new, innovative ideas could more easily be shared with others if there were a central collection of peer-vetted activities context-sensitive to our medical colleagues and families; and

Whereas, A central repository of ideas for appropriate group activities for members of our MMS — and, when appropriate, physicians in general — could facilitate more such activities, enhance a sense of belonging and professional community, and potentially fortify the efforts of organized medicine when dealing with shared challenges in the profession; therefore, be it

RESOLVED, That the Massachusetts Medical Society create, maintain, and grow a repository for MMS members of potential activities for group experiences to facilitate medical community members and families sharing in collegial activities. *(D)*

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	5
Code:	OFFICERS Report: I-18 C-2 [I-17 C-301]
Title:	MMS Former Speakers and House of Delegates Membership
Sponsor:	MMS Presidential Officers: Alain Chaoui, MD, FAAFP Maryanne Bombaugh, MD, MSc, MBA, FACOG David Rosman, MD, MBA
Report History:	Resolution I-17 C-301 Original Sponsors: Lee Perrin, MD, Kenneth Peelle, MD
Referred to:	Reference Committee C Mary Lou Ashur, MD, Chair

Background

At I-17, the House of Delegates (HOD) referred Resolution I-17 C-301, MMS Former Speakers and House of Delegates Membership, to the Board of Trustees (BOT) for report back with a recommendation at I-18. The BOT referred this resolution to the MMS Presidential Officers. The resolution states:

> RESOLVED, That the MMS request that the Bylaws be amended as appropriate to designate former speakers of the House of Delegates as ex-officio members of the House of Delegates as long as they remain members of the MMS. *(D)*

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

Reference Committee and HOD Testimony

At I-17, the reference committee recommended that this resolution be referred to the BOT for decision. The following is the reference committee's rationale:

Your reference committee heard testimony indicating that many supported the resolution. However, your reference committee also heard testimony opposing this resolution, questioning the need to expand ex-officio HOD designations and the limited scope of expansion to just speakers. Given the strategic implications and potential value of additional ex-officio HOD members, your reference committee recommends that the resolution be referred to the BOT for decision.

The resolution was extracted for discussion at the HOD second session. Testimony noted that this resolution could be a "step back," as many districts are trying to recruit *new* members to the HOD versus maintaining delegates that are not actively engaged. Testimony in favor of the resolution highlighted that former HOD speakers have unique expertise and a valuable understanding of how the HOD works which would benefit debate and meetings overall. Also, the ex-officio position would not take up a district seat, so

districts could still recruit new members. Testimony opposing the resolution acknowledged that any former speaker who is an out-of-state member would be voting on Massachusetts-specific issues, and it is more practical for these members to participate in their own state's policymaking. Also, there being no attendance requirement for ex officios, an out-of-state member would have life-long voting rights but might never attend, only sporadically, or for a single vote. Concerns were also raised about the potential "slippery slope" of recommendations to make other positions (such as special committee chairs, additional district leadership positions) ex officio.

Counter testimony regarding out-of-state members was that such members could bring a different and valuable perspective to an issue. Finally, minor testimony questioned whether the resolution should be referred to the BOT for decision since this was a House issue. Ultimately, the House voted to refer the resolution for a report back with a recommendation to the HOD.

Current MMS Policy

Per the MMS bylaws, the following are ex-officio members of the HOD:

6.02 Composition *The House of Delegates is composed of delegates elected by the district societies as provided in 3.15 and in addition:*

(1) One delegate from each designated medical specialty society as provided in 4.03.

(2) Two delegates duly authorized from the student membership in each medical school in the Commonwealth of Massachusetts and the Medical Student Section trustee and alternate as provided in 5.021.

(3) Eight delegates from the Resident and Fellow Section as provided in 5.031.

(4) One delegate from the Organized Medical Staff Section of the Society as provided in 5.041, one delegate from the Academic Physician Section of the Society as provided in 5.051, one delegate from the International Medical Graduate Section as provided in 5.061 and one delegate from the Minority Affairs Section as provided in 5.071.

(5) The President, President-elect, Vice President, Secretary-Treasurer, Assistant Secretary-Treasurer, Speaker, and Vice Speaker.

(6) The president and secretary of each district medical society.

(7) Chairs of all standing committees of the Society.

(8) Past Presidents of the Society.

(9) Delegates-at-large, as recommended by the Board of Trustees, may be elected by the House of Delegates. Delegates-at-large must be members of the Massachusetts Medical Society, must be elected individually, and will have the right to vote.

(10) The President of the Massachusetts Medical Society Alliance.

(11) Trustees and alternates from each district medical society as provided in 3.17.

(12) The President of the Boston Medical Library provided that he or she must be a member of the Society.

Discussion

The Presidential Officers discussed the resolution, the I-17 reference committee report, and HOD testimony. The officers also noted that at the American Medical Association (AMA) speakers of the HOD are trustees, and former trustees (and presidents) are ex-officio, non-voting members of the AMA HOD. (Also, nearly all former AMA speakers have become president.)

The officers discussed the point that the speakers offer a unique and valuable understanding of the HOD and a commitment to equitable and efficient meetings. However, it was noted that the speaker role is neutral, focused on the functioning of the HOD, and not the organization and issues themselves.

The officers discussed that the ex-officio position would affect, currently, just two former HOD speakers. Given that it would not have a far-reaching effect, it would be more practical to not propose this change (which also would require an MMS bylaw change). In addition, concern was expressed about assigning a perceived "value" of ex-officio status or deference to an MMS officer position, which may not reflect well to all members. It was concluded that perhaps the question should be taken up in the future, as the Task Force on Governance continues its discussion about the governance structure overall.

Conclusion

Given that a good portion of the HOD testimony was opposed to the resolution, and the officers' discussion, at this time, the officers recommend that this not be adopted. However, it does not close the door for future discussions.

Recommendation:

That the Massachusetts Medical Society not adopt Resolution I-17 C-301, which reads as follows:

RESOLVED, That the MMS request that the Bylaws be amended as appropriate to designate former speakers of the House of Delegates as ex-officio members of the House of Delegates as long as they remain members of the MMS. *(D)*

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	6
Code:	RFS/MSS Report I-18 C-3
Title:	Medical Student and Resident/Fellow Committee on Nominations Voting Rights
Sponsors:	Resident and Fellow Section Monica Wood, MD, Chair Medical Student Section Mr. Annirudh Balachandran, Chair
Referred to:	Reference Committee C Mary Lou Ashur, MD, Chair

Background

Medical students, residents, and fellows serve as voting members on the majority of the Massachusetts Medical Society's (MMS) standing, special, and advisory committees, the MMS Board of Trustees, and in the MMS House of Delegates.

An exception currently exists within the MMS Committee on Nominations, as stated in the MMS Bylaws. Specifically, the MMS Bylaws outline Medical Student and Resident and Fellow representation as follows:

In the MMS Bylaws, Chapter 5.024 — Section: Committee on Nominations, page 15, lines 28–30 state, "One member of the Medical Student Section is entitled to serve as a member of the Committee on Nominations, without the right to vote. Such member shall be elected annually by the Medical Student Section."

In the MMS Bylaws, Chapter 5.034 — Section: Committee on Nominations, page 16, lines 4–6 state, "One member of the Resident and Fellow Section is entitled to serve as a member of the Committee on Nominations, without the right to vote. Such member shall be elected annually by the Resident and Fellow Section."

In the MMS Bylaws, Chapter 11.01 — Section: Terms and Qualifications of Committee Members, page 27, lines 32–34 state, "The Medical Student Section and Resident and Fellow Section members of the Committee on Nominations shall be nonvoting members."

In the MMS Bylaws, Chapter 11.0412 — Section: Committee on Nominations, lines 13–16 state, "The Committee on Nominations shall consist of one delegate and alternate from each district society as provided in 3.14 and 3.21, and one member of the Medical Student Section, without the right to vote, and one member of the Resident and Fellow Section, without the right to vote, as provided in 5.204 and 5.34, respectively."

Current MMS Policy

MMS ADMINISTRATION AND ORGANIZATION

Membership/Dues

The MMS will continue to seek to broaden the diversity of its membership and member participation in its activities. (D)

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15

Leadership Development/Ambassador Program

The Massachusetts Medical Society will promote representation in its leadership and committees that reflects the Society's membership diversity, demographics, and gender. (D)

MMS House of Delegates, 12/3/16

Relevance to MMS Strategic Priorities

An MMS strategic priority is membership value and engagement. The membership of the MMS is diverse and includes physicians and physicians-in-training across the stages of their career. Membership of medical students, residents, and fellows represents 34 percent of MMS membership.

Discussion

The Committee on Nominations is an instrumental group that advises the MMS House of Delegates by providing a slate of nominees for each of the officers of the Society and American Medical Association (AMA) Delegates and Alternate Delegates. Furthermore, the MMS Bylaws include provisions for the Massachusetts Delegation to the AMA to include members from both the Medical Student Section (MSS) and Resident and Fellow Section (RFS). Members from the MSS and RFS are selected by the Committee on Nominations to fill seats on the AMA delegation. In addition, the Committee on Nominations presents a slate of nominees for each of the MMS officers who represent the entirety of the MMS membership.

Conclusion

The designated medical student and resident or fellow member serving on the Committee on Nominations should be encouraged to take an active role as fully engaged participants, reflecting the approximately one-third of MMS membership comprised by MSS and RFS members, by each having the right to vote.

Recommendation:

That the relevant MMS Bylaw sections be amended such that all members of the Committee on Nominations, including the Medical Student Section member and the Resident and Fellow Section member, have the right to vote. *(D)*

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	7
Code:	Resolution I-18 C-304
Title:	One Minute of Seated Silence during Each Opening Session
Sponsor:	Michael Medlock, MD
Referred to:	Reference Committee C Mary Lou Ashur, MD, Chair

Whereas, An MMS strategic priority is to advocate for health care environments that promote a sense of community, professional satisfaction, and meaning through physician wellness, education, training, support, mentoring, and networking opportunities; and

Whereas, The MMS has the following policies related to mindfulness:

CHILDREN AND YOUTH
Mindfulness Training
The MMS will support its members and other health care providers in educating parents, grandparents, and legal guardians of minors in mindfulness-based stress reduction. (D)

The Massachusetts Medical Society will encourage mindfulness-based education in Massachusetts schools. (D)

MMS House of Delegates, 5/7/16

; and

Whereas, Silent reflection, both individually and collectively, has been taught as a means of attaining peace, gratitude, and fulfillment for thousands of years by teachers worldwide; and

Whereas, Our House of Delegates currently observes a moment of silence in recognition of deceased colleagues during the opening session of every House of Delegates meeting; therefore, be it

RESOLVED, That the MMS create a separate item in the Order of Business at each House of Delegates opening session after the Memorial Resolutions to observe one minute (60 seconds) of seated silence in honor of our deceased colleagues and to promote goodwill going forward with our colleagues and our patients. *(D)*

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	8
Code:	COB Report I-18 C-4
Title:	Bylaws Changes
Sponsor:	Committee on Bylaws Lee Perrin, MD, Chair
Referred to:	Reference Committee C Mary Lou Ashur, MD, Chair

The following item approved by the House of Delegates (HOD) has been referred to the Committee on Bylaws by the Board of Trustees (BOT) for a report back at I-18:

CWIM Report: A-18 C-2 (Item 1) Establishing a Women Physicians Section

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)*

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THE REPORT

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

CWIM Report: A-18 C-2 (Item 1) Establishing a Women Physicians Section

CHAPTER 5 • Sections

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

• • •

5.08 Women Physicians Section
The Women Physicians Section is composed of members of the Massachusetts Medical Society who are women or other members by request.

5.081 House of Delegates Representation
The Women Physicians Section is entitled to one delegate in the House of Delegates. Such delegate shall be elected annually by the Women Physicians Section.

~~5.08~~ 5.09 Delegate Vacancies
A vacancy that occurs in the office of delegate shall be filled for the unexpired term by the President of the Massachusetts Medical Society after consultation with the representatives of the sections.

~~5.09~~ 5.10 Limitations
Sections of the Massachusetts Medical Society may not speak for or in behalf of the Massachusetts Medical Society.

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CHAPTER 6 • The House of Delegates

• • •

6.02 Composition
The House of Delegates is composed of delegates elected by the district societies as provided in 3.15 and in addition:
(1) One delegate from each designated medical specialty society as provided in 4.03.
(2) Two delegates duly authorized from the student membership in each medical school in the Commonwealth of Massachusetts and the Medical Student Section trustee and alternate as provided in 5.021.
(3) Eight delegates from the Resident and Fellow Section as provided in 5.031.
(4) One delegate from the Organized Medical Staff Section of the Society as provided in 5.041, one delegate from the Academic Physician Section of the Society as provided in 5.051, one delegate from the International Medical Graduate Section as provided in 5.061, ~~and~~ one delegate from the Minority Affairs Section as provided in 5.071, and one delegate from the Women Physicians Section as provided in 5.081.
(5) The President, President-elect, Vice President, Secretary-Treasurer, Assistant Secretary-Treasurer, Speaker and Vice Speaker.
(6) The president and secretary of each district medical society.
(7) Chairs of all standing committees of the Society.
(8) Past Presidents of the Society.
(9) Delegates-at-large, as recommended by the Board of Trustees, may be elected by the House of Delegates.
Delegates-at-large must be members of the Massachusetts Medical Society, must be elected individually, and will have the right to vote.
(10) The President of the Massachusetts Medical Society Alliance.
(11) Trustees and alternates from each district medical society as provided in 3.17.
(12) The President of the Boston Medical Library provided that he or she must be a member of the Society.
(D)

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

FTE: Existing Staff
(Staff Effort to Complete Project)

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	9
Code:	BOT Report I-18 C-5
Title:	Special Committee Renewals
Sponsor:	Board of Trustees Alain Chaoui, MD, FAAFP, Chair
Referred to:	Reference Committee C Mary Lou Ashur, MD, Chair

EXECUTIVE SUMMARY

Background

The House of Delegates (HOD) adopted policy in 2006 directing that all requests for approval of special committee continuance should include a brief written evaluation and recommendation by the Board of Trustees (BOT). Previously the BOT charged the Committee on Strategic Planning (CSP) with gathering the following information for special committees requesting term continuance. Per a motion approved at the October 5, 2016, BOT meeting, the MMS Presidential Officers are now charged with gathering the following information and providing recommendations to the BOT on special committee renewals:

- How well the committee met its stated objectives
- Frequency of meetings and attendance
- Evidence of an effective work product
- Additional evidence (such as educational benefit, publications, increased membership, etc.)
- Reasonable cost to the Massachusetts Medical Society for work performed
- Uniqueness of the committee (i.e., function not duplicated elsewhere in the Massachusetts Medical Society)

A summary of the officers' findings from the reports for the eight committees (Accreditation Review, Diversity in Medicine, Environmental and Occupational Health, Men's Health, Nutrition and Physical Activity, Sponsored Programs, Oral Health, and Senior Physicians) follows.

The Medical Society is engaged on several fronts to review its strategic planning, governance, and future focus. We anticipate that this work will encompass a review of committee purposes and alignment with other committees. To that end, we are recommending a one-year continuance for these committees while this work is taking place. The recommendation is not a reflection on the value of the work of these committees.

Recommendation

That the MMS support the renewal of the following special committees for one year: Accreditation Review, Diversity in Medicine, Environmental and Occupational Health, Men's Health, Nutrition and Physical Activity, Sponsored Programs, Oral Health, and Senior Physicians. *(D)*

Fiscal Note: (Out-of-Pocket Expenses):	Average Annual Expense per Committee (for 1 year beginning FY20): $3,000 per committee, for a total of $24,000
FTE: (Staff Effort to Complete Project)	Existing Staff

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	9
Code:	BOT Report I-18 C-5
Title:	Special Committee Renewals
Sponsor:	Board of Trustees Alain Chaoui, MD, FAAFP, Chair
Referred to:	Reference Committee C Mary Lou Ashur, MD, Chair

Background

The House of Delegates (HOD) adopted policy in 2006 directing that all requests for approval of special committee continuance should include a brief written evaluation and recommendation by the Board of Trustees (BOT). Previously the BOT charged the Committee on Strategic Planning (CSP) with gathering the following information for special committees requesting term continuance. Per a motion approved at the October 5, 2016, BOT meeting, the MMS Presidential Officers are now charged with gathering the following information and providing recommendations to the BOT on special committee renewals:

- How well the committee met its stated objectives
- Frequency of meetings and attendance
- Evidence of an effective work product
- Additional evidence (such as educational benefit, publications, increased membership, etc.)
- Reasonable cost to the Massachusetts Medical Society for work performed
- Uniqueness of the committee (i.e., function not duplicated elsewhere in the Massachusetts Medical Society)

Accreditation Review

Committee Purpose or Mission

To oversee and serve as a statewide resource for hospitals, specialty societies, and health care organizations seeking to offer continuing medical education (CME). To monitor compliance with nationally recognized CME standards and guidelines to ensure quality education for physicians throughout Massachusetts and its contiguous states.

Members of the Committee on Accreditation Review (CAR) include Byron Roseman, MD, chair, and Henry Tulgan, MD, vice chair, along with six other physician members, one resident and fellow section member, one medical student section member, and one medical student section alternate member.

FY17 Report on Goals/Activities

1. Goal/Activity

   To maintain compliance with the Accreditation Council for Continuing Medical Education (ACCME) Recognition Requirements: Markers of Equivalency.

   Status

   The ACCME conducted an audit of materials from recent accreditation decisions in order to assess Recognized Accreditors' interpretations and adherence to Markers of

Equivalency. The MMS was chosen as one of the Recognized Accreditors to be audited by the ACCME. This is a standard process, and data and information collected through this audit enables the ACCME to learn about the state system's practices in support of equivalency. The data collection/audits are quality assurance tools to support equivalency, enabling the ACCME to determine if Recognized Accreditors are applying the national standards for accreditation decisions and the accreditation process.

To meet the requirements needed for Maintenance of Recognition, the MMS facilitated and accomplished the delivery of data or information to ACCME as requested, including 2017 Annual Report data for all accredited providers, collection of the 2018 annual fees, submission of completed compliance grids for accreditation and progress report decisions, and participation at the State Medical Societies (SMS) recognized accreditor monthly webinars.

2. Goal/Activity

To continue to review and update all MMS accreditation policies and procedures to ensure equivalency with ACCME's policies, standards, and criteria.

Status

The MMS Recognized Accreditor Program continued to engage with MMS-accredited providers in a number of educational activities to ensure that providers are fully implementing the ACCME's Accreditation Criteria and policies and are aware of the established menu of Commendation Criteria, which will go into effect in November 2019. Education efforts such as the Directors of Medical Education (DME) Conference, the CME Accreditation Orientation Webinar Series, live chats, informational emails, and one-on-one and group training sessions for providers, surveyors, and CAR members are ongoing to ensure that all stakeholders are applying the same national standards and processes.

3. Goal/Activity

To effectively manage the accreditation process ensuring providers, surveyors, and CME staff are adopting the Accreditation Criteria and policies including the menu of criteria for Accreditation with Commendation.

Status

One of the roles of the CAR is to review MMS-accredited providers for compliance with CME standards and regulations. As of June 1, 2018, there are 45 MMS-accredited providers, including 36 hospitals/systems, four specialty societies, one government/military, and four other health care organizations.

From June 2017 to May 2018, the CAR made nine accreditation decisions: four providers received **Accreditation with Commendation**, which confers a six-year term of accreditation; five providers received **Accreditation** conferring a four-year accreditation term, of which three of the five providers were required to submit progress reports. The CAR also reviewed four progress report submissions, all of which demonstrated compliance with ACCME and MMS requirements previously found not in compliance.

For CY2017, MMS-accredited providers reported offering 918 CME activities yielding a collective physician interaction of 54,000 and non-physician interactions of 35,000 for a total of 89,000 interactions. Over the year, accredited providers presented more

than 7,000 hours of physician education designed to change physician competence, performance, or patient outcomes.

Accredited providers will have the option of utilizing the new menu of commendation criteria when seeking Accreditation with Commendation until November 2019. At that time all MMS-accredited providers will be required to pursue Accreditation with Commendation using the new criteria. Information and resources were shared with providers and a session at the DME conference focused on these new criteria.

4. Goal/Activity

To educate CME staff at MMS-accredited organizations on methods to achieve compliance with the MMS accreditation criteria and requirements.

Status

The Annual Directors of Medical Education Conference: "Leading and Designing for Change," co-sponsored by the MMS and Rhode Island Medical Society (RIMS), was held on May 17, 2018. Donald E. Moore Jr., PhD, director of the Division of Continuing Medical Education, director of evaluation and education, Office of Graduate Medical Education at Vanderbilt University School of Medicine, presented the *22nd Annual Ralph C. Monroe, MD, Memorial Lecture* and shared his thoughts on planning learning activities and assessing learners participating in continuing professional development activities. He also led an interactive workshop with MMS/NEJM Group staff on evaluating CME activities.

Danna Muir, director of Accreditation and Recognition at the MMS, shared program data for both the MMS- and RIMS-Recognized Accreditor Programs.

Kate Regnier, MA, MBA, executive vice president of the ACCME, presented on the recent collaboration in support of Maintenance of Certification (MOC), as well as the alignment with the American Medical Association (AMA), to support provider's roles as educators. Attendees participated in an interactive group exercise to explore the New Commendation Criteria and how to integrate these new criteria into CME activities and their overall CME program.

The DME Conference was attended by approximately 65 participants including 15 physicians. The program received positive reviews from participants who seemed energized to apply for Accreditation with Commendation using the new menu and many stated that they were motivated to offer Maintenance of Certification Credit(s) for some of their CME offerings. The participants appreciated the opportunity to interact with their peers and have their individual questions answered.

Live chats on CME Accreditation were established with RIMS in 2016 and continue to take place. These calls offer DMEs, CME coordinators, and others involved in CME the opportunity to get feedback to their accreditation queries and gain insight and information on recurring issues and changes to the accreditation processes/requirements, as well as share best practices and strategies.

Several consultations on the Accreditation Criteria and policies were conducted at MMS-accredited provider facilities and via teleconference.

5. Goal/Activity
   To improve compliance rates and reduce the number of MMS-accredited providers required to submit progress reports.

   Status
   To address recurring issues observed during reaccreditation surveys, live chats, and targeted emails focused on those recurring issues of non-compliance. Reinforcement through case examples, discussions, and links to resources are provided to assist in strengthening understanding for compliance with these recurring issues.

6. Goal/Activity
   To establish an annual accreditation fee structure for multisite organizations, in response to the mergers and acquisitions of hospitals and other institutions providing CME.

   Status
   The MMS is in the process of developing a new annual accreditation fee structure to include a multisite fee structure with differing fees for the parent organization and additional sites.

FY17 Committee Meetings Budget
$3,000

FY17 Number of Meetings and Percentage of Member Attendance
Four meetings with an average attendance rate onsite or via teleconference of 64 percent.

Uniqueness of Committee
Originating 43 years ago, the Massachusetts Medical Society's Recognized Accreditor Program is one of 41 state/territory medical societies' accreditation programs recognized by the Accreditation Council for Continuing Medical Education (ACCME). In 1997, the Massachusetts Medical Society (MMS) House of Delegates formally designated the Committee on Accreditation Review (CAR) as a special committee to focus exclusively on matters related to the recognized accreditation program and services. Tens of thousands of physicians and non-physicians annually participate in CME activities offered by the 45 intrastate-accredited organizations, including 36 hospitals/systems, four specialty societies, one government/military and four other health care organizations.

FY19 Goals/Activities

1. Goal/Activity
   To maintain compliance with the ACCME Recognition Requirements: Markers of Equivalency.

2. Goal/Activity
   To continue to review and update all MMS accreditation policies and procedures to ensure equivalency with ACCME's policies, standards, and criteria.

3. Goal/Activity
   To effectively manage the accreditation process ensuring providers, surveyors, and CME staff are adopting revised accreditation criteria and requirements including the new menu of criteria Accreditation with Commendation.

4. Goal/Activity
   To educate CME staff at MMS-accredited organizations on methods to achieve compliance with the MMS accreditation criteria and requirements.

5. Goal/Activity
   To improve compliance rates and reduce the number of MMS-accredited providers required to submit progress reports.

6. Goal/Activity
   Increase the MMS surveyor pool and train both new surveyors and committee members on the ACCME's accreditation policies, standards, and criteria.

Diversity in Medicine

Committee Purpose or Mission

The mission of the Committee on Diversity in Medicine (CDM) is to increase access to medical care for minority populations and other underrepresented groups, heighten awareness of cultural practices and barriers through education, create opportunities for more diversity within the medical profession, and be proactive in advocating for federal and state legislative action to eliminate disparities in health care.

FY18 Goals/Activities

1. Goal/Activity
   To work to promote increased diversity within the medical profession.

   Activity 1: Work with medical schools, health care facilities, or other entities to address strategies and barriers for minorities in medical schools and in medicine.

   Activity 2: Reach out to other organizations and associations to promote awareness of MMS efforts to increase diversity in the medical profession and reduce health care disparities.

   Status

   The committee engaged in communications related to diversity in the medical profession, including a full issue of MMS's member newsletter, *Vital Signs*, focused on diversity. The issue included an interview with Boston University School of Public Health Dean Sandro Galea, MD, on the importance of diversity in medicine and what medical schools and medicine should do to promote diversity, an article with UMass Medical School Dean Terrence Flotte, MD, about the importance of diversity in medical schools, as well as articles calling out the existence of bias in the medical workplace and highlighting strategies to address it.

The committee interfaced with and had representation on the newly formed Minority Affairs Section Steering Committee, highlighting the particular issues of underrepresented minorities in medicine and the need for data about physician demographics in Massachusetts.

2. Goal/Activity
To promote MMS engagement in efforts to reduce health care disparities.

Activity 1: Attend meetings of the MMS Committee on Public Health and other groups to highlight opportunities to reduce health care disparities, including in mental health services for minority populations.

Activity 2: Provide testimony and input, as needed, on policy and communications activities addressing health care disparities.

Status
The committee had regular representation at meetings of the Committee on Public Health, providing input and expertise on issues specifically related to health disparities and social determinants of health. Social determinants of health were identified as a priority area of the Committee on Public Health.

The committee reviewed and made recommendations on several policies scheduled for sunsetting relative to increasing diversity in the medical profession and in the medical school pipeline and promoting physician awareness of racial and ethnic disparities in health and access to care for minority populations.

The committee actively sought and reviewed nominations for the Society's Reducing Health Disparities Award. The honor was awarded to the committee's recommended recipient, Megan Sandel, MD, MPH, associate director of the GROW Clinic at Boston Medical Center, principal investigator with Children's Health Watch, associate professor of pediatrics at the Boston University Schools of Medicine and Public Health, and former pediatric medical director of Boston Healthcare for the Homeless program, is a nationally recognized expert on housing and child health. The committee hosted Dr. Sandel, who presented on the importance of addressing social determinants of health.

FY18 Committee Meetings Budget
$3,000

FY18 Number of Meetings and Percentage of Member Attendance
Four meetings with 63 percent average attendance.

Uniqueness of Committee
The Committee on Diversity in Medicine is the only committee in the organization actively examining issues facing physicians, medical students, and residents of underrepresented racial and ethnic minority backgrounds, issues related to health and health care disparities, and the effects of racism for minority populations.

According to a 2016 report by the Kaiser Family Foundation (KFF), people of color face significant disparities in access to and utilization of health care. Nonelderly Asians,

Hispanics, Blacks, American Indians, and Alaska Natives face increased barriers to accessing care and have lower utilization of care compared to Whites and Blacks, American Indians and Alaska Natives fare worse than Whites on the majority of measures of health status and outcomes KFF examined.[1]

The Agency for Health Care Quality and Research 2017 *National Healthcare Quality and Disparities Report* found that, while disparities are decreasing in some measures, disparities persist. Compared with Whites, 40% of quality measures were worse for Blacks, 30% were worse for American Indian/Alaska natives, and about one third for Hispanics.[2]

Additionally, Blacks and Latinos are underrepresented in medicine and in medical schools. In 2016, 5.2% and 5.4 % of medical school applicants from Massachusetts, and 3% and 3.2%, respectively, of medical school graduates from Massachusetts were Black and Hispanic, according to data from the American Association of Medical Colleges.[3] The Committee on Diversity actively discusses opportunities to increase the number of, and support for, underrepresented minorities in medicine, and to reduce health disparities.

FY19 Goals/Activities

In developing its goals and activities, the committee reviewed the MMS's strategic priorities for 2018–2019 and for 2017–2020.

1. To work to promote increased attention to diversity within the medical profession and health disparities in Massachusetts.

   Activity 1: Engage with the community to encourage careers in medicine for underrepresented minorities.

   Activity 2: Explore opportunities to engage with medical schools, health care facilities, or other entities to discuss strategies and barriers for underrepresented minorities in medical schools and in medicine.

   Activity 3: Explore opportunities for MMS engagement in promoting attention to the issue of racism and how it affects physicians and patients.

2. Goal/Activity
   To serve as a resource to the MMS and promote MMS engagement in efforts to increase diversity in medicine and reduce health care disparities.

   Activity 1: Engage with the MMS Committee on Public Health and the Minority Affairs Section and other groups to highlight opportunities to reduce health care disparities.

   Activity 2: Work to develop a policy recommendation related to the role of social determinants of health in health outcomes.

   Activity 3: Provide input, as needed, on policy and communications activities addressing health care disparities and diversity in medicine.

[1] https://www.kff.org/disparities-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/
[2] https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2017nhqdr.pdf
[3] https://www.aamc.org/data/facts/applicantmatriculant/85990/byraceandethnicity.html

Environmental and Occupational Health

Committee Purpose or Mission

To improve the health of the public by promoting professional understanding of and involvement in environmental and occupational health issues.

FY18 Report on Goals/Activities

1. Goal/Activity

   To promote awareness and understanding of environmental and occupational health among physicians, other health care professionals, and the general public.

   Activity: To assist with the development of content and messaging for the three-year public health campaign directive adopted by the HOD at A-17.

   Activity: To promote awareness among and educate physicians on issues related to environmental and occupational health.

   Status

   The committee took the lead on theme and message development for the environmental health campaign, and engaged with physicians from external organizations, including Boston University, the Medical Consortium for Climate and Health, My Green Doctor, Physicians for Social Responsibility, and others on issues related to climate change. The committee took the lead on a themed *Vital Signs* issue dedicated to environmental health and climate change, including interviews with members, and stories written by members. In addition, the committee discussed the impact of legal marijuana on physician practice, including risks for and testing of physicians.

2. Goal/Activity

   To provide advice and assistance to the MMS and external organizations on topical environmental and occupational health issues.

   Activity: To review and provide recommendations for MMS and external policies related to environmental and occupational health.

   Activity: Engage with the MMS Committee on Public Health through CEOH representation at Committee on Public Health meetings.

   Status

   The committee regularly attends meetings of, and provides input to, the Committee on Public Health. The committee provided recommendations to the MMS Board of Trustees and House of Delegates on a number of items referred for report back from the BOT. These reports on perfluorochemical exposure and neurotoxin exposure and occupational issues surrounding HIV exposure in the health care setting required significant research and review.

FY18 Committee Meetings Budget

$3,000

FY18 Number of Meetings and Percentage of Member Attendance
Five meetings with 68 percent average attendance.

Uniqueness of Committee
The Committee on Environmental and Occupational Health (CEOH) is the only committee at the Massachusetts Medical Society addressing issues specifically related to environmental and occupational health issues and provides expert advice to the MMS on issues related to worker's compensation, occupational health and safety, treatment guidelines, indoor air quality, and environmental health concerns. An increasing amount of attention is being paid by MMS members and the public to issues of environmental health as evidenced by news coverage and resolutions and reports presented to the HOD, as budgets for federal environmental agencies are being cut. CEOH provided careful review of several complex environmental health policy proposals and testimony. CEOH is taking the lead on the focus for the multiyear communications campaign on environmental health adopted at A-17.

Work Products/Additional Information
The committee engaged with Physicians for Social Responsibility to sponsor a timeline educational program on Climate Change and Nuclear War and responded to requests of local advocates and communities to review environmentally related ordinances and policies, including regarding gas-powered leaf blowers and biomass plants.

FY19 Goals/Activities
In discussing its goals and activities for 2018–2019, the committee reviewed the MMS's strategic priorities for 2018–2019 and 2017–2020 and developed its action plan for the year in keeping with these priorities.

FY19 Goals/Activities

1. Goal/Activity
   To promote awareness and understanding of environmental and occupational health among physicians, other health care professionals, and the general public.

   Activity: To assist with the development and dissemination of content and messaging for the three-year public health campaign directive adopted by the HOD at A-17.

   Activity: To promote awareness among and educate physicians on issues related to environmental and occupational health.

Men's Health

The mission of the Committee on Men's Health (CMH) is to monitor the ongoing and evolving topics concerning the physical and mental health issues affecting men, make recommendations to appropriate agencies and organizations, determine and act upon the best methods to educate and inform physicians, researchers, other health care providers, and the public toward improving the overall health of men, promote awareness of men's health issues, and support the federal and state government organizations that represent and act on men's health issues.

FY18 Report on Goals/Activities

1. Goal/Activity
   Focus on growing an active and engaged committee membership that includes representation from a wide variety of demographics and includes representation and participation of outside groups in order to promote well-balanced discussions and assist in engaging the medical community at large in the promotion of men's health topics.

   Status
   The committee successfully recruited five new members during FY18 and is under the direction of a new chair.

2. Goal/Activity
   Advise and assist the MMS response to key issues regarding men's physical, mental, and social health. This will be achieved by:
   a) Reviewing new findings in men's health and gender studies.
   b) Being a resource to the MMS officers, Board of Trustees, and committees on issues related to men's health.

   Status
   Ongoing.

3. Goal/Activity
   Increase access to relevant and timely information on men's health. This will be achieved by:
   a) Promoting education for physicians and other health care professionals regarding major issues related to the physical and mental health problems of men.
   b) Presenting the 16th *Annual MMS Symposium on Men's Health* with a focus on increasing attendance and reach of the educational material.
   c) Encouraging grand rounds presentations on men's health issues for delivery at Massachusetts hospitals.
   d) Maintaining liaison with national and international men's health organizations, associations, and scholarly publications.
   e) Maintaining awareness of research funding for issues specific to men's health.

   Status
   The Annual Men's Health Symposium and Awards program was held Thursday, June 15, 2017.

4. Goal/Activity
Provide patient-oriented resources to physicians and other health care professionals to improve preventive health care for men. This will be achieved by:
   a) Promoting the latest findings on men's health to patients via social media and the Society's existing communications vehicles.
   b) Publishing information on issues for preventive care for men's health in *Vital Signs*.
   c) Reviewing and updating appropriate website links to preventive men's health resources on the committee's section of the MMS website.

Status
Ongoing.

5. Goal/Activity
Monitor and inform Massachusetts and federal legislative and executive bodies to assure that attention is paid to men's issues of health and welfare. This will be achieved by:
   a) Working with the MMS Committee on Legislation to recommend positions on legislation relevant to men's health as necessary.
   b) Providing expertise to the MMS in developing and delivering testimony on relevant legislation, as needed.
   c) Continuing advocacy for a National Office of Men's Health in the United States Department of Health and Human Services.

Status
Advocated for increased state funding for prostate screening and smoking cessation programs.

FY18 Committee Meetings Budget
$3,000

FY18 Number of Meetings and Percentage of Member Attendance
Three meetings (in person with remote call-in capability and conference call meetings) with an average attendance of 65 percent.

Uniqueness of Committee
The Committee on Men's Health is the sole group at the Society dedicated to physical and mental health issues affecting men and focused on improving the overall health of men and promoting awareness of men's issues.

Work Products/Additional Information
The committee participated in the development of enduring education and broader curriculum development in collaboration with the Committee on Medical Education.

FY19 Goals/Activities

1. Goal/Activity
Focus on growing an active and engaged committee membership that includes representation from a wide variety of demographics and includes representation and participation of outside groups in order to promote well-balanced discussions and

assist in engaging the medical community at large in promotion of men's health topics.

2. Goal/Activity
Increase access to relevant and timely information on men's health. This will be achieved by:
   a) Promoting education for physicians and other health care professionals regarding major issues related to the physical and mental health problems of men.
   b) Presenting the 17th MMS Symposium on Men's Health with a focus on increasing attendance and reach of the educational material.
   c) Encouraging grand rounds presentations on men's health issues for delivery at Massachusetts hospitals.
   d) Maintaining liaison with national and international men's health organizations, associations, and scholarly publications.
   e) Maintaining awareness of research funding for issues specific to men's health.

3. Goal/Activity
Advise and assist the MMS response to key issues regarding men's physical, mental, and social health. This will be achieved by:
   a) Reviewing new findings in men's health and gender studies.
   b) Being a resource to the MMS officers, Board of Trustees, and committees on issues related to men's health.

4. Goal/Activity
Provide patient-oriented resources to physicians and other health care professionals to improve preventive health care for men. This will be achieved by:
   a) Promoting the latest findings on men's health to patients via social media and the Society's existing communications vehicles.
   b) Publishing information on issues for preventive care for men's health in *Vital Signs*.
   c) Reviewing and updating appropriate website links to preventive men's health resources on the committee's section of the MMS website.

5. Goal/Activity
Monitor and inform Massachusetts and federal legislative and executive bodies to assure that attention is paid to men's issues of health and welfare. This will be achieved by:
   a) Working with the MMS Committee on Legislation to recommend positions on legislation relevant to men's health as necessary.
   b) Providing expertise to the MMS in developing and delivering testimony on relevant legislation, as needed.
   c) Continuing advocacy for a National Office of Men's Health in the United States Department of Health and Human Services.

Nutrition and Physical Activity

Committee Purpose or Mission
To provide advice and counsel to the Society and its leadership in matters related to nutrition and physical activity, specifically to include food safety, dietary supplements, obesity treatment and the role of nutrition and physical activity in the prevention of chronic

disease. To act as liaison for other committees in the Society and appropriate outside organizations working in these areas to address nutrition- and physical activity-related issues.

FY18 Report on Goals/Activities

1. Goal/Activity
   To promote awareness among physicians and the public of matters related to nutrition, physical activity, and obesity prevention and treatment.

   Activity: To develop and promote educational information for physicians and physicians-in-training about weight stigma.

   Activity: To raise awareness among physicians of the link between food insecurity and health/cost outcomes.

   Activity: To pursue the development of a resource for physicians on bariatric surgery options.

   Status
   The committee reviewed external resources related to weight stigma and spoke with experts, including from the Rudd Center for Food Policy and Obesity. Resources for the MMS's web page were developed for posting on the MMS website.

   The committee submitted a report related to food insecurity screening to the House of Delegates to A-18, which was amended and adopted.

   In addition, committee members have been engaged in communications to MMS members through the MMS member newsletter articles on physical activity recommendations and clearance and promoting attention to food insecurity and social determinants of health.

2. Goal/Activity
   To serve as a resource to the MMS on issues related to obesity, physical activity, and nutrition.

   Activity: To assist the MMS in advocating for legislative policies and institutional practices to prevent weight stigma.

   Activity: To explore and pursue opportunities to advocate for insurance coverage for nutrition, behavioral, pharmacologic, and surgical interventions in a multidisciplinary setting.

   Activity: To review and provide input as needed on internal, legislative, and/or payer policies and efforts related to obesity, physical activity, and nutrition.

   Status
   The committee had representation on the MMS Committee on Public Health and provided advice and suggestions with regard to the issue of coverage for multidisciplinary weight management services for obesity with staff from the Committee on the Quality of Medical Practice. The committee also wrote and

submitted reports to the House of Delegates related to obesity, weight stigma, and physical activity.

FY18 Committee Meetings Budget
$3,000

FY18 Number of Meetings and Percentage of Member Attendance
Four meetings with 87 percent average attendance.

Uniqueness of Committee
The committee has expertise in nutrition, physical activity, treatment of obesity, weight stigma, and food insecurity as a social determinant of health. Obesity continues to be a leading public health issue. More than two-thirds of American adults are considered to have overweight or obesity and are at increased risk, for all-causes of death, hypertension, dyslipidemia, Type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, and certain cancers. Weight bias, which has been linked to poorer health outcomes, depression, anxiety, and social isolation, and, in young people, increased suicide attempts, remains pervasive in society, including in health care settings. The Committee on Nutrition and Physical Activity is the only committee at the Massachusetts Medical Society with specific expertise in these issues.

Work Products/Additional Information
The committee advises or represents the MMS in matters related to nutrition and physical activity, including legislation, regulations, and coalitions. The committee is developing education on weight stigma, keeps abreast of innovation in obesity treatment and bariatric surgery, and guidelines related to nutrition and physical activity, and provides content for member communications vehicles.

In developing its goals and activities, the committee reviewed MMS's strategic priorities for 2018–2019, and for 2017–2020, and developed its action plan for the year in keeping with these priorities.

FY19 Goals/Activities

1. Goal/Activity
   To promote awareness among physicians and the public of matters related to nutrition and physical activity, food insecurity, obesity prevention and treatment, and the prevention of weight stigma.

   Activity: Promote resources for physicians and physicians in training about weight stigma and preventing weight stigma in the health care setting.

   Activity: To promote to members and relevant health care organizations resources for food insecurity screening and referrals to food and nutrition assistance.

2. Goal/Activity
   To serve as a resource to the MMS on issues related to obesity, weight stigma, physical activity, nutrition, food insecurity, and other social determinants of health.

Activity: To assist the MMS in advocating for legislative policies and institutional practices to prevent weight stigma.

Activity: Serve as a resource to the MMS, its HOD, the Committee on Public Health, the communications team, and others on matters related to obesity, weight stigma, physical activity, nutrition, food insecurity, and other social determinants of health.

Sponsored Programs

Committee Purpose or Mission

The mission of the Committee on Sponsored Programs is to provide counsel to the MMS regarding continuing education activities; serve in an advisory role to organizations wishing to jointly provide educational activities with the Massachusetts Medical Society; review proposed activities submitted to the MMS, oversee and assist in the development of these educational activities, ensure that each activity is in compliance with the Accreditation Council for Continuing Medical Education (ACCME) Updated Accreditation Criteria; determine if these proposed activities contribute to improvements in physician competence, performance, and/or patient outcomes, are based on valid content, independent of commercial interest, and support the strategic priorities of the Massachusetts Medical Society.

FY18 Report on Goals/Activities

1. Goal/Activity

   To assist physicians in improving patient care by means of high quality, evidence-based continuing education. To meet the educational needs of the MMS membership, as outlined in the MMS strategic priorities, and successfully address identified gaps in knowledge and/or competence. This may include educational didactic activities; multiple format home study programs, online programming, Journal-based CME, manuscript review, performance improvement CME, as well as national and international symposia, when appropriate. To continue to work with the coordinators of NEJM Weekly CME Online Program, NEJM Interactive Medical Cases, NEJM Review CME Program, NEJM Knowledge+ Internal Medicine Board Review, NEJM Knowledge+ Family Medicine Board Review, NEJM Knowledge+ Pediatric Medicine Board Review, NEJM Manuscript Review, *NEJM Journal Watch General Medicine* print, and NEJM Weekly CME.

   Status

   The Committee met six times via teleconference to review submitted activities. Meetings were supplemented by periodic proxy votes on activities submitted for review throughout the year, keeping in mind the following:

   - The committee ensured that the educational activities were congruent with the overall mission of the Society, its strategic priorities and direction, and the MMS CME mission. They tracked compliance for future analysis.
   - The committee confirmed that educational activities provided by the MMS/NEJM are based on needs identified by changes in medical practice, House of Delegates, Board of Trustees, MMS committees, presidential initiatives, MMS departments, new technology, research, models of practice, trends, practice improvement, etc.

2. Goal/Activity
To evaluate each MMS accredited activity to ascertain it is in compliance with the ACCME, American Medical Association (AMA), Board of Registration in Medicine (BORM), and MMS standards governing continuing medical education. To work continuously to assure that all MMS-provided and jointly provided educational activities meet the highest standards for content and objectivity.

Status
- The committee recommended select content that is controversial in nature or with limited evidence to be revised and sent for external review to ensure that: all recommendations involving clinical medicine are based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients; all scientific research referred to, reported or used in CME in support or justification of a patient care recommendation conforms to the generally accepted standards of experimental design, data collection and analysis; that activities serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public or the profession; that the content is the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine and the provision of health care to the public; the references listed are appropriate, currently valid and support the content as indicated.
- The committee made recommendations regarding options to resolve potential conflicts of interest for all those in control of content.
- The committee reviewed speakers' slides and/or support materials from various MMS-provided and jointly provided programs when needed, ensuring that ACCME's Standards for Commercial Support were met and that content was supported by evidence-based medicine and is free from commercial influence.

3. Goal/Activity
To keep abreast of current information from the ACCME, AMA, American Academy of Family Physicians (AAFP), American Board of Medical Specialties (ABMS), BORM, and other continuing education entities to assess the impact of any changes on the MMS as a provider of continuing medical education, specifically as it applies to MMS-provided programs.

Status
The committee was invited to review and provide input regarding the MA Board of Registration in Medicine CME/CPD Pilot Program. The committee's input was shared with MMS leadership.

The committee met with the Committee on Medical Education and the Committee on Accreditation Review at the annual All-Education Committee Meeting in April 2018, where they discussed CME strategy and learned about updated information.

4. Goal/Activity
To build bridges with other stakeholders through collaboration and cooperation to enhance the patient-physician relationship and improve quality medical practice and access to care.

Status
The committee continues to support collaboration with both internal and external partners for CME activities that address pressing health care issues and regulatory changes that affect physicians' practice including education about the opioid crisis, MACRA, and MIPs.

5. Goal/Activity
To oversee and assist in the development of jointly provided programs submitted from MMS district medical societies, MMS-contracted specialty societies, and other health organizations that have close working relationships with the MMS. To review such program proposals and make determinations as to the quality of the offering. To lend support to these outside groups in the development of program content, objectives, faculty, and location and to be certain they are in compliance with the mission of the Society, its strategic plan, and applicable national education standards. To evaluate available resources necessary to support proposed joint providership or collaborative arrangements. To encourage joint providership activities that are compatible with the MMS's overall business and education missions.

Status
The committee reviewed proposed jointly provided activities and assessed the feasibility of awarding *AMA PRA Category 1 credit*™.

The committee reviewed proposed jointly provided activities to assess if they met the Massachusetts Board of Registration in Medicine's criteria for Risk Management credit.

FY18 Committee Meetings Budget
$3,500

FY18 Number of Meetings and Percentage of Member Attendance
Six meetings with an average attendance of 50 percent.

Uniqueness of Committee
The Committee on Sponsored Programs was established by the MMS as a special committee in May 1997. The committee's mission is stated above. As part of their mission, the committee members play a crucial role in ascertaining that the MMS is in full compliance with all regulations and seeing that said activities are in the best interest of the MMS membership and that the programming is of the highest quality and supports the strategic priorities of the Society.

The committee works in alignment with the Committees on Medical Education (CME) and Accreditation Review (CAR) but fulfills a unique and separate function. The CME establishes policy and provides counsel and advice to the Society, its leadership, the Board of Trustees, and the House of Delegates as it relates to medical education across the learning continuum, as well as education in the allied health professions. The CAR serves as a statewide resource for hospitals, specialty societies, and health care organizations seeking to provide their own CME credit for their organizations. The Committee on Sponsored Programs activity reviews and approves potential CME activities for the Society and for many organizations (joint providers) who are not providers of CME.

The committee is responsible for reviewing and approving MMS-provided and jointly provided CME activities in the following formats/areas:

- Live Courses including Journal Club
- Enduring Material — internet and print — including interactive medical cases, NEJM Journal Watch Print CME, NEJM Knowledge+ Internal Medicine Board Review (adaptive learning), NEJM Knowledge+ Family Medicine Board review (adaptive learning), and NEJM Knowledge+ Pediatric Medicine Board review (adaptive learning)
- Performance improvement
- Journal-Based CME including NEJM Weekly CME and NEJM Review CME Program
- NEJM Manuscript Review

As required by the ACCME, the MMS has implemented a mechanism for resolving conflicts of interest as it relates to CME activities. This peer-review process, as fostered by the Committee on Sponsored Programs, is used when there is an appearance of a potential conflict of interest on the part of a faculty member. A committee member (or members) reviews the presentation/program materials and other information about the potential conflict and makes a recommendation on how the conflict should be resolved.

The Committee continues to meet its goals of ensuring that the MMS provides quality educational activities, and that each activity is in compliance with the ACCME accreditation requirements and policies, the AMA's new formats for learning, and the Massachusetts Board of Registration in Medicine's requirements for risk management study, pain management and end-of-life care, and electronic health records. The committee lends support to both MMS-generated requests and those from outside organizations in the development of activity content, objectives, and faculty selection. The committee's role is to make certain that all activities are designed to change competence, performance, or patient outcomes as described in the MMS's CME mission statement.

<u>Activities Reviewed and Approved by the Sponsored Programs Committee</u>

In CY17, 48 live CME events and live webinars took place, 27 of which were jointly provided, for a total of 403 *AMA PRA Category 1 Credits™.* Physician attendees totaled 3,564 and non-physician attendees totaled 826.

In CY17, 277 internet enduring material CME activities were available on our MMS website or hosted by joint providers, 194 of which were jointly provided for a total of 1,051.5 *AMA PRA Category 1 Credits™.* This includes new and existing course content with varying term expirations. Physician attendees totaled 42,151 and non-physician participants totaled 23,628.

In CY17, the MMS accredited a total of 79 journal-based CME activities, for a total of 842 *AMA PRA Category 1 Credits™.* Physician participant totaled 99,639, while other learners accounted for 6,309.

In CY17, the MMS accredited two performance-improvement PI-CME activities attended by 16 physicians and 16 other learners. Forty (40) *AMA PRA Category 1 Credits™* were available.

In CY17, the MMS accredited one manuscript review activity, for a total of three *AMA PRA Category 1 Credits*™. For this activity, 2,166 physicians and 401 other learners participated.

In addition, NEJM Knowledge+ Internal Medicine Board Review continued to receive approval from the American Board of Internal Medicine for Maintenance of Certification (MOC) credit, and NEJM Knowledge+ Pediatric Medicine Board Review received approval from the American Board of Pediatrics for MOC credit. NEJM Knowledge+ Family Medicine received approval for AAFP Prescribed credits and AAPA Part 2 for Certification Maintenance for physician assistants, which is similar the MOC certification for physicians.

FY19 Goals/Activities

1. Goal/Activity
   To assist physicians in improving patient care by developing high-quality, evidence-based continuing education. To meet the educational needs of the MMS membership, as outlined in the MMS strategic priorities, and successfully address identified gaps in knowledge and/or competence. This may include educational didactic activities; multiple format home study programs, online programming, Journal-based CME, manuscript review, performance improvement CME, as well as national and international symposia, when appropriate. To continue to work with the coordinators of NEJM Weekly CME Online Program, NEJM Interactive Medical Cases, NEJM Review CME Program, NEJM Knowledge+ Internal Medicine Board Review, NEJM Knowledge+ Family Medicine Board Review, NEJM Knowledge+ Pediatric Medicine Board Review, NEJM Manuscript Review, *NEJM Journal Watch General Medicine* print*, a*s well as other educational activities as they develop.

2. Goal/Activity
   To evaluate each MMS-accredited activity to be certain it is in compliance with the ACCME, AMA, BORM, and MMS standards governing continuing medical education. To work continuously to assure that all MMS-provided and jointly provided educational activities meet the highest standards for content and objectivity.

3. Goal/Activity
   To keep abreast of current information from the ACCME, AMA, AAFP, ABMS, MA BORM, and other continuing education entities to assess the impact of any changes on the MMS as a provider of continuing medical education, specifically as it applies to MMS-provided programs.

4. Goal/Activity
   To build bridges with other stakeholders through collaboration and cooperation to enhance the patient-physician relationship and improve quality medical practice and access to care.

5. Goal/Activity
   To oversee and assist in the development of jointly provided programs submitted from MMS district medical societies, MMS-contracted specialty societies, and other health organizations with close working relationships with the MMS. To review such program proposals and make determinations as to the quality of the offering. To lend support to these outside groups in the development of program content, objectives, faculty,

and location and to be certain they are in compliance with the mission of the Society, its strategic plan, and applicable national education standards. To evaluate available resources necessary to support proposed joint providership or collaborative arrangements. To encourage joint providership activities that are compatible with the MMS's overall business and education missions.

Oral Health

Committee Purpose or Mission

The purpose of the Committee on Oral Health (COOH) is to increase public awareness of the relationship and importance of good oral health to good physical health; promote prevention and improve oral health literacy; and recommend ways to improve access to oral health care.

FY18 Report on Goals/Activities

1. Goal/Activity
   To inform MMS members and continue to support the emergency department dental pilot program which connects patients with dental issues with dental professionals in the region. This work will be achieved through brief articles in the MMS's *Vital Signs* newsletter, the creation of links and content for the MMS website, and potential communications and media initiatives.

Status

Committee members have remained informed and have offered recommendations on both the pilot and launch of the MassHealth Emergency Room/Urgent Care Dental Providers Diversion Program which serves to address the correlation between poor oral health and access gaps, a disproportionate distribution of dentists, insurance coverage, and affordability.

The goal is to reach all emergency rooms in the state to provide support and training around the identification of oral health-related conditions, the patient follow-up reporting tool, MassHealth member benefits, and the codes to utilize for billing oral health-related issues. Emergency room personnel are being trained in using the tools, collateral materials, and the information business web page to incorporate into each sites' workflow and billing practices.

The committee initiated an introduction with the president of the MA Chapter of Emergency Physicians and information was also presented to the Massachusetts Dental Society. The committee also suggested that medical assistants and nurses be included in the training and that dental interns be onboarded when they begin in July each year.

Further recommendations included co-located dental clinics with every emergency/ urgent care department. Federally Qualified Health Centers have "urgent" spots every day. Members were presented with an overview of the Franklin County Community Health Center, which includes a walk-in dental clinic in Greenfield that is accessible any day of the week, including weekends.

2. Goal/Activity
   To continue to develop and coordinate partnerships at the state level (Massachusetts Medical Society districts, the Massachusetts Dental Society, Massachusetts Chapter

of the American Academy of Pediatrics, Better Oral Health of Massachusetts Coalition, and other appropriate organizations) to increase connections between the medical and dental professions.

Status

The committee has been involved and committed to the Medical-Dental Transition Project, which promotes the medical and dental communities sharing an educational session of mutual interest, followed by introductions so that professionals can make informed referrals. In addition to discussions and collaboration with several district medical societies, the MA Dental Society simultaneously worked toward engaging that organization's districts and Better Oral Health of Massachusetts Collaborative worked with large hospitals and dental practices on the North Shore to develop interest.

A continuing medical education program, "Medical Dental Integration — Working Together to Address HPV and Establish a Dental Home," was developed for early spring 2018. The educational event was provided by the MMS and its Committee on Oral Health and From the First Tooth — Massachusetts, in collaboration with the Massachusetts Chapter of the American Academy of Pediatrics and the Hampshire and Valley District Dental Societies. Further events are planned dependent upon appropriate grant funding.

Additionally, the committee has begun discussion with the chair of the Massachusetts Chapter of the American Academy of Pediatric Committee on Oral Health on a collaborative medical-dental smoking cessation project. Initial discussions have focused on adolescent patients identified as smokers by pediatricians, who are sometimes unsure where to refer the child and their parent/caregiver. The American Dental Association website has multiple resources available. There is opportunity to share that information with primary care providers via the Society's usual communications methods.

3. Goal/Activity

Inform medical society members and other physicians and health care professionals on oral health best practices for the elder generation. The committee will aim to increase awareness, knowledge and skills in the medical community regarding illness prevention, hygiene, and other considerations for frail and impaired elders.

Status

Committee members were engaged in development, drafting, and finalizing an article for *Vital Signs*. Focusing on oral hygiene for elder patients, the article was prepared in collaboration with the MMS Committee on Geriatric Medicine and the MMS Alliance.

4. Goal/Activity

To connect with other MMS committees, including the Committee on Maternal and Perinatal Welfare, as well as the Massachusetts Dental Society, Division 1 of the ACOG, the Massachusetts League of Community Health Centers, and the MA Department of Public Health to educate and inform health care professionals regarding perinatal guidelines for oral health.

Status

Committee members were involved in the discussion and planning for a statewide educational event highlighting the Massachusetts Oral Health Practice Guidelines for Pregnancy and Early Childhood. The MA Department of Public Health oversaw the structure of the project, along with the Mass. League of Community Health Centers.

The COOH successfully sought continuing education credits for the day-long event; however, given a small window of time to advertise and encourage attendees, the committee agreed to forego the initial event and undertake a similar event in FY19. Invitees will include pediatrics, family medicine, nursing and dental hygienists, dental schools, obstetricians, deans of the dental schools, and directors of residency programs in pediatrics and obstetrics. Funding is available from the state specifically for this effort.

FY18 Committee Meetings Budget

$3,000

FY18 Number of Meetings and Percentage of Member Attendance

The committee held four meetings with an average of 57 percent member attendance. It is important to note that nine of the dozen members are active, with a 76 percent average attendance. In addition, there is an average 75 percent attendance of committee advisors, including dentists, dental professionals, and representatives from the Massachusetts Dental Society and Health Care for All.

Uniqueness of Committee

The committee, through its membership and its activities, actively demonstrates the important relationship between overall health, oral health, and patient care. It is the only medical society committee in the country comprised of physicians and dental professionals.

Work Products/Additional Information

The Committee on Oral Health continues to distribute a brochure on mouth guard use in youth. The brochure was developed in collaboration with the Committee on Student Health and Sports Medicine, the Massachusetts Dental Society and the MA Chapter of the American Academy of Pediatrics.

Additionally, committee members have worked to increase the number of children receiving fluoride varnish. An initiative was begun on the pediatric floors at the University of Massachusetts Memorial Hospital to apply varnish to all eligible children with parental consent as well as train the residents in this endeavor. An effort was also made to raise awareness about the fluoride varnish project with Worcester area Head Start programs.

FY19 Goals/Activities

In preparing the committee FY19 goals and activities, members reviewed the Society's priorities for the current fiscal year, as well as 2017–2020, focusing specifically on supporting physicians in building strong patient-physician relationships; promoting the integration of public health and social determinants of health across physician practices, and promoting a sense of community, professional satisfaction, and meaning through physician wellness, education, training, support, mentoring, and networking opportunities.

1. Goal/Activity

   To inform MMS members and continue to support ongoing Massachusetts projects such as the Emergency Room/Urgent Care/Dental Providers Diversion program for MassHealth clients; the state Perinatal Guidelines; oral health as a component of accountable care organizations; and Massachusetts's office-based and online training program for physicians and qualified personnel to apply fluoride varnish to eligible MassHealth members.

2. Goal/Activity
To develop information and training for primary care physicians and dentists on opioid prescribing best practices and other/alternate interventions for dental pain, in concert with the MMS Task Force on Opioid Therapy and Physician Communication.

3. Goal/Activity
Inform medical society members and other physicians and health care professionals on oral health best practices, including information for older/elder patients, dental pain management, and fluoride varnish.

4. Goal/Activity
To continue to connect with other MMS committees as well as the Massachusetts Dental Society, Division 1 of the American College of Obstetricians and Gynecologists, the Massachusetts League of Community Health Centers, and the MA Department of Public Health to educate and inform health care professionals regarding perinatal guidelines for oral health.

Senior Physicians

Committee Purpose or Mission
The mission of the Committee on Senior Physicians (CoSP) is to recognize the many diverse matters that are of concern to senior physicians age 65 and older, and to explore ways to address these unique issues. It also provides these professionals the opportunity to promote continued participation and personal enrichment.

FY18 Report on Goals/Activities

1. Goal/Activity
Serve as a source of pertinent education and information and provide opportunities for collegial interaction and participation.

Status
The committee held two events for MMS senior physician members and their spouses/significant others/guests to promote collegial sharing of experiences and concerns.

The October 4, 2017, event, *Smooth Transitions: Preparing for and Enjoying Retirement*, had two staff members from the MMS Physician Practice Resource Center discussing legal, regulatory, and business key considerations. Thomas Bryant, president of Physicians Insurance Agency of Massachusetts, a subsidiary of the MMS, discussed professional liability insurance coverage.

The event was well attended with active audience participation and feedback. Sixty-seven attended, of which 71 percent said that the event was helpful in learning about retirement. Seventy-one percent would recommend the event to other MMS members.

The May 23, 2018, event was about *Work and Volunteer Opportunities Upon Retirement*. Brendan Abel, Esq., MMS legal and regulatory affairs counsel, presented Board of Registration in Medicine (BORM) regulatory updates and legal implications about medical licenses upon retirement. Thomas Sullivan, MD, cardiologist and past

MMS president, provided insights and resources about transitioning from practice to other work opportunities. Lastly, Burton Mandel, MD, internist and committee member on both Committees of Senior Physicians and Senior Volunteer Physicians, provided information about volunteer opportunities locally through the MMS.

The event was exceedingly well attended and was a resounding success. The attendees especially enjoyed the breakout sessions that enhanced collegial sharing and networking. Ninety-six percent of the 111 attendees said that the event was helpful in learning about retirement. Ninety-three percent would recommend the event to other MMS members.

Feedback from the attendees of the respective events included interest in topics like continued up-to-date information about medical licenses, work and volunteer options post-retirement, psychological/social, financial/insurance, and community involvement.

At the A-18 American Medical Association (AMA) Senior Physician Section (SPS) Assembly Education Program on June 9, 2018, Dr. Luis Sanchez's presentation, *How to Successfully Transition Out of Medicine and Into Retirement,* was well-received.

2. Goal/Activity
   Engage and support physicians 65 years of age and over to understand the professional concerns and personal needs of senior physicians, and to develop strategies to assist MMS members.

   Status
   Activity 1: Encouraging senior physicians to be self-aware and to counsel their colleagues who experience cognitive decline issues to ensure competence and safe medical practice is an important concern. The AMA Work Group on Assessment of Senior/Late Career Physicians is determining the guidelines and will submit a report at the I-18 AMA meeting. The committee would like to adapt AMA guidelines when available with a potential report to the MMS HOD since there is no MMS policy.

   The Massachusetts Psychiatric Society Retirement Interest Group invited Dr. Sanchez to lead a discussion at its June 5, 2018, event about physician impairment: how to recognize it in self and others and what to do then.

   Activity 2: Dr. Sanchez represented the CoSP at the AMA Senior Physicians Section Assembly at the I-17 meeting in Hawaii and the A-18 meeting in Chicago.

   Dr. Sanchez was voted in May 2018 as the alternate delegate on the AMA SPS Governing Council, with a two-year term. His nomination was enthusiastically endorsed by the CoSP committee members.

3. Goal/Activity
   Educate, support, and advocate for the senior physicians with regards to medical licensing, regulatory requirements, and other professional matters.

   Status
   At the May 23, 2018, senior physicians event, Brendan Abel, Esq., MMS legal and regulatory affairs counsel, provided information about the new BORM CME Pilot

Program with less CME credit requirements (i.e., 50 vs. 100) and licensure options/legal implications when considering retirement.

FY18 Committee Meetings Budget
$3,000

FY18 Number of Meetings and Percentage of Member Attendance
Four meetings with an average attendance of 71 percent.

Uniqueness of Committee
Recognizing that the population of physicians in Massachusetts aged 65 and older is increasing and recognizing that the cohort ranges from physicians working full-time to part-time to fully-retired, the committee was created to address issues that are unique to the older physicians.

The committee continues to communicate with the senior membership to discover the most immediate concerns and how the committee can best address them.

This is the only MMS committee created to address the broad concerns of MMS members age 65 and older.

FY19 Goals/Activities

1. Goal/Activity
   Serve as a source of pertinent education and information and provide opportunities for collegial interaction and participation.

   Activity 1: Continue to plan events and find other ways to promote collegial sharing of experiences and concerns.

2. Goal/Activity
   Encourage and engage physicians 65 years of age and over to understand the professional concerns and personal needs of senior physicians, and to develop strategies to assist MMS members.

   Activity 1: Consider adapting AMA guidelines when available and submit a report regarding cognitive decline issues to the MMS HOD since there is no MMS policy.

   Activity 2: Consider mentoring opportunities for MMS physicians 50 years of age and over regarding pre-, during, and post-retirement concerns.

   Activity 3: Being proactive on local and national concerns of senior physicians expressed by the CoSP and/or AMA SPS Council.

3. Goal/Activity
   Educate, support, and advocate for the senior physicians with regards to medical licensing, regulatory requirements, and other professional matters.

   Activity 1: Invite Brendan Abel, Esq., MMS regulatory and legislative counsel, to provide updates of amendments from the BORM, when applicable.

Conclusion

The Medical Society is engaged on several fronts to review its strategic planning, governance, and future focus. We anticipate that this work will encompass a review of committee purposes and alignment with other committees. To that end, we are recommending a one-year continuance for these committees while this work is taking place. The recommendation is not a reflection on the value of the work of these committees.

Recommendation:

That the MMS support the renewal of the following special committees for one year: Accreditation Review, Diversity in Medicine, Environmental and Occupational Health, Men's Health, Nutrition and Physical Activity, Sponsored Programs, Oral Health, and Senior Physicians. *(D)*

Fiscal Note: (Out-of-Pocket Expenses):	Average Annual Expense per Committee (for 1 year beginning FY20): $3,000 per committee, for a total of $24,000
FTE: (Staff Effort to Complete Project)	Existing Staff

FISCAL NOTE COMPONENTS — REFERENCE COMMITTEE A

Item #: ***2***
Code: ***CME/CGM Report I-18 A-1***
Title: ***Alzheimer's Disease and Dementia Education***
Sponsors: ***Committee on Medical Education***
Michael Rosenblum, MD, Chair
Committee on Geriatric Medicine
Asif Merchant, MD, Chair

Webinar	**Cost**	**Notes**
Research and webinar	$10,000	One-time Expense
Total	**$10,000**	

Item #: ***8***
Code: ***CPREP Report I-18 A-5 [A-17 B-211]***
Title: ***Stop the Bleed/Save a Life***
Sponsor: ***Committee on Preparedness***
Eric Goralnick, MD, MS, Chair

Three-year bleeding control "train the trainer" demonstration project	**Cost**	**Notes**
Year 1 costs: higher to purchase needed equipment for the training which can then be utilized for trainings during the 3-year demonstration project. *Annual costs:* trainers Outside consultant(s) to market and plan the trainings, venues and logistics for MMS website and resource development and updates	$60,000	*$30,000 year one* *$15,000 year two* *$15,000 year three*
Total	**$60,000**	

FISCAL NOTE COMPONENTS — REFERENCE COMMITTEE B
(None)

FISCAL NOTE COMPONENTS — REFERENCE COMMITTEE C

Item #: ***3***
Code: ***Resolution I-18 C-302***
Title: ***Advancing Gender Equity in Medicine***
Sponsors: ***Julie Silver, MD***
Michael Sinha, MD, JD, MPH

Workshop	**Cost**	**Notes**
Workshop on role of medical societies/advancing women in medicine	$3,000	One-Time Expense
Total	**$3,000**	

Item #: ***9***
Code: ***BOT Report I-18 C-5***
Title: ***Special Committee Renewals***
Sponsor: ***Board of Trustees***
Alain Chaoui, MD, FAAFP, Chair

Special Committee Renewals	**Cost**	**Notes**
Meeting expenses: materials, catering, etc.	$24,000	**Notes** Eight Committees: Average Annual Expense per Committee (Out-of-Pocket Expenses): (for 1 year beginning FY20): $3,000 per committee, for a total of $24,000
Total	**$24,000**	