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.

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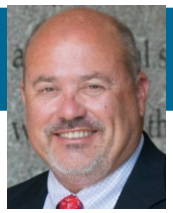
Delegates' Handbook Contents

The Speakers' Letter



Frank MacMillan Jr., MD, FACG
Speaker

McKinley Glover IV, MD, MHS
Vice Speaker

Massachusetts Medical Society

2019 Interim Meeting
December 6-7, 2019
MMS Headquarters and the Westin Hotel, Waltham

The following information is your guide to the 2019 Interim Meeting of the House of Delegates (HOD).

Interim Meeting Website

Please visit the Interim Meeting website at massmed.org/interim2019. 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 at massmed.org/interim2019/register for all Interim Meeting events. By pre-registering, it allows for ***faster*** express onsite check-in, an adequate number of seats for your district in the House of Delegates, and meals.

NEW Registration Location at the MMS: Atrium Foyer

On-site registration at the MMS on Friday, December 6, will now be located in the Atrium Foyer (the main lobby of the building).

New Delegate Orientation Luncheon

Join us at the New Delegate Orientation Luncheon on Friday, December 6, at 12:30 p.m. New and experienced delegates are welcome!

Online HOD Resources/Materials

Parliamentary Training Video

Please visit 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 on-site testimony. You may comment as many times as you like until 8:00 a.m., Friday, December 6. Reference committee members will review online testimony in preparation for the meeting, and all delegates should review the site as well.

HOD Remote Observation

Remote observation allows delegates who cannot attend the meeting to follow the HOD proceedings. Please visit massmed.org/interim2019/hod for more information.

2019 Interim Meeting Schedule

Friday, December 6, 2019
MMS Headquarters

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 Quarterly Meeting
10:00 a.m.	Reference Committee Hearings
11:30 a.m.	Alliance Luncheon
12:00 p.m.	HOD Luncheon *(available until 2:00 p.m.)*
12:30 p.m.	14th Annual Research Poster Symposium
12:30 p.m.	Official Lunch Break for Reference Committee Hearings
	District Leadership Council and Secretaries/Treasurers Meeting and Luncheon *(ends at 1:45 p.m.)*
	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
5:30 p.m.	MMS Minority Affairs Section Welcome and Networking Reception

Saturday, December 7, 2019
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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Informational Reports
Informational reports are posted online (only) at massmed.org/interim2019/handbook. (A list of the informational report titles is included in the handbook front materials.)

Late-File Resolution Deadline
The deadline for late-filed resolutions is Wednesday, November 20, at 5:00 p.m. Late files are reviewed by the Committee on Late and Deferred Resolutions and Reports at their December 5 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 massmed.org/policies.) For guidelines on submitting a late file, please visit massmed.org/resolutions.

Mother's Room Available
Private rooms will be available to nursing mothers on both days. Access to these rooms is available by request at the Registration Desk.

Family-Friendly Space for HOD Second Session
Family-friendly space for remote viewing of the House of Delegates (HOD) Second Session on Saturday, December 7, is available for delegates. Pre-registration is available and required when you register for the Interim Meeting.

Hotel Accommodations
The hotel deadline at the Westin Hotel, Waltham, has passed. Please contact Laura Bombrun at MMS Headquarters at (781) 434-7007 or lbombrun@mms.org to be added to the waitlist. If you are holding a reservation at the hotel and need to cancel, please contact Laura Bombrun to reassign the room as needed with the negotiated room rate.

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 massmed.org/interim2019/hotel.

District Caucus Meetings
Delegates are reminded to check-in at the registration desk.

Friday, December 6 (MMS)

7:00 a.m.	Berkshire/Franklin/Hampshire District Caucus
7:30 a.m.	Medical Student and Resident/Fellow Section Caucus
	Norfolk District Caucus
	Suffolk District Caucus

Saturday, December 7 (Westin)

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

Massachusetts Medical Society

2019 INTERIM MEETING

MMS Headquarters and the Westin Hotel, Waltham

DECEMBER 6–7

Pre-register online!

Go to www.massmed.org/interim2019/register

Automation

All registrants will require an MMS online account (most members have an account and use this login to access the MMS website). Should you forget your MMS password, you may reset it using the forgot password link.

After you log in, the registration form will auto-populate your contact information and walk you through each step.

All registrants, including guests, will have a custom experience and will need to register separately.

Access to a 24/7 Self-Service Portal

Once you have registered, you will receive a confirmation email and be able to easily modify your registration on the portal at any time.

You will also be able to add the MMS Interim Meeting to your calendar and access GPS directions with one tap on your phone.

Attendees will continue to scan QR codes for HOD and CME attendance at the meeting.

Save Time by Pre-Registering

If you pre-register before the event, the on-site check-in process will be a breeze. You may head directly to **Express Check-In** to check yourself in and get your badge.

Pre-registration is the preferred, faster method; however, on-site self-registration will continue to be available.

NEW Registration Location at MMS: Atrium Foyer

On-site registration at MMS on Friday, December 6 will now be located in the Atrium Foyer (the main lobby of the building).

Friday, December 6
MMS Headquarters
860 Winter Street
Waltham, MA 02451

Registration in the Atrium Foyer (Main Lobby at MMS)

Saturday, December 7
Westin Hotel
70 3rd Ave
Waltham, MA 02451

Registration in the Eden Vale Foyer

Need help?

Please email us at interim@mms.org should you need assistance with registering or have questions about the meeting.

#mmsinterim2019

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.

WARM HANDS WARM HEARTS

Join the **MASSACHUSETTS MEDICAL SOCIETY ALLIANCE** in supporting the **FRIENDS OF BOSTON'S HOMELESS** challenge to help reduce the danger to those on the streets this winter through the **WARM HANDS WARM HEARTS WINTER APPAREL DRIVE**.

We all put on gloves, hats, scarves, and a warm pair of socks every winter morning with hardly a thought, but for the homeless these items are often a luxury. By participating in Warm Hands Warm Hearts, you will not only help keep our community's neediest, most vulnerable citizens warm and safe this winter, but you will also help maintain their dignity and comfort during this most difficult time of year.

It's a simple and inexpensive way to make a lasting impact for the homeless women and men in our community.

Please Consider Donating at Least ONE NEW Winter Hat, Scarf, or Pair of Gloves, Mittens, or Socks.

A COLLECTION BASKET WILL BE LOCATED AT THE MMS ALLIANCE EXHIBIT DURING THE INTERIM MEETING ON DECEMBER 6, 2019.

MASSACHUSETTS MEDICAL SOCIETY ALLIANCE

Making a Difference

Friends of Boston's Homeless

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

MMS HEADQUARTERS
AUDITORIUM

FRIDAY, DECEMBER 6, 2019, 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. Acceptance of Resolutions and Reports for Action
   - Withdrawals or Minor Word Changes
   - Speakers' Consent Calendar (vote)
   - Object to Consideration
6. Consent Calendar: Informational Reports (vote)
7. Proceedings: May 2 and 4, 2019, House of Delegates Meeting (vote)
8. Presentation of Scrapbook to Immediate Past President
9. President's Report
10. Election of AMA Delegates and Alternate Delegates (vote)
11. American Medical Association Update
12. Boston Medical Library Update
13. Fiscal Notes Review
14. Announcements
15. Recess

Order of Reference Committee Report Presentation for HOD Second Session
(Reports available Saturday, December 7, at massmed.org/interim2019/refcommreports)

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

WESTIN HOTEL, WALTHAM

SATURDAY, DECEMBER 7, 2019, 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 massmed.org/interim2019/refcommreports
   - **Reference Committee A — Public Health**
   - **Reference Committee B — Health Care Delivery**
   - **Reference Committee C — MMS Administration**

6. Fiscal Notes Totals

7. Announcements

8. Adjournment

MASSACHUSETTS MEDICAL SOCIETY

2019 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
5	Sunset Policy Review Process	OFFICERS Report I-19 C-5

In this report, there is one policy scheduled for sunset with rationale provided. The proposed amendments to six policies are minor and noncontroversial.

MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

October 22, 2019

MEMORANDUM TO THE HOUSE OF DELEGATES

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

The Committee on Nominations (CON) met on Wednesday, October 2, 2019, at 4:00 p.m. at Society headquarters, Waltham, MA, with remote participation available. Committee Chair David T. Golden MD, presided.

There were 18 districts represented, constituting a quorum.

District/Section	Committee Members Present
Barnstable	Kenneth A. Heisler, MD
Berkshire	Bonnie H. Herr, MD
Bristol North	Brett S. Stecker, DO and Lorraine M. Schratz, MD
Bristol South	Walter J. Rok, MD and Stephen S. Kasparian, MD
Charles River	David T. Golden, MD and Hugh 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, DO
Hampden	None
Hampshire	Navneet Marwaha, MD and David P. Norton, MD
Middlesex	Deanna P. Ricker, MD and Ana-Cristina Vasilescu, MD
Middlesex Central	Paula Jo Carbone, MD and Eileen Deignan, MD
Middlesex North	Eric A. Meikle, MD
Middlesex West	Cecilia M. Mikalac, MD and Judd L. Kline, MD
Norfolk	Stephen K. Epstein, MD
Norfolk South	Bartley G. Cilento, MD
Plymouth	Edith M. Jolin, MD and Philip E. McCarthy, MD
Suffolk	Marian C. Craighill, MD and Subramanyan Jayasankar, MD
Worcester	Bruce G. Karlin, MD
Worcester North	None
Resident & Fellow Section	Monica Wood, MD
Medical Student Section	Jeff Breton

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

The committee interviewed seven (7) candidates for seven AMA Delegate positions, nine (9) candidates for three AMA Alternate Delegate positions, two (2) candidates for one open resident alternate delegation position and two (2) candidates for one open 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, 2020 through December 31, 2021

DELEGATES	**ALTERNATES**
Theodore A. Calianos, II, MD	Carole E. Allen, MD, MBA, FAAP
Alain A. Chaoui, MD, FAAFP	Matthew E. Lecuyer, MD
Ronald W. Dunlap, MD	Kenath J. Shamir, MD
Lee S. Perrin, MD	
David A. Rosman, MD, MBA	
Spiro G. Spanakis, DO	
Lynda M. Young, MD	

MMS Alternate Delegates to the AMA House of Delegates
January 1, 2020 through December 31, 2020

Samia Y. Osman, 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

House of Delegates List
Report Generated: 11/6/19

Full Name	First Name	Last Name	District	Primary Position on the HOD	Secondary Position on the HOD	Specialty Society/Standing Committee
Todd E. Abbott, M.D.	Todd	Abbott	CR	Member		
Susan A. Abookire, M.D.	Susan	Abookire	N	Member		
George Abraham, M.D., M.P.H.	George	Abraham	W	Member		
Janet C. Abrahamian, M.D.	Janet	Abrahamian	W	Member		
Ronald D. Abramson, M.D.	Ronald	Abramson	MW	Member		
Albert A. Ackil, M.D.	Albert	Ackil	PL	Member		
Jaya R. Agrawal, M.D.	Jaya	Agrawal	HMS	Specialty Society Delegate		Massachusetts Gastroenterology Association
Elsa J. Aguilera, M.D.	Elsa	Aguilera	PL	Member		
Cynthia O. Akagbosu, M.D.	Cynthia	Akagbosu	S	Member		
Geetanjali A. Akerkar, M.D.	Geetanjali	Akerkar	MN	Member		
Alan J. Albert, M.D.	Alan	Albert	W	Member		
Alexandre Alexeyenko, M.D.	Alexandre	Alexeyenko	ES	Member		
Mr. Syed H. Ali, M.D.	Syed	Ali	W	Member		
Roger A. Allcroft, M.D.	Roger	Allcroft	HMS	Member		
Carole E. Allen, M.D., M.B.A.	Carole	Allen	M	MMS Vice President		
Soheil Amin-Hanjani, M.D.	Soheil	Amin-Hanjani	PL	Member		
Thomas A. Amoroso, M.D.	Thomas	Amoroso	M	Member		
Michael S. Annunziata, M.D.	Michael	Annunziata	S	Trustee		
Karen Antman, M.D.	Karen	Antman	S	Delegate At Large		
Michael S. Argenyi, M.D.	Michael	Argenyi	W	Resident/Fellow		
Nicolas Argy, M.D.	Nicolas	Argy	N	District President		
Odysseus Argy, M.D.	Odysseus	Argy	BS	Member		
Ronald A. Arky, M.D.	Ronald	Arky	S	Member		
Grayson W. Armstrong, M.D.	Grayson	Armstrong	M	Member		
Mary Louise C. Ashur, M.D.	Mary Louise	Ashur	N	Member		
Katherine J. Atkinson, M.D.	Katherine	Atkinson	HMS	Member		
Lawrence F. Audino, M.D.	Lawrence	Audino	BS	Member		
Bruce S. Auerbach, M.D.	Bruce	Auerbach	BN	MMS Past President		
Joseph E. August, M.D.	Joseph	August	ES	Member		
Sanjay Aurora, M.D.	Sanjay	Aurora	ES	Member		
Canan Avunduk, M.D.	Canan	Avunduk	M	Member		
Ms. Asha Ayub	Asha	Ayub	S	Member		
David S. Babin, M.D.	David	Babin	BA	Member		
Adarsha S. Bajracharya, M.D.	Adarsha	Bajracharya	M	Member		
Frederic Baker, M.D.	Frederic	Baker	W	Member		
Robert S. Baratz, M.D.	Robert	Baratz	NS	Member		
Richard M. Bargar, M.D.	Richard	Bargar	EN	Member		
John Barravecchio, M.D.	John	Barravecchio	N	Member		
Brian J. Battista, M.D.	Brian	Battista	NS	Member		
Tedi Begaj, M.D.	Tedi	Begaj	ES	Member		
Renee Bennett O'Sullivan, M.D.	Renee	Bennett O'Sullivan	CR	Member		
Ernest W. Bergel, M.D.	Ernest	Bergel	N	Member		
Joseph C. Bergeron, Jr., M.D.	Joseph	Bergeron	MN	MMS Secretary-Treasurer		
Shelly Z. Berkowitz, M.D.	Shelly	Berkowitz	HMS	Member		
Stephen B. Berkowitz, M.D.	Stephen	Berkowitz	MW	Trustee		
Harris A. Berman, M.D.	Harris	Berman	S	Delegate At Large		
Bruce K. Bertrand, M.D.	Bruce	Bertrand	W	Member		
Michael F. Bierer, M.D.	Michael	Bierer	S	Specialty Society Delegate		MA Society of Addiction Medicine
Ms. Amanda E. Bilski, M.D.	Amanda	Bilski	S	Member		
Ihor J. Bilyk, M.D.	Ihor	Bilyk	ES	Member		
Linda A. Bishop, M.D.	Linda	Bishop	BA	Member		
Paul A. Bizinkauskas, M.D.	Paul	Bizinkauskas	BA	Member		
Barbara H. Bjornson, M.D.	Barbara	Bjornson	ES	Member		
Brian B. Bloom, M.D.	Brian	Bloom	PL	Member		
John W. Blute, Jr., M.D.	John	Blute	MC	Member		
Sophia Bogdasarian, R.N.	Sophia	Bogdasarian		Alliance President		
John R. Bogdasarian, M.D.	John	Bogdasarian	WN	Alternate Trustee	District President	
Maryanne C. Bombaugh, M.D. M.Sc. M.B.A.	Maryanne	Bombaugh	BA	MMS President		
Kim E. Bowman, M.D.	Kim	Bowman	N	Member		
Ylisabyth S. Bradshaw, D.O.	Ylisabyth	Bradshaw	EN	Alternate Trustee		
Jeffry B. Brand, M.D.	Jeffry	Brand	ES	Member		
Lance C. Braye, M.D.	Lance	Braye	EN	Member		
Richard A. Bream, M.D.	Richard	Bream	W	Member		
Mr. Jeffrey Breton	Jeffrey	Breton	S	Member		
James B. Broadhurst, M.D.	James	Broadhurst	W	Chair, Standing Committee		Committee on Public Health
Alison R. Brookes, M.D.	Alison	Brookes	ES	Member		
T. Desmond Brown, M.D.	T. Desmond	Brown	S	Chair, Standing Committee		Committee on Ethics, Grievances, and Professional Standards
Cynthia B. Brown, M.D.	Cynthia	Brown	ES	Member		
Richard K. Brown, M.D.	Richard	Brown	M	Member		
Carl N. Brownsberger, M.D.	Carl	Brownsberger	CR	Member		
Jean M. Bruch, M.D.	Jean	Bruch	BA	Trustee		
Frederick O. Buckley, Jr., M.D.	Frederick	Buckley	ES	Member		
William J. Burtis, M.D.	William	Burtis	MC	Secretary, Treasurer of District		
Marylou Buyse, M.D.	Marylou	Buyse	CR	MMS Past President		
Helen E. Cajigas, M.D.	Helen	Cajigas	N	Member		
Theodore A. Calianos, II, M.D.	Theodore	Calianos	BA	Alternate Trustee		
Brian T. Callahan, Jr., M.D.	Brian	Callahan	MC	Member		
William E. Callahan, M.D.	William	Callahan	FR	MMS Past President		

House of Delegates List
Report Generated: 11/6/19

Full Name	First Name	Last Name	District	Primary Position on the HOD	Secondary Position on the HOD	Specialty Society/Standing Committee
Francis X. Campion, M.D.	Francis	Campion	N	Member		
Linda J. Canty, M.D.	Linda	Canty	HMD	Member		
Hubert I. Caplan, M.D.	Hubert	Caplan	CR	Member		
Paula Jo Carbone, M.D.	Paula Jo	Carbone	MC	Alternate Trustee	District President	
Frank S. Carbone, Jr., M.D.	Frank	Carbone	ES	Member		
John V. Chang, D.O.	John	Chang	M	Member		
Alain A. Chaoui, M.D.	Alain	Chaoui	ES	MMS Immediate Past President		
Marcia C.T. Chatfield, D.O.	Marcia	Chatfield	EN	Member		
Ms. Melanie Chen	Melanie	Chen	S	Member		
Jenny S. Chiang, MD	Jenny	Chiang	M	Member		
Cheng-Chieh Chuang, M.D.	Cheng-Chieh	Chuang	NS	Member		
Bartley G. Cilento, Sr., M.D.	Bartley	Cilento	NS	District Secretary		
George J. Clairmont, Jr., M.D.	George	Clairmont	PL	Alternate Trustee		
Emily Cleveland, M.D.	Emily	Cleveland	S	Resident/Fellow		
William R. Cohen, M.D.	William	Cohen	W	Member		
Robert B. Coit, M.D.	Robert	Coit	WN	District Secretary		
Corey E. Collins, D.O.	Corey	Collins	ES	Member		
Don Condie, M.D.	Don	Condie	S	Member		
Rachael JM Consoli, M.D., M.P.H.	Rachael	Consoli	M	Member		
Peter H. Contompasis, M.D.	Peter	Contompasis	M	Member		
Alice A. Coombs, M.D.	Alice	Coombs	NS	MMS Past President		
Marian C. Craighill, M.D., M.P.H.	Marian	Craighill	S	Member		
Elizabeth T. Curtis, M.D.	Elizabeth	Curtis	ES	Member		
Seth Curtis, M.D.	Seth	Curtis	WN	Member		
Michelle Dalal, M.D.	Michelle	Dalal	W	Member		
George Q. Daley, M.D.	George	Daley	N	Delegate At Large		
Lauren Grace Daniels, D.O.	Lauren	Daniels	BA	Member		
Jatin K. Dave, M.D.	Jatin	Dave	CR	Member		
Snehlata V. Dave, M.D.	Snehlata	Dave	MN	Member		
Mr. David Davila, B.A.	David	Davila	N	Student		
Allen B. Davis, M.D.	Allen	Davis	PL	Member		
Eileen M. Deignan, M.D.	Eileen	Deignan	MC	Member		
Mary Lally Delaney, M.D.	Mary	Delaney	NS	Member		
John A. DeLoge, M.D.	John	DeLoge	MW	Alternate Trustee		
Salvatore A. DeLuca, M.D.	Salvatore	DeLuca	M	Member		
Phillip M. Devlin, M.D.	Phillip	Devlin	M	Specialty Society Delegate		MA Radiological Society
Uma V. Dhanabalan, M.D., F.A.A.F.P., M.P.H.	Uma	Dhanabalan	M	Member		
Dennis M. Dimitri, M.D.	Dennis	Dimitri	W	MMS Past President		
Chetan Dodhia, M.D.	Chetan	Dodhia	EN	Member		
Henry L. Dorkin, M.D.	Henry	Dorkin	S	MMS Past President		
Patricia Downs, M.D.	Patricia	Downs	N	Member		
Karl J. D'Silva, M.D.	Karl	D'Silva	ES	Member		
Joseph M. Dulac, M.D.	Joseph	Dulac	MN	District President		
Ronald W. Dunlap, M.D.	Ronald	Dunlap	NS	MMS Past President		
Melody J. Eckardt, M.D.	Melody	Eckardt	NS	Trustee		
Howard M. Ecker, M.D.	Howard	Ecker	S	Member		
N. Lynn Eckhert, M.D.	N.	Eckhert	W	Member		
Julia F. Edelman, M.D.	Julia	Edelman	BN	Trustee		
Heidi Eichenberger, M.D.	Heidi	Eichenberger	S	Member		
Stephen K. Epstein, M.D.	Stephen	Epstein	N	Member		
Jason M. Erlich, M.D.	Jason	Erlich	NS	Member		
Jack T. Evjy, M.D.	Jack	Evjy	MN	MMS Past President		
Patricia Rose Falcao, M.D.	Patricia	Falcao	CR	Member		
Ms. Isabella Farina	Isabella	Farina	S	Member		
Louis Fazen, III, M.D., M.P.H.	Louis	Fazen	W	Member		
James A. Feldman, M.D.	James	Feldman	S	District President		
Steven Feldman, M.D.	Steven	Feldman	BN	Member		
Marianne E. Felice, M.D.	Marianne	Felice	W	Member		
Leonard M. Finn, M.D.	Leonard	Finn	CR	District President		
Lloyd D. Fisher, M.D.	Lloyd	Fisher	W	Member		
Lisa Flaherty, M.D.	Lisa	Flaherty	BA	Member		
Athanasios P. Flessas, M.D.	Athanasios	Flessas	PL	Member		
Richard G. Florentine, M.D.	Richard	Florentine	N	Member		
Terence R. Flotte, M.D.	Terence	Flotte	W	Delegate At Large		
Heather B. Flynn, M.D.	Heather	Flynn	BK	Member		
Amy G. Fogelman, M.D.	Amy	Fogelman	CR	Member		
Heidi J. Foley, M.D.	Heidi	Foley	WN	Trustee		
Mr. Sina Foroutanjazi	Sina	Foroutanjazi	S	Member		
Marcia L. Franklin, M.D.	Marcia	Franklin	BA	Member		
Amanda B. Freeman, M.D.	Amanda	Freeman	CR	Member		
Eli C. Freiman, M.D.	Eli	Freiman	S	Member		
Carolyn M. Fruci, M.D.	Carolyn	Fruci	BS	Member		
Douglas P. Fusonie, M.D.	Douglas	Fusonie	FR	District Secretary		
Sandro Galea, M.D.	Sandro	Galea	S	Delegate At Large		
Jeffrey P. Gallo, M.D.	Jeffrey	Gallo	W	Member		
Shaan-Chirag C. Gandhi, M.D., M.B.A., Ph.D.	Shaan-Chirag	Gandhi	S	Secretary, Treasurer of District		
Lawrence D. Garber, M.D.	Lawrence	Garber	W	Member		
Antonio Manuel Garcia, D.O.	Antonio	Garcia	PL	Member		
Katherine Garlo, M.D.	Katherine	Garlo	S	Member		
Christopher Garofalo, M.D.	Christopher	Garofalo	BN	Alternate Trustee		
Wayne A. Gavryck, M.D.	Wayne	Gavryck	FR	Member		
Kavitha Gazula, M.D.	Kavitha	Gazula	MC	Member		

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Full Name	First Name	Last Name	District	Primary Position on the HOD	Secondary Position on the HOD	Specialty Society/Standing Committee
Susan V. George, M.D.	Susan	George	W	Member		
James S. Gessner, M.D.	James	Gessner	N	MMS Past President		
Ms. Rachel Getz	Rachel	Getz	S	Member		
George E. Ghareeb, M.D.	George	Ghareeb	M	Member		
Katarzyna Gilek-Seibert, M.D.	Katarzyna	Gilek-Seibert	PL	Member		
Wayne B. Glazier, M.D.	Wayne	Glazier	W	Member		
McKinley Glover IV, MD, MHS, M.D.	McKinley	Glover	S	MMS Vice Speaker of the House		
Matthew D. Gold, M.D.	Matthew	Gold	M	Specialty Society Delegate		MA Neurologic Association
David T. Golden, M.D.	David	Golden	CR	Trustee	Chair, Standing Committee	Committee on Nominations
Michael Goldstein, M.D.	Michael	Goldstein	ES	Member		
Joan R. Golub, M.D.	Joan	Golub	N	Member		
William S. Goodman, M.D.	William	Goodman	MW	Member		
Eric Goralnick, M.D.	Eric	Goralnick	S	Member		
Dennis S. Gordan, M.D.	Dennis	Gordan	HMD	Member		
Allan H. Goroll, M.D.	Allan	Goroll	S	MMS Past President		
Michele J. Gottlieb, M.D.	Michele	Gottlieb	MW	Member		
David F. Gouveia, M.D.	David	Gouveia	BA	Member		
Herbert E. Gray, III, M.D.	Herbert	Gray	BA	District Secretary		
Donald J. Greeley, Jr., M.D.	Donald	Greeley	BK	Member		
Robert S. Greenberg, M.D.	Robert	Greenberg	PL	Member		
Raj R. Gupta, M.D.	Raj	Gupta	M	Member		
Richard A. Haas, M.D.	Richard	Haas	W	Member		
Ms. Emma Hadley	Emma	Hadley	S	Member		
Angela Haliburda, D.O.	Angela	Haliburda	BS	Member		
Richard J. Hannah, M.D.	Richard	Hannah	ES	Member		
Samantha Harrington, M.D.	Samantha	Harrington	M	Resident Alternate Trustee		
Gregory G. Harris, M.D.	Gregory	Harris	N	Chair, Standing Committee		Committee on Interspecialty
Chelsea A. Harris, M.D.	Chelsea	Harris	EN	Member		
Alan M. Harvey, M.D.	Alan	Harvey	N	MMS Past President		
Mark J. Hauser, M.D.	Mark	Hauser	N	Specialty Society Delegate		MA Psychiatric Society
Mr. Dylan Heckscher	Dylan	Heckscher	S	Member		
Bernhard Heersink, M.D.	Bernhard	Heersink	EN	Member		
Kenneth Avery Heisler, M.D.	Kenneth	Heisler	BA	District President		
Kenneth J. Hekman, M.D.	Kenneth	Hekman	MC	Member		
Barbara Herbert, M.D.	Barbara	Herbert	M	Member		
Pablo Hernandez-Itriago, M.D.	Pablo	Hernandez-Itriago	W	Specialty Society Delegate		MA Academy of Family Physicians
Bonnie H. Herr, M.D.	Bonnie	Herr	BK	Member		
Douglas V. Herr, M.D.	Douglas	Herr	BK	Member		
Joseph M. Heyman, M.D.	Joseph	Heyman	EN	MMS Past President		
Richard S. Hill, M.D.	Richard	Hill	NS	Member		
Mark R. Hilty, M.D.	Mark	Hilty	BS	Member		
Kevin T. Hinchey, M.D.	Kevin	Hinchey	HMD	Member		
Cyrus C. Hopkins, M.D.	Cyrus	Hopkins	S	Member		
Hemant Hora, M.D.	Hemant	Hora	N	Member		
Lisbeth Howe, M.D.	Lisbeth	Howe	CR	Member		
Kathleen A. Hoye, M.D.	Kathleen	Hoye	BN	District Secretary		
Julian C. Huang, M.D.	Julian	Huang	NS	Member		
Pei-Li Huang, M.D.	Pei-Li	Huang	CR	Member		
Heather J. Hue, M.D.	Heather	Hue	PL	Member		
Kathryn A. Hughes, M.D.	Kathryn	Hughes	BA	Member		
Sadia S. Hussain, M.D.	Sadia	Hussain	PL	Member		
J. Bryan Iorgulescu, M.D.	J. Bryan	Iorgulescu	S	Member		
Ms. Hye Rim Jang	Hye Rim	Jang	S	Student		
Joseph J. Jankowski, M.D.	Joseph	Jankowski	CR	Member		
Subramanyan Jayasankar, M.D.	Subramanyan	Jayasankar	S	Alternate Trustee		
Hans Jeppesen, M.D.	Hans	Jeppesen	ES	Member		
Lawrence P. Johnson, M.D.	Lawrence	Johnson	MN	Member		
Edith M. Jolin, M.D.	Edith	Jolin	PL	District Secretary		
Bradley Judson, M.D.	Bradley	Judson	MC	Specialty Society Delegate		MA College of Emergency Physicians
John N. Julian, M.D.	John	Julian	S	Member		
Lynda G. Kabbash, M.D.	Lynda	Kabbash	N	MMS Asst Secretary-Treasurer		
Morton G. Kahan, M.D.	Morton	Kahan	CR	Member		
Brinda R. Kamat, M.D.	Brinda	Kamat	S	Member		
Michael S. Kaplan, M.D.	Michael	Kaplan	BK	Member		
Bruce G. Karlin, M.D.	Bruce	Karlin	W	Member		
Mark A. Kashtan, M.D.	Mark	Kashtan	S	Member		
Stephen S. Kasparian, M.D.	Stephen	Kasparian	BS	District President		
David R. Kattan, M.D.	David	Kattan	HMD	Member		
Jeffrey L. Kaufman, M.D.	Jeffrey	Kaufman	HMD	Member		
James F.X. Kenealy, M.D.	James	Kenealy	MW	Member		
Joseph L. Kennedy, Jr., M.D.	Joseph	Kennedy	N	Member		
Peter C. Kenny, M.D.	Peter	Kenny	HMS	District Secretary		
Alan T. Kent, M.D.	Alan	Kent	MN	Member		
David A. Kieff, M.D.	David	Kieff	CR	Secretary, Treasurer of District		
Glenn P. Kimball, M.D.	Glenn	Kimball	EN	Member		
James M. Kirshenbaum, M.D.	James	Kirshenbaum	N	Specialty Society Delegate		MA Chapter American College of Cardiology
Aaron Kithcart, M.D.	Aaron	Kithcart	S	Member		
Laurence Klein, M.D.	Laurence	Klein	FR	District President		
Teresa I. Klich-Nowak, M.D.	Teresa	Klich-Nowak	HMD	Member		
Roger M. Kligler, M.D.	Roger	Kligler	PL	Member		

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Full Name	First Name	Last Name	District	Primary Position on the HOD	Secondary Position on the HOD	Specialty Society/Standing Committee
Judd L. Kline, M.D.	Judd	Kline	MW	Member		
Srilatha Kodali, M.D.	Srilatha	Kodali	MN	Member		
Mr. Jordan Kondo	Jordan	Kondo	N	Student		
Stanley H. Konefal Jr, M.D.	Stanley	Konefal Jr	HMD	Member		
Claudia L. Koppelman, M.D.	Claudia	Koppelman	HMD	Member		
Constantine Kostas, M.D.	Constantine	Kostas	ES	Member		
Kenneth H. Kronlund, Jr., M.D.	Kenneth	Kronlund	W	Member		
Elliot Lach, M.D.	Elliot	Lach	W	Specialty Society Delegate		MA Society of Plastic Surgery
Ms. Stephanie K. LaFollette	Stephanie	LaFollette	S	Member		
Nidhi K. Lal, M.D.	Nidhi	Lal	MN	Alternate Trustee	Secretary, Treasurer of District	
Thomas A. LaMattina, M.D.	Thomas	LaMattina	MC	Member		
Everett Lamm, M.D.	Everett	Lamm	BK	Member		
Raul A. Landa, M.D.	Raul	Landa	MW	Member		
Mr. Tyler Lang	Tyler	Lang	S	Student, Alternate Trustee		
William G. Lavelle, M.D.	William	Lavelle	W	MMS Past President		
Matthew E. Lecuyer, M.D.	Matthew	Lecuyer	BS	Member		
Stanley M. Leitzes, M.D.	Stanley	Leitzes	PL	Member		
Joseph M. Lenehan, M.D.	Joseph	Lenehan	NS	Member		
Sarah Leonard, D.O.	Sarah	Leonard	WN	Member		
Mr. Emal Lesha	Emal	Lesha	NS	Member		
Ms. Alexis A. LeVee, M.D.	Alexis	LeVee	S	Member		
Peter E. Levesque, M.D.	Peter	Levesque	BN	Member		
Benjamin R. Levin, M.D.	Benjamin	Levin	BA	Member		
Michael A. Lew, M.D.	Michael	Lew	CR	Member		
Raymond H. Lewis, Jr., M.D.	Raymond	Lewis	MN	Member		
Olivia C. Liao, M.D.	Olivia	Liao	M	Member		
Annie S. Liau, M.D.	Annie	Liau	M	Member		
Ruth M. Liberfarb, M.D.	Ruth	Liberfarb	CR	Member		
Janet C. Limke, M.D.	Janet	Limke	NS	District President		
Manuel Lipson, M.D.	Manuel	Lipson	S	Member		
Amy C. Lisser, M.D.	Amy	Lisser	N	Member		
Mr. Mark Liu	Mark	Liu	W	Student		
Sten B. Lofgren, M.D.	Sten	Lofgren	MC	Member		
John J. Looney, M.D.	John	Looney	N	Member		
Mr. Patrick P. Lowe	Patrick	Lowe	W	Member		
Michael Christopher Lubrano, M.D.	Michael	Lubrano	S	Member		
Brita E. Lundberg, M.D.	Brita	Lundberg	CR	Member		
Carolyn Lundy, M.D.	Carolyn	Lundy	S	Member		
Francis P. MacMillan, Jr., M.D.	Francis	MacMillan	EN	MMS Speaker of the House		
Mangadhara Rao Madineedi, M.D.	Mangadhara	Madineedi	N	Trustee		
B. Dale Magee, M.D.	B.	Magee	W	MMS Past President		
Arul Mahadevan, M.D.	Arul	Mahadevan	ES	Member		
Tony Makdisi, M.D.	Tony	Makdisi	BK	Member		
Anna A. Manatis, M.D., M.P.H.	Anna	Manatis	BA	Member		
Matthew B. Mandel, M.D.	Matthew	Mandel	BK	District Secretary		
Burton G. Mandel, M.D.	Burton	Mandel	M	Member		
Barry M. Manuel, M.D.	Barry	Manuel	M	MMS Past President		
Sharon L. Marable, M.D.	Sharon	Marable	MW	Member		
Eugenia Marcus, M.D.	Eugenia	Marcus	CR	Member		
Glenn R. Markenson, M.D.	Glenn	Markenson	S	Member		
John E. Markis, M.D.	John	Markis	N	Member		
Edgar Leonardo Martinez Salazar, M.D.	Edgar	Martinez Salazar	MW	Resident/Fellow		
Navneet Marwaha, M.D.	Navneet	Marwaha	HMS	Member		
Ms. Erica J. Mascarenhas	Erica	Mascarenhas	S	Member		
Mr. Pawan J. Mathew	Pawan	Mathew	W	Member		
Lydia E. Mayer, M.D., M.P.H.	Lydia	Mayer	N	Member		
Beth Kurtz Mazyck, M.D.	Beth	Mazyck	WN	Member		
Richard B. McArdle, M.D.	Richard	McArdle	PL	Member		
Laura L. McCann, M.D.	Laura	McCann	CR	Alternate Trustee		
Darrolyn McCarroll, M.D.	Darrolyn	McCarroll	BN	Member		
Kevin E. McCarthy, M.D.	Kevin	McCarthy	PL	District President		
Philip E. McCarthy, M.D.	Philip	McCarthy	PL	MMS Past President		
Helena McCracken, D.O.	Helena	McCracken	HMS	Member		
Julie A. McCullough, M.D.	Julie	McCullough	ES	Member		
Michael D. Medlock, M.D.	Michael	Medlock	ES	Member		
Darshan H. Mehta, M.D.	Darshan	Mehta	CR	Member		
Meena M. Mehta, M.D.	Meena	Mehta	MC	Member		
Mr. Saharsh Mehta	Saharsh	Mehta	W	Member		
Eric A. Meikle, M.D.	Eric	Meikle	MN	Member		
Stephen A. Metz, M.D.	Stephen	Metz	HMD	Chair, Standing Committee		Committee on Professional Liability
Robert G. Miceli, M.D.	Robert	Miceli	S	Member		
Basil M. Michaels, M.D.	Basil	Michaels	BK	Trustee	District President	
Cecilia M. Mikalac, M.D.	Cecilia	Mikalac	MW	District Secretary		
Yelena Mikich, M.D.	Yelena	Mikich	HMD	Member		
M Denise Mills, M.D.	M	Mills	MN	Member		
Mary Elizabeth A Miotto, M.D., M.P.H.	Mary Elizabeth	Miotto	MW	District President		
Armineh Mirzabegian, M.D.	Armineh	Mirzabegian	MW	Member		
Ms. Megan Mishra	Megan	Mishra	N	Student		
Gerald J. Monchik, M.D.	Gerald	Monchik	BS	Member		

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Full Name	First Name	Last Name	District	Primary Position on the HOD	Secondary Position on the HOD	Specialty Society/Standing Committee
Jason E. Mondale, M.D.	Jason	Mondale	ES	Member		
Marcelo Montorzi, M.D.	Marcelo	Montorzi	N	Member		
Barbara J. Moore, M.D.	Barbara	Moore	NS	Member		
Sheila L. Morehouse, M.D.	Sheila	Morehouse	MN	Member		
Kevin P. Moriarty, F.A.C.S.	Kevin	Moriarty	HMD	Member		
Thomas A. Morris, III, M.D.	Thomas	Morris	PL	Member		
Leonard J. Morse, M.D.	Leonard	Morse	W	MMS Past President		
Mr. Richard Moschella	Richard	Moschella	W	Member		
Michael Fred Moses, M.D.	Michael	Moses	PL	Member		
Mario E. Motta, M.D.	Mario	Motta	ES	MMS Past President		
Susan E. Moynihan, M.D.	Susan	Moynihan	ES	Member		
Mark J. Mullan, M.D.	Mark	Mullan	HMD	Trustee	Secretary, Treasurer of District	
Kerim M. Munir, M.D.	Kerim	Munir	N	IMG Delegate		
Thomas A. Murray, III, M.D.	Thomas	Murray	ES	Alternate Trustee		
Katherine A. Murray Leisure, M.D.	Katherine	Murray Leisure	PL	Member		
Kollegal S. Murthy, M.D.	Kollegal	Murthy	HMD	Member		
Nicole R. Mushero, M.D., Ph.D.	Nicole	Mushero	N	Member		
Lisa L. Nagy, M.D.	Lisa	Nagy	BA	Member		
Robert G. Nahill, M.D.	Robert	Nahill	PL	Member		
Faina Nakhlis, M.D.	Faina	Nakhlis	N	Specialty Society Delegate		MA Chapter of the American College of Surgeons
Saira Naseer, M.D.	Saira	Naseer	EN	Member		
Ronald J. Nasif, M.D.	Ronald	Nasif	BA	Member		
Dilip Nataraj, M.D.	Dilip	Nataraj	NS	Member		
Ronald R. Newman, M.D.	Ronald	Newman	ES	District President		
Najmosama Nikrui, M.D.	Najmosama	Nikrui	S	Member		
Mr. Michael A. Nitz	Michael	Nitz	S	Member		
Keith C. Nobil, M.D.	Keith	Nobil	ES	Trustee		
Donna M. Norris, M.D.	Donna	Norris	N	Member		
Matthias M. Nurnberger, M.D.	Matthias	Nurnberger	MW	Member		
Kevin D. OBrien, M.D.	Kevin	OBrien	BS	Member		
Daniel J O'Brien, M.D.	Daniel	O'Brien	WN	Member		
Luke M. O'Connell, M.D.	Luke	O'Connell	NS	Specialty Society Delegate		MA Assoc. Practicing Urologists
Samia Y. Osman, M.D.	Samia	Osman	N	Member		
Kimberley L. O'Sullivan, M.D.	Kimberley	O'Sullivan	CR	Member		
Donald M. Pachuta, M.D.	Donald	Pachuta	MW	Member		
Kelly C. Pajela, M.D.	Kelly	Pajela	ES	Member		
Mr. Jason Andrew Park	Jason	Park	S	Member		
Yeri Park, M.D.	Yeri	Park	EN	Member		
Sahdev R. Passey, M.D.	Sahdev	Passey	W	Trustee	District President	
Samir K. Patel, M.D.	Samir	Patel	NS	Chair, Standing Committee		Committee on Membership
Diane F. Patrick, M.D.	Diane	Patrick	BS	Member		
Kenneth R. Peelle, M.D.	Kenneth	Peelle	MN	MMS Past President		
Gracia B. Perez-Lirio, M.D.	Gracia	Perez-Lirio	CR	Member		
Lee S. Perrin, M.D.	Lee	Perrin	M	District President	Chair, Standing Committee	Committee on Bylaws
Richard S. Pieters, M.D.	Richard	Pieters	PL	MMS Past President	President, Boston Medical Library	
Anthony A. Pikus, M.D.	Anthony	Pikus	ES	Member		
Roger A. Pompeo, M.D.	Roger	Pompeo	NS	Member		
Paul JP Pongor, M.D.	Paul	Pongor	MW	Specialty Society Delegate		MA Orthopedic Association
Navin Popat, M.D.	Navin	Popat	MN	Trustee		
Pranav Prakash, M.D.	Pranav	Prakash	BN	Member		
Brenda Anders Pring, M.D.	Brenda Anders	Pring	CR	Member		
Mr. Jacob Radparvar	Jacob	Radparvar	S	Student		
Jean E. Ramsey, M.D.	Jean	Ramsey	S	Specialty Society Delegate		MA Society of Eye Physicians & Surgeons (Ophthalmology)
Alwyn F. Rapose, M.D.	Alwyn	Rapose	W	Member		
Peter D. Rappo, M.D.	Peter	Rappo	PL	Member		
Sharon J. Rawlings, M.D.	Sharon	Rawlings	BK	Member		
Harvey A. Reback, M.D.	Harvey	Reback	BS	Member		
Mohammad G. Reda, M.D.	Mohammad	Reda	S	Member		
Muralidharan T. Reddy, M.D.	Muralidharan	Reddy	MW	Member		
Eric J. Reines, M.D.	Eric	Reines	ES	District Secretary		
Keith M. Reisinger-Kindle, D.O.	Keith	Reisinger-	HMD	Member		
Meegan L. Remillard, M.D.	Meegan	Remillard	M	Member		
Salah E. Reyad, M.D.	Salah	Reyad	PL	Member		
Jason E. Reynolds, M.D.	Jason	Reynolds	BS	Member		
Michael P. Richardson, M.D.	Michael	Richardson	M	Alternate Trustee		
Deanna P. Ricker, M.D.	Deanna	Ricker	M	Secretary, Treasurer of District		
Alyssa Ivy Robinson, M.D.	Alyssa	Robinson	S	Member		
Kristen M. Robson, M.D.	Kristen	Robson	M	Member		
William E. Rockett, M.D.	William	Rockett	MW	Member		
Barbara A. Rockett, M.D.	Barbara	Rockett	N	MMS Past President		
Francis X. Rockett, M.D.	Francis	Rockett	N	MMS Past President		
Grant V. Rodkey, M.D.	Grant	Rodkey	S	MMS Past President		
Walter J. Rok, M.D.	Walter	Rok	BS	Alternate Trustee		
Peter C. Roos, M.D.	Peter	Roos	PL	Member		
B. Hoagland Rosania, M.D.	B.	Rosania	PL	Trustee		
Michael J. Rosenblum, M.D.	Michael	Rosenblum	HMD	Chair, Standing Committee		Committee on Medical Education
Philip G. Rosene, M.D.	Philip	Rosene	EN	Member		
Thomas L. Rosenfeld, M.D.	Thomas	Rosenfeld	W	Member		
Eric J. Rosenthal, D.O.	Eric	Rosenthal	WN	Member		

House of Delegates List
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Full Name	First Name	Last Name	District	Primary Position on the HOD	Secondary Position on the HOD	Specialty Society/Standing Committee
Samantha L. Rosman, M.D.	Samantha	Rosman	S	Member		
David A. Rosman, M.D., M.B.A.	David	Rosman	S	MMS President Elect		
Alicia O.M. Ross, M.D.	Alicia	Ross	HMD	Member		
Tuhin K. Roy, M.D.	Tuhin	Roy	EN	Member		
Abhijit Roychowdhury, M.D.	Abhijit	Roychowdhury	W	Member		
Mr. Prithwijit Roychowdhury	Prithwijit	Roychowdhury	W	Member		
Joel J. Rubenstein, M.D.	Joel	Rubenstein	CR	Member		
Daniel B. Rubin, M.D.	Daniel	Rubin	S	Member		
Eric J. Ruby, M.D.	Eric	Ruby	BN	District President		
Vincent J. Russo, M.D.	Vincent	Russo	EN	Member		
Shakti S. Sabharwal, M.D.	Shakti	Sabharwal	N	Secretary, Treasurer of District		
Flora F. Sadri-Azarbayejani, D.O.	Flora	Sadri-Azarbayejani	FR	Trustee		
Ahmed Salama, M.D.	Ahmed	Salama	S	IMG Delegate		
Luis T. Sanchez, M.D.	Luis	Sanchez	CR	Member		
George P. Santos, M.D.	George	Santos	CR	Member		
Michele T. Sasmor, M.D.	Michele	Sasmor	EN	Member		
Ilana L. Schmitt, M.D., M.P.H.	Ilana	Schmitt	HMS	District President		
Peter B. Schneider, M.D.	Peter	Schneider	W	Member		
Lorraine M. Schratz, M.D.	Lorraine	Schratz	BN	Member		
Diane J. Schweitzer, M.D.	Diane	Schweitzer	CR	Member		
Reiner Henson B. See, M.D.	Reiner Henson	See	S	Member		
Alan Semine, M.D.	Alan	Semine	CR	Member		
Jagdish R. Shah, M.D.	Jagdish	Shah	BS	District Secretary		
Natasha Shah, M.D.	Natasha	Shah	ES	Member		
Pankaj M. Shah, M.D.	Pankaj	Shah	N	Member		
Kenath J. Shamir, M.D.	Kenath	Shamir	BS	Trustee		
Fred E. Shapiro, D.O.	Fred	Shapiro	S	Member		
Ms. Faizah Shareef	Faizah	Shareef	S	Member		
Mark M. Sherman, M.D.	Mark	Sherman	HMD	Alternate Trustee		
Mawya Shocair, M.D.	Mawya	Shocair	S	Member		
Manjul Shukla, M.D.	Manjul	Shukla	W	Member		
Biljana Simikic, D.O.	Biljana	Simikic	HMS	Member		
Michael S. Sinha, M.D., J.D., M.P.H.	Michael	Sinha	S	Chair, Standing Committee		Committee on Communications
Paul A. Skudder, Jr., M.D.	Paul	Skudder	BA	Member		
Nancy S. Slater, M.D.	Nancy	Slater	M	Member		
Charles T. Smallwood, Jr., M.D.	Charles	Smallwood	PL	Member		
Christopher R. Smith, M.D.	Christopher	Smith	MW	Member		
Vincent C. Smith, M.D.	Vincent	Smith	N	Member		
Linda Smothers, M.D.	Linda	Smothers	BK	Member		
Renee E. Snow, M.D.	Renee	Snow	EN	Member		
Ms. Avneet Soin, B.S.	Avneet	Soin	S	Member		
Robert W. Sorrenti, M.D.	Robert	Sorrenti	W	Member		
Spiro G. Spanakis, D.O.	Spiro	Spanakis	W	Member		
Ann B. Spires, M.D.	Ann	Spires	EN	Trustee		
Barbara S. Spivak, M.D.	Barbara	Spivak	M	Chair, Standing Committee		Committee on the Quality of Medical Practice
Joshua H. St. Louis, M.D.	Joshua	St. Louis	EN	District President		
Fatima Cody Stanford, M.D.	Fatima	Stanford	S	Member		
Rebecca S. Starr, M.D.	Rebecca	Starr	HMS	Member		
Brett S. Stecker, D.O.	Brett	Stecker	BN	Member		
Lance M. Sterman, M.D.	Lance	Sterman	BK	Member		
Ellana Stinson, M.D., M.P.H.	Ellana	Stinson	N	Alternate Trustee		
Leo L. Stolbach, M.D.	Leo	Stolbach	W	Member		
Sharon A. Stotsky, M.D.	Sharon	Stotsky	M	Member		
Carl G Streed, Jr., M.D., M.P.H.	Carl	Streed	S	Member		
Subramony Subramonia Iyer, M.D.	Subramony	Subramonia Iyer	HMD	District President		
Ronan P Sugrue, M.D.	Ronan	Sugrue	N	Member		
Kevin G Sullivan, M.D.	Kevin	Sullivan	S	Member		
Stephen R. Sullivan, M.D.	Stephen	Sullivan	M	Member		
Thomas E. Sullivan, M.D.	Thomas	Sullivan	ES	MMS Past President		
Preeyanka Sundar, M.D.	Preeyanka	Sundar	BK	Member		
Shobita Sundar, M.D.	Shobita	Sundar	BS	Member		
Ammu Thampi Susheela, M.D.	Ammu	Susheela	N	Member		
Sally A. Sveda, M.D.	Sally	Sveda	CR	Member		
William J. Swiggard, M.D.	William	Swiggard	HMS	Member		
Irma OV Szymanski, M.D.	Irma	Szymanski	N	Member		
Ludwik S. Szymanski, M.D.	Ludwik	Szymanski	N	Member		
Hugh M. Taylor, M.D.	Hugh	Taylor	ES	Member		
Helena O. Taylor, M.D.	Helena	Taylor	M	Member		
Sarah F. Taylor, M.D.	Sarah	Taylor	MC	Trustee	Chair, Standing Committee	Committee on Legislation
Nikhil M. Thakkar, M.D.	Nikhil	Thakkar	HMD	Member		
Jennifer R. Thulin, M.D.	Jennifer	Thulin	MW	Member		
Stefan A. Topolski, M.D.	Stefan	Topolski	FR	Member		
Mr. Matthew Townsend, M.S.	Matthew	Townsend	N	Member		
Erin E. Tracy, M.D.	Erin	Tracy	S	Specialty Society Delegate		MA Section - American Congress of Obstetricians & Gynecologists
Rajendra M. Trivedi, M.D.	Rajendra	Trivedi	M	Member		
Glenn A. Tucker, M.D.	Glenn	Tucker	BN	Member		
Ye M. Tun, M.D.	Ye	Tun	PL	Member		

House of Delegates List
Report Generated: 11/6/19

Full Name	First Name	Last Name	District	Primary Position on the HOD	Secondary Position on the HOD	Specialty Society/Standing Committee
Ms. Rebecca U. Ukaegbu	Rebecca	Ukaegbu	W	Member		
Sita Ram Upadhyay, M.D.	Sita	Upadhyay	W	Member		
Brent H Upchurch, M.D.	Brent	Upchurch	PL	Member		
Mr. Nishant Uppal	Nishant	Uppal	S	Student Trustee		
Nadia Satya Urato, M.D.	Nadia	Urato	MW	Member		
Rohit D. Vakil, M.D.	Rohit	Vakil	W	Alternate Trustee		
Francis X. Van Houten, M.D.	Francis	Van Houten	MC	MMS Past President		
Ana-Cristina Vasilescu, M.D.	Ana-Cristina	Vasilescu	M	Trustee		
Danny Alberto Vazquez, M.D.	Danny	Vazquez	N	Resident/Fellow		
Danny Alberto Vazquez, M.D.	Danny	Vazquez	N	Resident/Fellow		
Joseph J. Viadero, M.D.	Joseph	Viadero	FR	Alternate Trustee		
Agnes Virga, M.D.	Agnes	Virga	MC	Member		
Anil M. Vyas, M.D.	Anil	Vyas	BA	Member		
Jerry Wacks, M.D.	Jerry	Wacks	MC	Member		
Andrew C. Wagner, M.D.	Andrew	Wagner	S	Member		
Sohail A. Waien, M.D.	Sohail	Waien	FR	Member		
John Joseph Walsh, M.D.	John	Walsh	NS	Member		
Marie T. Walsh Condon, M.D.	Marie	Walsh Condon	M	Member		
Arthur C. Waltman, M.D.	Arthur	Waltman	S	Member		
James K. Wang, M.D.	James	Wang	HMD	Member		
Victor Wang, M.D.	Victor	Wang	N	Member		
Nicholas A. Weida, M.D.	Nicholas	Weida	EN	District Secretary		
Charles A. Welch, M.D.	Charles	Welch	S	MMS Past President		
Giles F. Whalen, M.D.	Giles	Whalen	W	District Secretary		
William M. Wheeler, M.D.	William	Wheeler	N	Member		
Simone S. Wildes, M.D.	Simone	Wildes	NS	Alternate Trustee		
Audra D. Williams, M.D.	Audra	Williams	EN	Member		
David G. Wong, M.D.	David	Wong	NS	Member		
Susan Wong, M.D.	Susan	Wong	M	Member		
Monica J. Wood, M.D.	Monica	Wood	M	Member		
Alan C. Woodward, M.D.	Alan	Woodward	MC	MMS Past President		
Christopher M. Worsham, M.D.	Christopher	Worsham	S	Resident Trustee		
Caroline Yang, M.D.	Caroline	Yang	CR	Resident/Fellow		
Ms. Xinmiao Yang	Xinmiao	Yang	W	Student		
Ira S. Yanowitz, M.D.	Ira	Yanowitz	S	Member		
Michael W. Yogman, M.D.	Michael	Yogman	M	Member		
Lynda M. Young, M.D.	Lynda	Young	W	MMS Past President	Chair, Standing Committee	Committee on Publications
Steven Young, M.D.	Steven	Young	S	Resident/Fellow		
M. Donna Younger, M.D.	M. Donna	Younger	S	Member		
Ms. Marguerite Youngren	Marguerite	Youngren	MW	Member		
Ms. Leah Yuan	Leah	Yuan	S	Member		
Peter T. Zacharia, M.D.	Peter	Zacharia	W	Member		
Aimie Zale, M.D.	Aimie	Zale	FR	Member		
Tomislav Zargaj, M.D.	Tomislav	Zargaj	ES	Member		
Mr. Max Zhu	Max	Zhu	N	Student		
Mr. Thomas M. Zink	Thomas	Zink	S	Member		
Geoffrey M. Zucker, M.D.	Geoffrey	Zucker	HMS	Trustee		

2019 Interim Meeting Informational Report Titles
(Reports Available Online at massmed.org/interim2019/handbook)

Report #	TITLE	SPONSOR
1.	Summary of Official Actions	Board of Trustees
2.	*Actions Taken on A-19 Items Referred to Board of Trustees for Decision:* • Support for Modern Abortion Laws and Access • Primary Care Spending • Support for Physicians Experiencing Burnout	Board of Trustees
3.	Advancing Gender Equity in Medicine	Board of Trustees MMS Presidential Officers
4.	Clarification on Specificity and Flexibility of Investment Policy on Fossil Fuels, Climate Change, and Socially Responsible Investments	Board of Trustees Administration and Management Communications Finance
5.	Charitable and Educational Fund	Charitable and Educational Fund Board of Directors
6.	Report of the Secretary-Treasurer	Secretary-Treasurer
7.	Informational Updates: I-18 and A-19 Directives/Implementation	

1a	Committee Reports on Activities and Initiatives *(Separate PDF-Online Only at (massmed.org/interim2019/handbook)*	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 massmed.org/interim2019/handbook. (A list of the informational report titles is included on next page.)

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 2018, Annual Meeting 2019, Interim Meeting 2019, and Annual Meeting 2020.

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:

- 2019 Annual Meeting *Proceedings* (www.massmed.org/recentproceedings/#hod)
- *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.

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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:	CMPW Report: I-19 A-1 [LGBTQ Report I-18 A-2(b)]
Title:	Evidence-Based Care of Individuals Born with Differences in Sex Development (DSD)/Intersex
Sponsor:	Committee on Maternal and Perinatal Welfare Sara Shields, MD, Chair
Report History:	Original Sponsor: Committee on LGBTQ Matters
Referred to:	Reference Committee A Mary Beth Miotto, MD, MPH, Chair

Background

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

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

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

Reference Committee and HOD Testimony

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

Your reference committee heard significant debate in person and online regarding the second recommendation. Many spoke in favor of adoption, and there was consensus that it is important to respect the autonomy of patients. However, many raised compelling medical concerns regarding how best to care for these patients, as evidenced by the differing positions of medical specialty societies. Your reference committee heard testimony noting that the NIH is currently working on a report on this issue. Given the need to evaluate more evidence in this area, the disagreement among clinicians regarding the evidence-based standard of care for these issues, and the complexity and heterogeneity of the medical conditions involved, your reference committee recommends referral.

HOD testimony heard several people speak against referral, noting the extensive research in the original report documenting the evidence of potential harms that come from performing nonessential gender reassignment surgery and underscoring support for a resolution that will improve the care of an underserved population. Testimony in support of adoption further noted the support of relevant medical and legal groups in support (e.g., American Academy of Family Physicians, the WHO, Physicians for Human Rights, Amnesty International, and the Gay and Lesbian Medical Association). Another person offered that additional research in the year after the resolution report is not likely to change the recommendation, and informed the HOD that the report had been made incorporating the recommendations from pediatric neurology and pediatric endocrinology.

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

Current MMS Policy

The MMS has the following policy on this item:

CHILDREN AND YOUTH

Differences in Sex Development (DSD)/Intersex

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

Relevance to MMS Strategic Initiatives

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

Discussion

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

A discussion ensued pertaining to the research and data referenced in the LGBTQ committee report. Committee members considered recommendations from the Gay and Lesbian Medical Association: Health Professionals Advancing LGBT Equality, the Word Health Organization, three former surgeon generals, the American Academy of Family Physicians, and Physicians for Human Rights. CMPW members also reviewed and considered testimony from the AMA, as well as research from the *Journal of Pediatric Urology*. CMPW members acknowledged that an NIH report was forthcoming, possibly in summer 2020, but came to understand the report was largely not expected to deviate from existing research and ultimately believed that the MMS should not wait for that report to act on the resolution. A CMPW member desired to wait on that report and inquired about the status of certain specialty societies — including pediatric, endocrinology, urology, and neonatology — and whether they've weighed in on the matter. Members of the committee

offered to follow up with relevant local specialty societies. It was noted that similar resolutions/recommendations are making their way through these bodies at the national level and are expected to be adopted, and that should not delay the MMS. Furthermore, it was noted that [per HOD testimony] when the original resolution was drafted the report had been made incorporating the recommendations from pediatric urology and pediatric endocrinology. Ultimately, given the evidence to date and the strong desire to support the right of self-determination to those born with DSD/intersex, the CMPW desired to move forward with a recommendation on this resolution.

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

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

Conclusion

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

Recommendation:

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

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

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	No Significant Impact

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	2
Code:	Resolution I-19 A-101
Title:	E-Cigarette Consumer Warning Labels and Health Risk Research
Sponsors:	Noreen Siddiqi Hasmeena Kathuria, MD Faizah Shareef
Referred to:	Reference Committee A Mary Beth Miotto, MD, MPH, Chair

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Whereas, An MMS strategic initiative is Patients/2/Critical: Assess vulnerable populations and determine where the MMS can have the strongest impact on access to appropriate care, including social determinants of health and health disparities; and

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

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

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

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

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

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

MMS House of Delegates, 5/4/19

Liquid Nicotine Packaging *(Please See Additional Policy under Prescription and Non-prescription Drugs & Children and Youth)*
That the MMS advocate for state, local, and federal legislation and regulation to require child-resistant packaging and appropriate warning of the toxicity of this product for liquid nicotine refill products. *(D)*

MMS House of Delegates, 5/2/15

; and

Whereas, There have been 18 reported deaths linked to use of e-cigarette products (defined as personal vaporizing devices and e-liquids) as of 10/01/2019;[1] and

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

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

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

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

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

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

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

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

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[1] Centers for Disease Control and Prevention. Office on Smoking and Health. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html. Published 2019.

[2] NIDA. Electronic cigarettes (E-cigarettes). National Institute on Drug Abuse website. https://www.drugabuse.gov/publications/drugfacts/electronic-cigarettes-e-cigarettes. Published June 6, 2018. Accessed September 11, 2019.

[3] Jo CL, Golden SD, Noar SM, Rini C, Ribisl KM. Effects of e-cigarette advertising messages and cues on cessation outcomes. *Tob Regul Sci*. 2018;4(1):562–572. doi:10.18001/TRS.4.1.3.

[4] Hammond D, Fong GT, McNeill A, et al. Effectiveness of cigarette warning labels in informing smokers about the risks of smoking: Findings from the International Tobacco Control (ITC) Four Country Survey. *Tobacco Control.* 2006;15:iii19–iii25.

[5] American Lung Association. Do not use e-cigarettes: Nation's leading lung health organization warns of irreversible lung damage and disease associated with e-cigarette use. https://www.lung.org/about-us/media/press-releases/do-not-use-eigarettes.html. Published 2019.

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

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s)	Ongoing Expense of $3,000

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	3
Code:	Resolution I-19 A-102
Title:	Informing Physicians, Health Care Providers, and the Public That Cooking with a Gas Stove Increases Household Air Pollution and the Risk of Childhood Asthma
Sponsors:	T. Stephen Jones, MD Regina LaRocque, MD Brita Lundberg, MD
Referred to:	Reference Committee A Mary Beth Miotto, MD, MPH, Chair

Whereas, An MMS strategic initiative is Patients/2/Critical: Assess vulnerable populations and determine where the MMS can have the strongest impact on access to appropriate care, including social determinants of health and health disparities; and

Whereas, The MMS has the following relevant policies:

ENVIRONMENTAL HEALTH

Gas-Powered Leaf Blowers/Noise and Pollution

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

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

MMS House of Delegates, 4/29/17

Natural Gas

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

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

MMS House of Delegates, 4/29/17

; and

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

Whereas, Asthma in Massachusetts disproportionately affects Black and Hispanic children and children from low-income families;[2] and

[1] Asthma and Allergy Foundation of America. Asthma capitals 2019: The most challenging places to live with asthma. https://www.aafa.org/media/2426/aafa-2019-asthma-capitals-report.pdf. Published 2019. Accessed October 9, 2019.

[2] Massachusetts Department of Public Health. Prevalence of asthma in adults and children in Massachusetts. https://www.mass.gov/files/documents/2018/05/09/burden-in-mass.pdf. Published 2017. Accessed October 5, 2019.

Whereas, Household air pollution is a major health problem. Worldwide, it is responsible for more than three million deaths a year,[3] and indoor air pollution is strongly linked to asthma;[4] and

Whereas, Household and outdoor air pollution are social determinants of health and associated with an increased risk of asthma;[5,6] and air pollution contributes to health disparities in asthma;[7] and

Whereas, According to the United States Environmental Protection Agency (EPA), a growing body of scientific evidence indicates that, even in large cities, indoor air can be more polluted than the outdoor air;[8] and

Whereas, Burning natural gas creates nitrogen dioxide (NO_2), particulate matter ($PM_{2.5}$), carbon monoxide (CO), and other byproducts that contribute to air pollution;[9] and

Whereas, Nitrogen dioxide levels are significantly higher in homes with gas stoves than homes with electric stoves;[10,11] and

Whereas, In a simulation of homes where gas cooking stoves are used without exhaust ventilation hoods, indoor NO_2 levels exceed outdoor air quality standards in 41%–70% of homes;[12] and

Whereas, The burning of natural gas in stoves releases nitrogen oxides (NO_X) into indoor air and is an important source of household air pollution in the United States;[13] and

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[3] The World Health Organization. Household air pollution and health. https://www.who.int/news-room/fact-sheets/detail/household-air-pollution-and-health. Published May 8, 2018. Accessed October 5, 2019.

[4] Breysse PN, Diette GB, Matsui EC, Butz AM, Hansel NN, McCormack MC. Indoor air pollution and asthma in children. *Proc Am Thorac Soc*. 2010;7(2):102–106. doi:10.1513/pats.200908-083RM.

[5] Sharma H, Hansel N, Matsui E, Diette G, Eggleston P, Breysse P. Indoor environmental influences on children's asthma. *Pediatr Clin North Am.* 2007;54:103–120. https://doi.org/10.1016/j.pcl.2006.11.007.

[6] Guarnieri M, Balmes JR. Outdoor air pollution and asthma. *Lancet*. 2014;383(9928):1581-92.

[7] Forno E, Celedón JC. Health disparities in asthma. *Am J Respir Crit Care Med*. 2012;185(10):1033–1035. doi:10.1164/rccm.201202-0350ED.

[8] Environmental Protection Agency. The inside story: A guide to indoor air quality.https://www.epa.gov/indoor-air-quality-iaq/inside-story-guide-indoor-air-quality. Accessed April 8, 2019.

[9] Environmental Protection Agency . Natural gas combustion. www3.epa.gov/ttn/chief/ap42/ch01/final/c01s04.pdf. Accessed February 14, 2019.

[10] Belanger K, Gent JF, Triche EW, Bracken MB, Leaderer BP. Association of indoor nitrogen dioxide exposure with respiratory symptoms in children with asthma. *Am J Respir Crit Care Med*. 2006;173(3):297–303. doi:10.1164/rccm.200408-1123OC.

[11] Mullen NA, Li J, Russell, ML, Spears, M, Less, BD, Singer BC. Results of the California Health Homes Indoor Air Quality Study of 2011–2013: impact of natural gas appliances on air pollutant concentrations. *Indoor Air*. 2016;26: 231–245. https://doi.org/10.1111/ina.12190.

[12] Logue JM, Klepeis NE, Lobscheid AB, Singer BC. Pollutant exposures from natural gas cooking burners: A simulation-based assessment for Southern California. *Environ Health Perspect*. 2014;122:43–50. https://dx.doi.org/10.1289/ehp.1306673.

[13] Environmental Protection Agency. Nitrogen dioxide's impact on indoor air quality. https://www.epa.gov/indoor-air-quality-iaq/nitrogen-dioxides-impact-indoor-air-quality. Accessed October 12, 2019.

Whereas, According to the EPA, "Breathing air with a high concentration of NO_2 can irritate airways in the human respiratory system. Such exposures over short periods can aggravate respiratory diseases, particularly asthma, leading to respiratory symptoms (such as coughing, wheezing or difficulty breathing), hospital admissions and visits to emergency rooms. Longer exposures to elevated concentrations of NO_2 may contribute to the development of asthma and potentially increase susceptibility to respiratory infections. People with asthma, as well as children and the elderly are generally at greater risk for the health effects of NO_2";[14] and

Whereas, The World Health Organization recognized the associations between cooking with gas stoves, indoor NO_2 levels, and asthma in their 2010 guidelines for indoor air quality;[15] and

Whereas, Children living in a home with a gas cooking stove have a 42% increased risk of current asthma and a 24% increased lifetime risk of asthma according to a meta-analysis;[16] and

Whereas, A year-long, prospective study of NO_2 exposure in 1,342 children with active asthma in Massachusetts and Connecticut found a dose-response relationship between the amount of NO_2 exposure and risk of asthma severity. Every five-fold increase in NO_2 exposure above 6 parts per billion (ppb) was associated with a dose-dependent increase in the risk of asthma severity, wheeze, and rescue medication use;[17] and

Whereas, About one-third of households in the United States cook with gas stoves;[18] and

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

Whereas, In a randomized study comparing replacing gas stoves with electric stoves, using a free-standing high efficiency particulate air (HEPA) filters and installing above-stove hoods with exhaust fans were effective in reducing NO_2 levels;[20] and

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[14] Environmental Protection Agency. Nitrogen dioxide (NO_2) pollution. https://www.epa.gov/no2-pollution/basic-information-about-no2. Accessed April 8, 2019.

[15] Jarvis DJ, Adamkiewicz G, Heroux ME, et al. Nitrogen dioxide. WHO Guidelines for Indoor Air Quality: Selected Pollutants. Geneva: World Health Organization; 2010. https://www.ncbi.nlm.nih.gov/books/NBK138707/.

[16] Lin W, Brunekreef B, Gehring, U. Meta-analysis of the effects of indoor nitrogen dioxide and gas cooking on asthma and wheeze in children. *Int J Epidemiol*. 2013;42:1724–1737. doi:10.1093/ije/dyt150.

[17] Belanger K, Holford TR, Gent JF, Hill ME, Kezik JM, Leaderer BP. Household levels of nitrogen dioxide and pediatric asthma severity. *Epidemiology.* 2013;24(2):320–330. doi:10.1097/EDE.0b013e318280e2ac.

[18] US Department of Housing and Urban Development and US Census Bureau, American Housing Survey for the United States. www.census.gov/prod/2011pubs/h150-09.pdf. Published 2009. Accessed February 13, 2019.

[19] Kile ML, Coker ES, Smit E, Sudakin D, Molitor J, Harding AK. A cross-sectional study of the association between ventilation of gas stoves and chronic respiratory illness in U.S. children enrolled in NHANESIII. *Environ. Health*. 2014;13:71. doi:10.1186/1476-069X-13-71.

[20] Paulin LM, Diette GB, Scott M, McCormack MC, Matsui EC, Curtin-Brosnan J, Williams DL, Kidd-Taylor A, Shea M, Breysse P, Hanse NN. Home interventions are effective at decreasing indoor nitrogen dioxide concentrations. *Indoor Air*. 2014;24:416–424. doi:10.1111/ina.12085

Whereas, In Massachusetts, informal questioning found that many parents, health professionals, local health departments, local boards of health, and others did not know about the association between cooking with gas stoves and increased risk of asthma;[21] and

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

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

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

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

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

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	One-Time Expense $2,000

[21] Personal communication from T. Stephen Jones and Andee Krasner April 4, 2019.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	4
Code:	Resolution I-19 A-103
Title:	Expanding Access to Buprenorphine for Patients with Opioid Use Disorder
Sponsor:	Nicolas Trad
Referred to:	Reference Committee A Mary Beth Miotto, MD, MPH, Chair

Whereas, An MMS strategic initiative is Patients/2/Critical: Improving access to health care for vulnerable populations and cutting regulations that unnecessarily hinder physicians' ability to care for patients; and

Whereas, The opioid epidemic is a public health crisis of historic proportions that has contributed to a decline in the US life expectancy[1,2] and requires the coordinated efforts of Congress, health professionals, and health systems; and

Whereas, Buprenorphine is an evidence-based, lifesaving treatment for opioid use disorder, shown in the medical literature to reduce remission rates, medical complications, and overdose mortality rates tied to opioids;[3,4] and

Whereas, Physicians must meet burdensome requirements in order to prescribe buprenorphine, as per the federal Drug Addiction Treatment Act of 2000 (DATA 2000), including an eight-hour training course, a waiver application, and a cap on the number of patients they are eligible to treat;[5] and

Whereas, These restrictions have hampered our national response to the opioid crisis, with fewer than 8% of American physicians having obtained the DATA 2000 waiver[6] and more than half of US counties lacking a buprenorphine prescriber;[7] and

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[1] Murphy S, Xu J, Kochanek K, Arias E. Mortality in the United States, 2017. Published 2018. https://www.cdc.gov/nchs/products/databriefs/db328.htm.

[2] Hedegaard H, Miniño A, Warner M. Drug overdose deaths in the United States, 1999–2017. Published 2018. https://www.cdc.gov/nchs/products/databriefs/db329.htm.

[3] Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ*. 2017;357:j1550. doi:10.1136/bmj.j1550

[4] Tsui JI, Evans JL, Lum PJ, Hahn JA, Page K. Association of opioid agonist therapy with lower incidence of hepatitis C virus infection in young adult injection drug users. *JAMA Internal Medicine*. 174(12):1974–1978. doi:10.1001/jamainternmed.2014.5416

[5] Bliley T. H.R.2634 - Drug Addiction Treatment Act of 2000. Published 2000. https://www.congress.gov/bill/106th-congress/house-bill/2634. Accessed October 16, 2019.

[6] SAMHSA. Number of DATA-waived practitioners. https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/certified-practitioners. Published October 16, 2019. Accessed October 16, 2019.

[7] Rosenblatt RA, Andrilla CHA, Catlin M, Larson EH. Geographic and specialty distribution of US physicians trained to treat opioid use disorder. *Ann Fam Med*. 2015;13(1):23–26. doi:10.1370/afm.1735

Whereas, Rapidly expanding access to office-based buprenorphine treatment has the potential to save tens of thousands of lives, as it did in France, which witnessed a 79% drop in opioid-related overdoses in the three years following the deregulation of buprenorphine in 1995;[8] and

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

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

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	No Significant Impact

[8] Fatseas M, Auriacombe M. Why buprenorphine is so successful in treating opiate addiction in France. *Curr Psychiatry Rep*. 2007;9(5):358–364. doi:10.1007/s11920-007-0046-2

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

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

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

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

PRESCRIPTION AND NON-PRESCRIPTION DRUGS
Reduction of Illegal Drug Use
The MMS supports enhanced medical and public health approaches as effective methods of reducing the illegal use of illegal drugs. (HP)
MMS House of Delegates, 11/17/01
Amended and Reaffirmed MMS House of Delegates, 5/9/08
; and

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

PRESCRIPTION AND NON-PRESCRIPTION DRUGS
Substance Use and Misuse
…The MMS will work to advance policy and programmatic efforts to address gaps in voluntary substance-use treatment services. (D)...

…The MMS will advocate that the American Medical Association work to advance policy and programmatic efforts to address gaps in voluntary substance-use treatment services. (D)...
MMS House of Delegates, 4/28/18

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

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

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

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

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

; and

Whereas, Massachusetts is in the midst of an opioid crisis in which 1,981 citizens of the Commonwealth died of opioid-related overdoses in 2017;[1] and

Whereas, The three medications approved by the Food and Drug Administration for the treatment of opioid use disorder are methadone, buprenorphine, and naltrexone;[2-8] and

Whereas, Methadone has been used since the early 1960s for long-term treatment of opioid use disorder;[4,9-12] and

Whereas, Methadone has been shown to be effective in the treatment of opioid use disorder (OUD),[3,13-15] including reducing opioid use and overdose mortality;[5,15-17] and

Whereas, Interim methadone, allowing prescribing clinicians in licensed opioid treatment programs to induce waitlist patients onto methadone without psychosocial counseling, has been shown to be safe, and has been shown to reduce opioid use, HIV risk behavior, less illegal income, and days incarcerated compared to waiting list participants;[18-20] and

Whereas, Medical maintenance, allowing office-based prescribing clinicians to manage stable patients referred from opioid treatment programs has been shown to be safe and effective at reducing treatment dropout, overdoses, mortality, HIV transmission, emergency department and hospital utilization, and cost of care;[5,14,15,21,22] and

Whereas, Office-based methadone treatment for opioid use disorder, in collaboration with community pharmacists that can dispense and supervise methadone dosing, has been shown to be safe and improves retention in treatment for patients while reducing costs and increasing treatment capacity, especially in rural areas where access to specialty clinics may be limited;[5,23,24] and

Whereas, Methadone prescribing for opioid use disorder treatment from emergency departments has been associated with reduced risk of fatal overdose and all-cause mortality, increased patient use of ambulatory care, reduced use of ED and inpatient care, and indicated no net increase in expenditures;[25,26] and

Whereas, Methadone prescribing for opioid use disorder treatment from hospitals has been associated with improved retention in treatment, decreased readmission among patients with opioid use disorder, and reduced rates of serious infections requiring hospitalization;[27-29] and

Whereas, Methadone prescribing for opioid use disorder treatment in jails and prisons has been associated with increased medication initiation on release, improved continuity and coordination of care, and less injection drug use six months after release;[17,30-33] and

Whereas, Many patients with opioid use disorder prefer methadone over buprenorphine and/or naltrexone;[6,34-36] and

Whereas, Current federal and state regulations are highly restrictive of the use of methadone for the indication of opioid use disorder;[16,18,21,37-42] and

Whereas, Many parts of the Commonwealth, particularly rural areas, have been described as “Methadone Deserts”, because of poor access to this lifesaving treatment;[43,44] and

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

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

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

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

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

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

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	Ongoing Expense of $3,000

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MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	6
Code:	Resolution I-19 A-105
Title:	An MMS-Sponsored Educational Session to Explore the Impact of Decriminalizing the Use of Illegal Drugs and Their Possession in Amounts Consistent with Personal Use Only
Sponsor:	Ronald Newman, MD
Referred to:	Reference Committee A Mary Beth Miotto, MD, MPH, Chair

Whereas, An MMS strategic initiative is MMS/8/Immediate: To expand advocacy efforts in collaboration with key stakeholders on issues deemed critical to physicians and patients; and

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

PRESCRIPTION AND NON-PRESCRIPTION DRUGS

Substance Use and Misuse

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

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

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

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

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

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

The MMS will work with the Department of Public Health, the legislature, and other appropriate state agencies to advocate for the state wide expansion of pre-booking jail diversion programs that redirect criminally-involved, eligible, non-violent individuals with substance use disorders to treatment programs. (D)

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

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

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

MMS House of Delegates, 5/7/16

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

MMS House of Delegates, 5/4/19

; and

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

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

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

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[1] Downloaded from: "Harrison Narcotics Tax Act, 1914", Schaffer Library of Drug Policy, Published 12/17/1914, http://www.druglibrary.org/schaffer/history/e1910/harrisonact.htm. Accessed 12/22/2018

[2]Downloaded from: "Four Decades and Counting: The Continued Failure of the War on Drugs", Christopher J. Coyne and Abigail R. Hall, Published April 2017, https://www.cato.org/publications/policy-analysis/four-decades-counting-continued-failure-war-drugs#full.Accessed 12/22/2018.

[3]Downloaded from: "The Underestimated Cost of the Opioid Crisis", The Council of Economic Advisors, November 2017, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/The%20Underestimated%20Cost%20of%20the%20Opioid%20Crisis.pdf
Accessed 10/11/2019

[4] Downloaded from: "Drug Overdose Deaths", Centers for Disease Control and Prevention", Published June 27, 2019, https://www.cdc.gov/drugoverdose/data/statedeaths.html. Accessed 10/11/2019

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

Whereas, Some other countries wage war on illegal drugs based on assumptions and philosophies that are different from those used by the United States;[5] and

Whereas, Some of these countries have had success in decreasing both the morbidity and mortality related to drug use and the impact illegal drugs have had on the social and financial health of their people by decriminalizing the use of illegal drugs and the possession of small amounts consistent with personal use only;[5] and

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

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

Fiscal Note: (Estimated Expenses)	One-Time Expense of $8,000
Estimated Staff Effort to Complete Directive(s):	One-Time Expense of $4,500

[5] Downloaded from: "It's Time for the U.S. to Decriminalize Drug Use and Possession", Drug Policy Alliance, Published July 2017, http://www.drugpolicy.org/sites/default/files/documents/Drug_Policy_Alliance_Time_to_Decriminalize_Report_July_2017.pdf. Accessed 12/15/2018.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

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

Background

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

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

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

Current MMS Policy

ADVANCE CARE PLANNING/END-OF-LIFE CARE

Advance Care Planning

The MMS will continue to support the use of Medical Orders for Life Sustaining Treatment (MOLST) in Massachusetts, including providing education to Massachusetts providers regarding MOLST forms. (D)

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

[1] The Serious Illness Care and MOLST Challenge. Honoring Choices Website. www.honoringchoicesmass.com/resources/explore-information/molst-event-timeline/. Updated 2019. Accessed October 18, 2019.

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

MMS House of Delegates, 4/28/18

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

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

MMS House of Delegates, 5/18/07
Item 1: Amended and Reaffirmed MMS House of Delegates, 5/17/14
Item 2: Reaffirmed MMS House of Delegates, 5/17/14

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

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

MMS House of Delegates, 5/21/11
Amended and Reaffirmed MMS House of Delegates, 4/28/18
Reaffirmed MMS House of Delegates, 5/4/19

Current AMA Policy

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

AMA Policy D-85.992

Relevance to MMS Strategic Initiatives

Three MMS strategic priorities include the following:

- Patients/1/Intermediate: Advocate for technology and communication tools that improve health literacy, price transparency, and increase patient engagement.
- Patients/2/Critical: Assess vulnerable populations and determine where the MMS can have the strongest impact on access to appropriate care, including social determinants of health and health disparities.

- Patients/5/Intermediate: Enhance collaboration with patients; health care and technology organizations; community resources; and state, federal, and other stakeholders; with a focus on our patient-centered objectives.

Discussion

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

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

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

In October 2019, the 28-person MOLST Advisory Committee voted to recommend to the Massachusetts Department of Public Health that it adopt the national POLST form, to be accompanied by a Massachusetts Implementation Guide that reflects an improved governing structure and key implementation components.[2]

Adopting the national POLST form would bring Massachusetts into compliance with the national standard and builds in a standardized, evidence-based process and form. Every individual, their health care agent, and their guardian can engage in planning discussions with clinicians to receive quality care from first diagnosis of a serious illness, through managing treatment, to end-of-life care. Use of the POLST form would align the policies and procedures of all major stakeholders for better care transitions.[3]

Free multilingual documents and downloadable tools for consumers and care providers are available on the NPP website, as well as key implementation components such as online professional education, consumer education, and quality monitoring. The Massachusetts Medical Society's original goal of achieving reciprocity across states would be partially realized. Twenty-four states have adopted the POLST form, including New Hampshire, New York, and Maine, and 21 states are developing a POLST program.[4]

Conclusion

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

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[2] Ibid.

[3] A Game Changer for Living Well with Serious Illness. Honoring Choices Massachusetts website. www.honoringchoicesmass.com/a-gamechanger-for-ma-serious-illness-care/. Published October 4, 2019. Accessed October 18, 2019.

[4] National POLST Paradigm Program Designations. National POLST Paradigm website. https://polst.org/programs-in-your-state/. Updated 2019. Accessed October 21, 2019.

It is important that in addition to the NPP documents and tools, a Massachusetts-specific guide be developed. This would include education for physicians, the patient, the surrogate (if the patient lacks capacity), as well as physician assistants, nurse practitioners, advance practice registered nurses, advanced practice nurse practitioners, and emergency medical services.

The Massachusetts Medical Society should be the leading voice in educating physicians on the newly revised national POLST form for Massachusetts. This will include information on the proper use of the form for community-dwelling patients with serious illness, as well as use of the form throughout health care facility transition. The Society will have a strong impact on access to appropriate care for patients with serious illness, and the new national POLST form, Implementation Guide, and physician trainings will serve to "enhance collaboration with patients, health care and technology; community resources; and state, federal, and other stakeholders; with a focus on our patient-centered objectives."[5]

Recommendations:

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

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

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

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

Fiscal Note: (Estimated Expenses)	One-Time Expense of $10,000
Estimated Staff Effort to Complete Directive(s):	One-Time Expense of $2,500

[5] MMS Strategic Plan FY2020–FY2024. Massachusetts Medical Society website. www.massmed.org. Published March 2019. Accessed October 3, 2019.

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Reference Committee B — Health Care Delivery

Hearing Order

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	1
Code:	OFFICERS Report: I-19 B-1 [A-19 B-201]
Title:	Endorse “Medicare for All”
Sponsor:	MMS Presidential Officers: Maryanne Bombaugh, MD, MSc, MBA, FACOG David Rosman, MD, MBA Carole Allen, MD, MBA, FAAP
Report History:	Resolution A-19 B-201
	Original Sponsors: Hubert Caplan, MD, Patricia Downs, MD
Referred to:	Reference Committee B Odysseus Argy, MD, Chair

Background

At A-19, the House of Delegates (HOD) referred Resolution A-19 B-201, Endorse “Medicare for All,” to the Board of Trustees (BOT) for report back with recommendations at I-19. The BOT referred this resolution to the MMS Presidential Officers. The resolution states the following:

That the MMS take an important leadership role in the implementation of a universal healthcare system in the Commonwealth by endorsing and supporting “Medicare for All” by administrative, legislative, and educational (through existing channels) measures. *(HP/D)*

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff to Complete Directive(s):	Ongoing Expense of $3,000

Reference Committee and HOD Testimony

At A-19, 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 impassioned testimony both in favor and against this resolution. Those in favor of it stated that it is a call to action to have the Society pick from amongst the various options for improving the healthcare system; those who opposed it agreed, but felt that the Society needs to have all options at its disposal so that its advocacy and work can proceed along the lines most likely to succeed politically and practically. Some testimony suggested that the phrase “Medicare for All” means different things to different people, while some testified about language in a bill currently pending in the Massachusetts Legislature. In light of the divided testimony, and the current legislative environment, your reference committee recommends that this resolution be referred for decision.

The report was extracted by the resolution sponsor with a motion to refer to the Board of Trustees for a report back at I-19. Debate centered on addressing this issue in a timelier manner due to the current political environment and public discussions of this topic. The motion passed.

Current MMS Policy

The MMS has many policies in this area (please see Appendix A) that are not in alignment with one another, and the officers believe that if the proposed new policy (recommendation at end of report) is adopted, the Society should invest some time and "clean-up" existing policy and make recommendations to reflect alignment with the new policy if adopted.

Relevance to MMS Strategic Initiatives

The MMS strategic plan has a goal for patients relative to Access to Care that states, "All people will achieve optimal health and wellbeing through patient engagement and improved health literacy, and equal access to timely, comprehensive affordable, high-quality, integrated health care throughout their lives. (Access to Care goal of MMS strategic plan)

The MMS strategic plan also identifies that health, in all its dimensions, including health care, is a human right. (Patients/4/Critical)

Discussion

The officers discussed this matter both with the sponsors and, on a separate occasion, among themselves. The officers posed a series of questions to the resolution sponsors in advance.

The questions were are as follows:

"What do you mean by the term 'Medicare for All'? Specifically, what would MMS be supporting or endorsing? Please be as specific and descriptive as possible in your response; what would such a system look like, how would it function, what payment mechanisms would support it, and how would it be implemented? If you are simply referring to a payment mechanism, would it co-exist with other mechanisms such as employer provided insurance, Medicaid, Medicare/Medicare Advantage, and Connector plans, or would it replace all or some of these?"

The teleconference with the sponsors occurred on July 24, 2019, after which the sponsors responded in writing to the questions (on August 21, 2019), as follows:

"Medicare for All would be publicly funded through an equitable tax-based system and is privately delivered. It is not a socialist system. Probably the best way to answer the questions is to look at the bill. We feel that Massachusetts has been a leader in health care reform in the past and we should be able to be a leader now along with several other states that are close to passing Medicare for All bills. It is clear that the ACA is being destroyed in front of our eyes by massive cuts to Medicare and Medicaid, the deadly and unprecedented rise in the cost of prescription drugs, and the ever-rising cost of premiums and deductibles that make it hard for millions of Massachusetts residents to get the medical care they need. In addition, there are 200,000 to 300,000 people in the Commonwealth who have no insurance coverage. Our present system is broken; fragmented, complicated, difficult to navigate, too expensive, and is based on the premise that the quality of medical care a person gets depends on how much money they have. Is it really fair to have bronze to gold plans because some people can't afford

to buy the best? Where is the equity in this system? And of course, we must remember that medical outcomes in our present healthcare system are way below all the other industrialized countries'. And finally, the Commonwealth is spending 46% of the state budget on health care, and the figure climbs each year forcing cuts in education, housing, infrastructure, public safety and other important programs. We need a healthcare system that saves money and controls cost. So, we feel strongly that now is the time to support a Medicare for All system as defined by the Medicare for All bill currently in the [Massachusetts] legislature.

"One specific question about whether Medicare for All would replace all or some of the other programs is difficult to answer because in order for a state to have a true all-encompassing system it must have waivers from the Federal government. Medicaid waivers are quite common and could possibly be obtained, but there is no precedent for Medicare waivers. If Medicare would have to continue in its present form the Medicare for All state bill provides for coverage of services that are not covered by Medicare (wrap around coverage, vision, hearing, dental for example). This arrangement would not be as cost effective as a true National Medicare for All system, but would save money, cover everybody, and control costs and would show other states that they would benefit from this type of system.

"How would the Medicare for All bill be implemented? The bill states: The legislators may decide in their deliberations that there isn't enough time to bring the new system in. That is something that can be amended and of course the MMS can have a say in this particular question."

The officers deliberated at length over the resolution. There was a reluctance to endorse the concept of "Medicare for All" as it has so many different interpretations in Massachusetts and across the nation. The officers also felt that MMS policy should be broad-based to allow the MMS the ability to review multiple proposals guided by the new strategic initiatives and in particular the MMS principle that declares that health in all its dimensions, including health care, is a human right.

As noted previously, the MMS has many policies in this area that are not in alignment with one another, and the officers believe that if the proposed new policy is adopted, the Society should invest some time and "clean-up" existing policy and make recommendations to reflect alignment with the new policy if adopted.

<u>Conclusion</u>

The officers recommend adopting new language in lieu of the resolution as follows: That the Massachusetts Medical Society adopt in lieu of Resolution A-19 B-201 the following:

That the Massachusetts Medical Society supports a system for health insurance coverage that allows for universal access to quality, equitable, affordable coverage, including but not limited to a universally accessible public option. *(HP)*

That the Massachusetts Medical Society take a leadership role in advocating for health insurance coverage that allows for universal access to quality, equitable, affordable coverage, including but not limited to a universally accessible public option. *(D)*

That the Massachusetts Medical Society undertake a review of its policies regarding principles of health insurance coverage with a goal of consolidating such policies. *(D)*

Recommendation:
That the Massachusetts Medical Society adopt in lieu of Resolution A-19 B-201 the following:

1. **That the Massachusetts Medical Society supports a system for health insurance coverage that allows for universal access to quality, equitable, affordable coverage, including but not limited to a universally accessible public option. *(HP)***

2. **That the Massachusetts Medical Society take a leadership role in advocating for health insurance coverage that allows for universal access to quality, equitable, affordable coverage, including but not limited to a universally accessible public option. *(D)***

3. **That the Massachusetts Medical Society undertake a review of its policies regarding principles of health insurance coverage with a goal of consolidating such policies. *(D)***

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	Item 2: Ongoing Expense of $3,000 Item 3: One-Time Expense of $5,000

APPENDIX A

MMS Policy

The Massachusetts Medical Society adopted the policy on ***Health Care as a Basic Human Right****:*

1. *That the Massachusetts Medical Society asserts that enjoyment of the highest attainable standard of health, in all its dimensions, including health care, is a basic human right.*

2. *That the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.*

MMS House of Delegates, 5/4/19

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

1. *Physician leadership. Physician leadership is seen as essential for the implementation of new payment reform models. Strong leadership from primary care and specialty care physicians in both the administrative structure of accountable care organizations (ACOs) and other payment reform models, as well as in policy development, cost containment and clinical decision-making processes, is key.*
2. *One size will not fit all. One single payment model will not be successful in all types of practice settings. Many physician groups will have a great deal of difficulty making a transition due to their geographic location, patient mix, specialty, technical and organizational readiness, and other factors.*
3. *Deliberate and careful efforts must be undertaken to guard against the risk of unintended consequences in any introduction of a new payment system.*
4. *Fee-for-service payments have a role. While a global payment model could encourage collaboration among providers, care coordination, and a more holistic approach to a patient's care, fee-for-service payments should be a component of any payment system.*
5. *Infrastructure support. Sufficient resources for a comprehensive health information technology infrastructure and hiring an appropriate team of physician assistants, nurse practitioners, and other relevant staff are essential across all payment reform models.*
6. *Proper risk adjustment. In order to take on a bundled, global payment or other related payment models, funding must be adequate, and adequate risk adjustment for patient panel sickness, socioeconomic status, and other factors is needed. Current risk adjustment tools have limitations, and payers must include physician input as tools evolve and provide enough flexibility regarding resources in order to ensure responsible approaches are implemented. In addition, ACOs and like entities must have the infrastructure in place and individuals with the skills to understand and manage risk.*
7. *Transparency. There must be transparency across all aspects of administrative, legal, measurement, and payment policies across payers regarding ACO structures and new payment models. There must also be transparency in the financing of physicians across specialties. Trust is a necessary ingredient of a successful ACO or other payment reform model. The negotiations between*

specialists, primary care physicians, and payers will be a determining factor in establishing this trust.

8. *Proper measurements and good data. Comprehensive and actionable data from payers regarding the true risks of patients is key to any payment reform model. Without meaningful, comprehensive data, it becomes impractical to take on risk. Nationally accepted, reliable, and validated clinical measures must be used to both measure quality performance and efficiency and evaluate patient experience. Data must be accurate, timely, and made available to physicians for both trending and the ability to implement quality improvement and cost-effective care. The ability to correct inaccurate data is also important.*
9. *Patient expectations. Patient expectations need to be realigned to support the more realistic understanding of benefits and risks of tests and clinical services or procedures when considering new payment reform models. Physicians and payers must work together to provide a public health educational campaign, with an opportunity for patients to provide input as appropriate and engage in relevant processes.*
10. *Patient incentives. Patient accountability coupled with physician accountability will be an effective element for success with payment reform. An important aspect of benefit design by payers is to exclude cost sharing for preventive care and other selected services.*
11. *Benefit design. Benefit designs should be fluid and innovative. Any contemplation of regulation and legislation with regard to benefit design should balance mandating minimum benefits, administrative simplification, with sufficient freedom to create positive transparent incentives for both patients and physicians to maximize quality and value.*
12. *Professional liability reform. Defensive medicine is not in the patient's best interest and increases the cost of healthcare. In an environment where physicians have the incentive to do less, but patients request more, physicians view litigation as an inevitable outcome unless there is effective professional liability reform.*
13. *Antitrust reform. As large provider entities, ACO definitions and behavior may collide with anti-trust laws. The state legislature may be the adjudicator of antitrust issues. Accountable care organizations and other relevant payment reform models should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.*
14. *Administrative simplification. Physicians and others who participate in new payment models, including ACOs, should work with payers to reduce administrative processes and complexities and related burdens that interfere with delivering care. Primary care physicians should be protected from undue administrative burdens or should be appropriately compensated for it.*
15. *The incentives to transition. In order to transition to a new model, incentives must be predominantly positive.*
16. *Planning must be flexible. Accommodations must be made to take into account the highly variable readiness of practices to move to a new system.*
17. *Primary care physician. All patients should be encouraged to have a primary care physician with whom they can build a trusted relationship and from whom they can receive care coordination.*
18. *Patient access. Health care reform must enable patient choice in access to physicians, hospitals and other services while recognizing economic realities.*

MMS House of Delegates, 5/21/11
Amended and Reaffirmed MMS House of Delegates, 5/4/19

Fee-for-Service

The MMS recognizes that fee-for-service and private practice medicine can be efficient, ethical, and high quality medical care, with a long tradition of patient-centered care and cost-effective care which keeps patients at the center of treatment decisions.

The MMS, when advocating for system reform, enthusiastically advocates for preserving the viability of a private practice option, for the benefit of patients and our members.

MMS House of Delegates, 12/1/12
Reaffirmed MMS House of Delegates, 5/4/19

The Massachusetts Medical Society (MMS) acknowledges the unsustainable escalation of health care costs.

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

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

The MMS encourages a pluralistic compensation system to include fee-for-service, salary, and limited pilot studies that utilize global payment system.

The MMS acknowledges that the fee-for-service system has positive value in the payment for medical services.
The MMS will continue its strong support for medical liability reform to reduce the waste resulting from over utilization resulting from defensive medicine.

MMS House of Delegates, 5/14/10
Amended and Reaffirmed MMS House of Delegates, 4/29/17

The practice of defensive medicine is a major contributor to rising health care costs and liability reform should be a priority in health care reform legislation.

MMS House of Delegates, 12/5/09
Amended and Reaffirmed MMS House of Delegates, 5/7/16

Ideal Payer System

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

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

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

- *acute and chronic illness care;*
- *prevention of disease and disability by risk assessment and education to change behaviors that may lead to disease or injury, early disease detection and treatment: to prevent, diminish, compress, and delay its disablements;*
- *rehabilitation of disabled persons: to improve their function for work and living;*

- *immunization;*
- *counseling;*
- *unimpeded access to appropriate specialty and subspecialty care; and*

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

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

The MMS definition of an ideal payer system encompasses characteristics for payment of services and insurance, that include:

- *simplicity: uniform administrative criteria for eligibility and billing, single forms, and a single open formulary;*
- *accountability;*
- *consistency in benefit coverage limitations related to scientific evidence and expert opinion;*
- *timeliness;*
- *responsiveness: correction of defects; and*
- *appropriate funding*

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

The Massachusetts Medical Society (MMS) supports the achievement of universal insurance coverage and adopts the five principles from the Institute of Medicine's report Insuring America's Health: Principles and Recommendations:

i. *Health care coverage should be universal.*
ii. *Health care coverage should be continuous.*
iii. *Health care coverage should be affordable to individuals and families.*
iv. *The health insurance strategy should be affordable and sustainable for society.*
v. *Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable. (HP)*

MMS House of Delegates, 5/13/05
Amended and Reaffirmed MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
(Item 2 of Original: Sunset)

The MMS will continue to investigate options that work toward the goal of achieving ***universal insurance coverage****, that may include:*

a. *A non-disruptive and evolutionary approach to improving our current health care system, that is politically and economically viable and sustainable, and that includes quality and public health components.*
b. *The development of health care coverage products that are sufficiently comprehensive to provide meaningful health care, and that are affordable and can be obtained through appropriate purchasing pools for individuals or smaller employers.*
c. *A bi-modal approach of expanding public and private payer responsibilities; patients should have a choice between private and public financing.*
d. *Efforts to enhance current enrollment of Medicaid-eligible individuals and families, including appropriate opportunities through public and private entities.*
e. *Both individual and employer mandates, provided that affordable private health insurance and/or appropriate subsidies are made available.*
f. *Collaboration across all health care segments, including employers, health plans, health care organizations, legislators, and the administration for the State.*
g. *A single-payer health care reform as an option for achieving universal, comprehensive, equitable, patient centered, sustainable, and affordable health care for our patients.*

MMS House of Delegates, 5/13/05
Amended MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14

The Massachusetts Medical Society will utilize existing research and data to explore various options for providing universal access to health care, including single-payer, and convey this information to Society members.

The Massachusetts Medical Society strongly asserts that the ***fundamental goal of any change to the American health care system*** *should be to provide universal access to medical care for all Americans.*

Any proposed change to the American health care system which will decrease the likelihood of movement towards universal access to health care for all Americans will be strongly opposed by the Massachusetts Medical Society.

MMS House of Delegates, 11/17/95
Reaffirmed MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/14/10
(Item 3 of Original, Sunset)
Reaffirmed MMS House of Delegates, 4/29/17

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	2
Code:	Resolution I-19 B-101
Title:	Resolution for "Medicare for All" Defining the Term and Outlining the Payment Strategy and Reimbursement
Sponsor:	Nadia Urato, MD
Referred to:	Reference Committee B Odysseus Argy, MD, Chair

Whereas, An MMS strategic initiative is Patients/3/Intermediate: Advocate for affordability of care; and

Whereas, The MMS has the following policies:

HEALTH SYSTEM REFORM

Health Care Is a Basic Human Right

The Massachusetts Medical Society asserts that enjoyment of the highest attainable standard of health, in all its dimensions, including health care, is a basic human right. (HP)

The provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society. (HP)

MMS House of Delegates, 5/4/19

Ideal Payer

The MMS definition of an ideal payer system encompasses characteristics for payment of services and insurance, that include:

- *simplicity uniform administrative criteria for eligibility and billing, single forms, single open formulary;*
- *accountability;*
- *consistency in benefit coverage limitations related to scientific evidence and expert opinion;*
- *timeliness;*
- *responsiveness: correction of defects; and*
- *appropriate funding*

(HP)

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

; and

Whereas, The "Medicare for All" bill is before the Massachusetts Legislature;[1] and

[1] H.1194 (https://malegislature.gov/Bills/191/H1194/), S.683 (https://malegislature.gov/Bills/191/SD2062)

Whereas, In the opinion of many, getting prior authorizations and referrals from primary doctors places an undue administrative burden on all physicians and their patients; and

Whereas, Complicated credentialing and the ever-increasing health plans' "lines of business" cause confusion on whether a physician is a part of the plan for that patient; and

Whereas, Cost sharing models of health care systems are shown to be resulting in substandard health care (Health Serv Re. 2008 Apr, 43 (2):451–457); and

Whereas, Increasing co-payments, coinsurance, and deductibles require physicians to discuss financial costs with patients who then must make difficult choices compromising their care because of financial burden; and

Whereas, In the opinion of many, MassHealth does not provide adequate reimbursement for physician services and requires referrals from primary care doctors to see specialists, thereby placing administrative burden on physicians; and

Whereas, There is administrative hassle in collecting co-pays and sending invoices to patients for balances owed; and

Whereas, There is public concern that "Medicare for All" would restrict individuals' ability to select their physicians of choice; and

Whereas, There is doubt on the public's part that "Medicare for All" is affordable; and

Whereas, The current state legislation proposed has a payroll tax to fund the "Medicare for All" proposal; therefore, be it

1. **RESOLVED, That the MMS work with our representatives in the MA Legislature to specify that all health insurance reimbursements to physicians must at least match the then-current Medicare rates; that no referrals may be required to access specialists, and no deductibles and no co-pays may be present for patients, and patients must be allowed choice of doctors; and, be it further *(D)***

2. **RESOLVED**, **That the MMS use social media and public platforms to publicize the benefits of Medicare as listed here: sustainable for physicians; choice of doctors for patients; with no co-pays, no deductibles, and no premiums; and affordable if a payroll tax is instituted. *(D)***

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	Resolve 1: Ongoing Expense of $3,000 Resolve 2: One-Time Expense of $2,000

Item #:	3
Code:	Resolution I-19 B-102
Title:	Improving Access to Shingles Vaccination for Medicare Patients
Sponsors:	Keith Nobil, MD Essex South District Medical Society Ronald Newman, MD, President
Referred to:	Reference Committee B Odysseus Argy, MD, Chair

Whereas, An MMS strategic initiative is Patients/6/Intermediate: Advocate for access, affordability and quality of patient care to be the primary objectives of care integration; and

Whereas, The MMS has no policy concerning the shingles vaccine and the place of administration; and

Whereas, It is the policy of the MMS to improve and protect the health of our patients; and

Whereas, Over the past two years a new shingles vaccine, Shingrix, has become available. However, that vaccine is only reimbursed under Medicare Part D, which does not pay for office-based treatment. It remains unclear why that decision was made as the previous shingles vaccine, Zostavax, was covered in an office-based practice (Medicare Part B); and

Whereas, Medicare does cover other vaccines (influenza, both pneumococcal vaccines and Td) in the office; and

Whereas, Commercial insurers in Massachusetts, unlike Medicare, cover this vaccine in an office-based practice as they do with other vaccines; and

Whereas, This policy of the Centers for Medicaid and Medicare Services (not to cover in-office administration of the Shingrix vaccine) encourages our patients to forego the convenience of having their vaccine while being present for an office visit. They must travel to the pharmacy to obtain the vaccine; and

Whereas, It is generally acknowledged that patients are much more likely to accept a treatment as part of a meeting with their health care provider than if they have to make a separate trip to access the treatment, such that deferring the vaccination lessens the likelihood that the patient will receive it; and

Whereas, It is important to improve our patients access to this vaccine; therefore, be it

RESOLVED, That the MMS advocate to our AMA to encourage the Centers for Medicare and Medicaid Services to improve coverage of the new Shingrix vaccine in office-based practices. ***(D)***

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	No Significant Impact

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	4
Code:	Resolution I-19 B-103
Title:	Instituting Regulations on Large Multispecialty Groups to Prevent Denial of Referrals outside the Company and Pressure on Physicians within the Company to Refer to Company Specialists
Sponsor:	Nadia Urato, MD
Referred to:	Reference Committee B Odysseus Argy, MD, Chair

Whereas, Two MMS strategic initiatives are: Patients/6/Immediate: Advocate for access, affordability, and quality of patient care to be the primary objectives of care integration, and Physicians/1/Critical: Identify and implement three high-impact initiatives to advocate for the reduction of unnecessary regulations and administrative burdens; and

Whereas, The MMS has the following policies:

HEALTH CARE DELIVERY

Out-of-Network Referrals

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

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

MMS House of Delegates, 4/29/17

HEALTH INSURANCE/MANAGED CARE PLANS

Antitrust/Anticompetitive Markets

The Massachusetts Medical Society adopts the following adapted from an American Medical Association directive:

That the Massachusetts Medical Society work locally and with national stakeholders to monitor and oppose consolidation in the health insurance industry, given that it may result in anticompetitive markets. (D)

MMS House of Delegates, 5/7/16

The Massachusetts Medical Society (MMS) supports state and federal solutions to antitrust issues; and the MMS will continue efforts aimed at easing practice constraints on physicians engendered by Managed Care Plans. (HP)

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

The Massachusetts Medical Society supports legislation in the United States Congress that would allow physicians as a group to negotiate without fear of antitrust violation with payers, such as insurance companies, HMOs, and managed care companies on the

terms of physicians' contracts, such as payment rates, clinical decision-making and administrative responsibilities. (HP)

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

; and

Whereas, The MMS does not currently have a policy on the growing size of multispecialty corporations that are having and impact on the delivery of health care in the community; and

Whereas, Some large multispecialty corporations do one of the following:

- They refuse to give referrals to specialists outside of their corporation, thereby forcing providers to refer only to specialists within the corporation.
- They have centralized referral centers that decline out-of-corporation referrals even when requested by the patient.
- They refer to a specialist that is part of the corporation but inconvenient for the patient, because (a) the specialist is geographically remote from the patient, (b) there is a long wait time for an appointment, or (c) the specialist does not provide comprehensive services in the patient's community (e.g., only outpatient services when the patient requires in-hospital services).

; and

Whereas, The large multispecialty groups are increasing in size and domination in the marketplace, thereby approaching a monopoly on health care; and

Whereas, The consequence of large corporations being allowed to restrict their referrals to out-of-company physicians is hardship for patients and limits how comprehensive and timely care may be; and

Whereas, Some have heard that the attorney general's office of Massachusetts has received multiple complaints about the monopoly power of the multispecialty groups inhibiting free competition in the marketplace; and

Whereas, There are no current regulations or accountability placed on the multispecialty groups in the community regarding their ability to deny referrals; therefore, be it

1. **RESOLVED**, **That the MMS work with the attorney general's office and other appropriate entities to ensure that large multispecialty corporations are not permitted to force their physicians to refer to in-company specialists who may not be providing comprehensive services (hospital and outpatient services) that are convenient to the patient (in place or time) *(D)*; and, be it further**

2. **RESOLVED, That the MMS work with the attorney general's office and other appropriate entitites to ensure that large multispecialty corporations are not impeding the ability of patients or providers to obtain referrals to a particular specialist of their choosing outside the large multispecialty company. *(D)***

Fiscal Note: (Estimated Expenses) — No Significant Impact

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

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	5
Code:	Resolution I-19 B-104
Title:	Definition and Encouragement of the Appropriate Use of the Word “Physician”
Sponsors:	Christopher Garofalo, MD, FAAFP Bristol North District Medical Society Eric Ruby, MD, President
Referred to:	Reference Committee B Odysseus Argy, MD, Chair

Whereas, An MMS strategic initiative is Physicians/4/Intermediate: Identify factors that contribute to satisfying work environments and advocate with stakeholders for action, where needed; and

Whereas, The MMS has no policy concerning the definition and appropriate use of the word “physician”; and

Whereas, American Medical Association policy H-405.951 defines a physician as having a Doctor of Medicine or Doctor of Osteopathic Medicine, advocates for the definition of physician to be as above, and encourages physicians to insist on being identified as such and to use such a term rather than provider;[1] and

Whereas, The American Academy of Pediatrics (AAP) has a policy in its publications and conferences to cease using the term “provider” to describe board-certified pediatricians. The AAP also encourages fellows and the media to use the term “pediatrician,” “doctor,” or “physician,” instead of “provider” when describing board-certified pediatricians;[2] and

Whereas, The American Academy of Family Physicians has a position that the term "provider" implies uniformity of expertise and knowledge among health care professionals, and this terminology implies an interchangeability that is inappropriate and erroneous. The term "provider" is of bureaucratic origin and has no significance beyond regulators and insurers. The implication is that patients can expect to receive the same level of care from any “provider”;[3] and

Whereas, The term “provider” makes no reference to professional values, suggesting these values are not important. It has been noted that using the “provider” designation for health professionals risks deprofessionalizing them. Physicians, nurses, nurse practitioners, and physician assistants value their specific professional identities and are

[1] Ref: https://policysearch.ama-assn.org/policyfinder/search/Definition%20and%20Use%20of%20the%20Term%20Physician%20H-405.951/relevant/1/

[2] American Academy of Pediatrics, 2019 Annual Leadership Forum, Resolution #53 Calling Pediatricians “Doctors” Instead of “Providers”

[3] https://www.aafp.org/about/policies/all/provider-term-position.html

proud to be referred to as such and respected for the professional values they connote[4]; and

Whereas, Under federal regulations, a "health care provider" is defined as a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker... or a Christian Science practitioner;[5] and

Whereas, Physician burnout is a well-acknowledged problem in medicine. Jordan Cohen, MD, in his farewell address as president of the Association of American Medical Colleges noted that: “One of the biggest contributors to burnout is the high level of stress inherent in our job, combined with the lack of control over many aspects of our work. Not being in control of how we are addressed is the most basic of all issues that is ‘low hanging fruit’ to fix.”;[6] therefore, be it

1. **RESOLVED, That the MMS affirms that the term “physician” be applied and limited to those people who have attained a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), or a recognized equivalent physician degree; and, be it further *(HP)***

2. **RESOLVED, That the MMS utilize the term “physician” and discontinue use of the term “provider” when referring to an MD or DO in all communications, including but not limited to conferences, media, publications, and public relations messaging; and, be it further *(D)***

3. **RESOLVED, That the MMS advocate that references to physicians by state government, insurance companies and other health care entities in contracts, advertising, agreements, published descriptions, and other communications utilize the term “physician” and discontinue use of the term “provider;” and, be it further *(D)***

4. **RESOLVED, That the MMS urge physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and not to let the term physician be used by any other person involved in health care; and, be it further *(D)***

5. **RESOLVED, That the MMS advocate that our American Medical Association, American Academy of Family Physicians, American Academy of Pediatrics and any other appropriate medical organizations that have similar policy regarding the use of the term “physician” actively partner and cooperate in developing a sustained and wide-reaching public relations campaign to encourage use of the term “physician” and discourage use of the term “provider.” (*D)***

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	Resolved 3 and 4: Ongoing Expense of $4,500 Resolved 5: One-Time Expense of $1,500

[4] https://jamanetwork.com/journals/jama/fullarticle/2506307
[5] https://hr.berkeley.edu/node/3777
[6] Jordan J. Cohen, MD. AAMC Presidential Farewell Address, July 2006.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	6
Code:	Resolution I-19 B-105
Title:	Prohibiting Insurance Companies from Dictating How Much and How Often Medication Can Be Dispensed
Sponsor:	Cecilia Mikalac, MD
Referred to:	Reference Committee B Odysseus Argy, MD, Chair

Whereas, An MMS strategic initiative is Physicians/1/Critical: Identify and implement three high-impact initiatives to advocate for the reduction of unnecessary regulations and administrative burdens.

Whereas, The MMS has the following policies:

PRESCRIPTION AND NON-PRESCRIPTION DRUGS

Drug Formularies

Principles on Prescription Coverage

The Committee on Legislation shall support legislative and regulatory positions which support the rights of patients and physicians to choose the appropriate medication for the patient on a clinical basis. (HP)

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Item 1: Amended and Reaffirmed MMS House of Delegates, 5/19/12
(Items 2 and 3 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/14/19

Limits on Medications and Testing or Treatment Supplies

The MMS will advocate with third-party payers and federal and state entities to ensure that, if a payer uses quantity limits for prescription drugs or testing and treatment supplies, an exceptions process is in place to make certain that patients can access higher or lower quantities of prescription drugs, testing, or treatment supplies based on medical necessity, and that any such process should minimize the burden upon patients, physicians and their staff. (D)

The MMS supports the protection of the patient-physician relationship from interference by insurers' various utilization control mechanisms, including medication limits and testing or treatment supply quantity limits. (HP)

MMS House of Delegates, 12/1/12
Reaffirmed MMS House of Delegates5/4/19
(Item 2 of Original: Due for Review at I-19)

; and

Whereas, Some insurers are refusing to authorize payment for prescriptions unless they are dispensed in a 90-day supply, thus prohibiting the dispensing of more or less than a 3-month supply regardless of the physician request or medical appropriateness; therefore, be it

RESOLVED, That the MMS advocate to prevent health care insurers from basing their coverage of a prescription on how many days' supply is ordered or dispensed. *(D)*

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	Ongoing Expense of $3,000

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	7
Code:	Resolution I-19 B-106
Title:	Requiring Health Insurance Companies to Post Formularies Online
Sponsor:	Cecilia Mikalac, MD
Referred to:	Reference Committee B Odysseus Argy, MD, Chair

Whereas, An MMS strategic initiative is Patients/1/Intermediate: Advocate for technology and communication tools that improve health literacy, price transparency, and increase patient engagement; and

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

PREAUTHORIZATIONS

Preauthorizations/Decision-Making

It should be the responsibility of the insurer to provide transparency and full disclosure of formulary medications, acceptable alternatives, covered products and services, co-pays, and restrictions in electronic format to facilitate a less costly, more patient-centered, more expedient, and more satisfying method of pre-authorization. (HP)

MMS House of Delegates, 12/7/13

; and

Whereas, In the experience of the sponsor, Blue Cross Blue Shield of Massachusetts does not make its complete formulary available to patients online *except* if they are in a Medicare plan, thus depriving non-Medicare patients of an ability to research their formulary *before* their appointment and indicate in their visit which medications they would prefer based on cost. While patients can call or look up a single specifically named medication, they cannot, by phone or online, obtain a list of similar medications by indication (anti-asthmatic, antibiotic, cardiac, etc.), making it impossible to discover their options for a certain condition before their visit; and

Whereas, In the experience of the sponsor, Blue Cross Blue Shield of Massachusetts enables only the provider to view the current formulary online by category, thus requiring physicians whose patients have a formulary and limited financial resources to look the medication up during the visit, when the patient might be able to do so ahead of time; and

Whereas, Since these formulary lists by both medication name and category by indication already exist in digital form, it is unlikely to entail much cost or difficulty for the insurance company to make these available to beneficiaries; therefore, be it

1. **RESOLVED, That the MMS advocate with Blue Cross Blue Shield of Massachusetts (BCBS) to make their complete formulary available to all BCBS beneficiaries online; and be it further *(D)***

2. **RESOLVED, That the MMS advocate for legislation to require that private health insurance companies post their formularies online in a format that includes categorization by indication in order to allow all beneficiaries to view their options before their appointment. *(D)***

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	Resolved 1: Ongoing Expense of $1,500 Resolved 2: Ongoing Expense of $3,000

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	8
Code:	Resolution I-19 B-107
Title:	Defining a Core Electronic Health Record
Sponsors:	Michael Medlock, MD Maximilian Pany
Referred to:	Reference Committee B Odysseus Argy, MD, Chair

Whereas, An MMS strategic initiative is Patients/1/Intermediate: Advocate for technology and communication tools that improve health literacy, price transparency, and increase patient engagement; and

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

MEDICAL RECORDS/ELECTRONIC HEALTH RECORDS

Electronic Health Records

It is the policy of the Massachusetts Medical Society (MMS) that the clinical information contained in the Electronic Health Records (EHRs) be in a standardized format with nonproprietary, affordable exportability. (HP)

MMS House of Delegates, 11/6/04
Item 2 of Original: Reaffirmed, MMS House of Delegates, 5/21/11
Item 1 of Original: Reaffirmed MMS House of Delegates, 5/19/12
Item 1 of Original: Reaffirmed MMS House of Delegates, 5/7/16
(Item 2 of Original: Sunset MMS House of Delegates, 5/7/16)

The MMS will encourage the Office of the National Coordinator for Health Information Technology (ONC) to define HIT standards that can be freely used by HIT vendors/innovators to exchange medical information between EHRs and other HIT tools. (D)

MMS House of Delegates, 12/3/16

; and

Whereas, In the opinion of many, a comprehensive and accurate EHR is essential for good medical care; and

Whereas, there are many barriers to EHR interoperability; and

Whereas, EHR interoperability has been recognized as a major problem that limits the efficiency of care, negatively impacts the safety of care, and contributes to physician burnout;[1] and

[1] A Crisis in Health Care: A Call to Action on Physician Burnout. http://www.massmed.org/News-and-Publications/MMS-News-Releases/Physician-Burnout-Report-2018/

Whereas, Universal EHR interoperability is problematic because of ongoing innovation by different vendors; and

Whereas, After important information from other facilities is obtained, interoperability is usually not important for acute care in a single facility; and

Whereas, EHR information is generated from a wide variety of sources; and

Whereas, Acute care EHRs contain much redundant information; and

Whereas, Requiring a complete EHR in many locations is inefficient; and

Whereas, The medical information collected on patients varies widely in terms of acuity and long-term importance. At one end of the spectrum (high acuity, low long-term importance) is information such as a normal EKG trace during surgery, individual progress notes from a remote hospital admission, or unselected images from a normal abdominal CT scan. This information is of little value in longitudinal care. At the other end of the spectrum (low acuity, high long-term importance) is information that should be retained in the EHR over a lifetime, such as immunizations, adverse reactions to medications, operative reports, pathology reports, and hospital discharge summaries. Low-acuity documents that are most important for longitudinal care are usually textual, amendable to storage in a PDF format, and easily shared; and

Whereas, Defining a core EHR with low-acuity information of high long-term importance would facilitate longitudinal care; and

Whereas, Designating a primary custodian of the core EHR for every patient would i) limit redundancy and ii) ensure that patients and physicians know where to find the most comprehensive source of the most important documents for longitudinal care; therefore, be it

1. **RESOLVED, That the MMS endorses the principle of a core electronic health record (EHR) containing the most important documents for longitudinal care across the lifetime of every patient to be held by a primary custodian designated by the patient; and, be it further *(HP)***

2. **RESOLVED, That the MMS study and refine the specifications of a core EHR that are useful, adequate, practical, and achievable, with a report back at I-20; and, be it further *(D)***

3. **RESOLVED**, **That the MMS advocate that documents specified as a part of the EHR be submitted by every health care provider in a timely fashion to the primary custodian of the core EHR of each patient. *(D)***

Fiscal Note: (Estimated Expenses)	Resolved 2: One-Time Expense of $20,000
Estimated Staff Effort to Complete Directive(s):	Resolved 2: One-Time Expense of $3,500 Resolved 3: Ongoing Expense of $3,000

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	9
Code:	COL Report: I-19 B-2 [I-18 B-206]
Title:	Board of Registration Reporting Practices
Sponsor:	Committee on Legislation Theodore Calianos II, MD, FACS, Chair
Report History:	Resolution I-18 B-206 Original Sponsor: Kimberley O'Sullivan, MD
Referred to:	Reference Committee B Odysseus Argy, MD, Chair

Background

At I-18, the House of Delegates (HOD) referred Resolution I-18 B-206, Board of Registration Reporting Practices, to the Board of Trustees (BOT) for report back with recommendations at I-19. The BOT referred this resolution to the Committee on Legislation. The resolution states:

1. 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. *(D)*

2. 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. *(D)*

3. 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. *(D)*

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

Reference Committee and HOD Testimony

At I-18, the reference committee recommended that this resolution/report be adopted as amended. The following is the reference committee's proposed amendments and rationale:

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 unproven 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~~ consequences 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, if an inquiry into unproven allegations reveals anything likely to lead to discipline, the new inquiry must not ~~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~~ unproven allegations or ~~subsequent event~~ consequences that stemmed from the ~~unsubstantiated~~ unproven 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; and, be it further *(D)*

5. RESOLVED, That the MMS work with appropriate stakeholders to initiate reforms in the way the National Practitioner Data Bank (NPDB) and the Board of Registration in Medicine (BORIM) address rebuttals to unproven allegations. (*D*)

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

Your reference committee received copious testimony, both in person and online regarding this resolution. No testimony opposed the resolution; rather, the testimony was divided between recommending referral to the Board of Trustees (BOT), and recommending adoption. Generally, testimony was persuasive that physicians should have a way to remediate the harms caused by unsubstantiated allegations, and that the MMS should work toward the creation of such a mechanism. Those who recommended adoption were impassioned in their request that if the resolution were referred to the BOT, item 4 (dealing with a physician's ability to make a rebuttal statement on the BORIM profile about the physician) should nevertheless be adopted.

Some testimony indicated that the complexity of the wording of the resolution might obfuscate its intent, so your reference committee worked to revise the wording to clarify the intent as described in testimony. Other testimony suggested adding a fifth resolved clause to address the way the National Practitioner Data Bank handles rebuttals to unproven allegations. Your reference committee believes the general intent of the resolution, and of the testimony received, supports adoption of this resolved clause and expansion to include the BORIM.

For these reasons, your reference committee recommends that this resolution be adopted as amended.

The HOD discussion transcripts were provided to the Committee on Legislation for its review. The Committee on Legislation reviewed the discussion and took it under advisement during its deliberation of this resolution.

Current MMS Policy

No current MMS policy addresses the issues confronted by Resolution I-18 B-206.

Relevance to MMS Strategic Initiatives

This resolution does not relate to a strategic initiative.

Discussion

The Committee on Legislation concurred in the need to ensure greater due process protections for physicians against whom Board of Registration in Medicine complaints have been made, and to address the publication of allegations that are ultimately found to be unsupported in order to protect physicians' public profiles from containing erroneous information. The committee further felt it prudent to clarify the language of the resolution to more precisely reflect the intention behind it. To that end, resolves 1 and 2 were revised to address more accurately the current procedures of the Board of Registration in Medicine pertaining to physician profiles and reporting to the National Practitioner Data Bank. Furthermore, resolve 3 was amended to clarify the intent of holding a physician accountable for only allegations that have been found to be sufficiently supported by evidence. Resolve 4 was strongly supported as drafted.

Accordingly, the COL made suggestions for amending the language as follows (added text shown as "text" and deleted text shown as "~~text~~"):

~~1. That the MMS advocate, when allegations against a physician have been proven to be unsubstantiated, that the Board of Registration in Medicine 12 (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. *(D)*~~

1. That the MMS supports the disclosure on a physician's Board of Registration in Medicine (BORIM) or National Practitioner Data Bank (NPDB) profile of disciplinary actions, pleas, admissions, or findings of guilt or liability only when determinations are finalized and adverse to the physician. *(HP)*

~~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. *(D)*~~

2. That the MMS advocate for rescission from a physician's BORIM and/or NPDB profile of all information pertaining to disciplinary actions that have been fully reversed/annulled/rescinded/voided by the originating entity. *(D)*

3. That the MMS advocate that any ~~Board of Registration in Medicine (~~BORIM~~)~~ discipline that results from the BORIM scrutiny initiated from ~~unsubstantiated~~ original allegations that have since been found in favor of the physician must be a stand-alone discipline that does not include any reference to the ~~unsubstantiated~~ original allegations or subsequent event that stemmed from the ~~unsubstantiated~~ original allegations. (D)

4. 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)*

Ultimately, the committee recommended adopting the resolution as so amended.

Conclusion

It is recommended that the Massachusetts Medical Society adopt Resolution I-18 B-206 as amended by Committee on Legislation recommendation.

<u>Recommendation</u>:

That the Massachusetts Medical Society adopt as amended Resolution I-18 B-206 to read as follows:

1. **That the MMS supports the disclosure on a physician's Board of Registration in Medicine (BORIM) or National Practitioner Data Bank (NPDB) profile of disciplinary actions, pleas, admissions, or findings of guilt or liability only when determinations are finalized and adverse to the physician. *(HP)***

2. **That the MMS advocate for rescission from a physician's BORIM and/or NPDB profile of all information pertaining to disciplinary actions that have been fully reversed/annulled/rescinded/voided by the originating entity. *(D)***

3. **That the MMS advocate that any BORIM discipline that results from the BORIM scrutiny initiated from original allegations that have since been found in favor of the physician must be a stand-alone discipline that does not include any reference to the original allegations or subsequent event that stemmed from the original allegations. *(D)***

4. **That the MMS advocate for 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: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	Ongoing Expense of $3,000

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	10
Code:	Resolution I-19 B-108
Title:	Potentially Dangerous Consequences of the Well-Meaning Recently Adopted Policy That Health Care Is a Basic Human Right: Suggest That It Should be Reconsidered and Withdrawn
Sponsor:	William R. Cohen, MD
Referred to:	Reference Committee B Odysseus Argy, MD, Chair

Whereas, An MMS strategic initiative is to evaluate the impact and relevance of member-related products, services, and activities, and initiate a plan to discontinue those that do not offer strategic value to the membership; and

Whereas, The MMS has the following policy from the (American Medical Association) Principles of Medical Ethics:

…

 # VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

…

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

; and

Whereas, the MMS adopted the following policy at A-19:

HEALTH SYSTEM REFORM

Health Care Is a Basic Human Right

The Massachusetts Medical Society asserts that enjoyment of the highest attainable standard of health, in all its dimensions, including health care, is a basic human right. (HP)

The provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society. (HP)

MMS House of Delegates, 5/4/19

; and

Whereas, Taken literally, as physicians are the providers of health care, the concept that health care is a basic human right means that patients are entitled to such care. There is no conflict of interest between doctors and those who need their care and they are and should remain free to enter into an agreement or contract for the provision of such care. There is a distinction between saying that they each have the right to choose to enter such a contract and saying that one is entitled to the productive efforts of the other; and

Whereas, No one has the right to the productive efforts of another. Plantation owners did not have the moral right to the productive efforts of those who picked their cotton; “Need” itself does not constitute a just claim; and

Whereas, The assertion attributed to Karl Marx: “From each according to his ability and to each

according to his need", is wrong as it flies in the face of the concept of free men choosing to interact of their own free will; therefore, be it

1. **RESOLVED, That the MMS advocate for a free market in the realm of health care and health insurance, without intervention by the State; and, be it further *(D)***

2. **RESOLVED**, **That the MMS rescinds the Health Care is a Basic Human Right policy adopted at A-19, which reads as follows:**

   The Massachusetts Medical Society asserts that enjoyment of the highest attainable standard of health, in all its dimensions, including health care, is a basic human right. (HP)

   The provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society. (HP)

   MMS House of Delegates, 5/4/19

; and, be it further

3. **RESOLVED, That physicians as well as patients in need of health care are free to deal with each other by mutual consent without coercive interventions by the State. *(HP)***

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	Resolved 1: Ongoing Expense of $3,000

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.

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(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 C — MMS Administration

Hearing Order

**Placed on Speakers' Consent Calendar*

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	1
Code:	COB Report I-19 C-1 [A-19-C-301]
Title:	Bylaws Changes
Sponsor:	Committee on Bylaws Lee Perrin, MD, Chair
Report History:	Resolution A-19 C-301
Referred to:	Reference Committee C Tom Amoroso, MD, MPH, Chair

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The following item approved by the House of Delegates (HOD) has been referred to the Committee on Bylaws by the Board of Trustees (Board) for a report back at I-19:

ITEM A: Resolution A-19 C-301 Bylaw Change for Districted Appointed Member and Alternate Member to MMS Committees on Legislation and Nominations

That the MMS request that the MMS Bylaws be amended to implement the following:

Committee on Legislation Membership: Members of the Committee on Legislation of the Massachusetts Medical Society shall serve one-year terms with a maximum of nine consecutive years. Alternate members of the Committee on Legislation of the Massachusetts Medical Society shall serve one-year terms with a maximum of nine consecutive years.

Notwithstanding the foregoing, each district may, by a three-quarter vote at a District Annual meeting by ballot, extend eligibility of a member or alternate member of the Committee on Legislation beyond nine consecutive years.

Committee on Nominations Membership: Notwithstanding the foregoing, each district may, by a three-quarter vote by ballot at a District Annual meeting, extend eligibility of a member or alternate member of the Committee on Nominations beyond eight consecutive years. *(D)*

Pursuant to Section 21 of the Procedures of the House of Delegates, on behalf of the Board of Trustees of the Massachusetts Medical Society, the President sent a memorandum dated March 18, 2019, to the Committee on Bylaws recommending the following Bylaws change:

ITEM B: That the Committee on Bylaws propose a Bylaws amendment to change the composition of the Committee on Finance (COF) of the Massachusetts Medical Society so that of the nine appointed members of the COF, five at a minimum must be appointed from the members of the Board of Trustees.

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~~"):

ITEM A:

CHAPTER 3 • District Societies

• • •

3.21 Committee on Nominations Membership

Only delegates who have served as such for at least two years and have been members of the Society for at least five years are eligible to become members or alternate members of the Committee on Nominations of the Massachusetts Medical Society. Members of the Committee on Nominations shall serve one-year terms and shall not serve for more than eight total years as a member, after which they shall not be eligible for re-election. Alternate members of the Committee on Nominations shall serve one-year terms and shall not serve for more than eight total years as an alternate member, after which they shall not be eligible for re-election. Total years served includes all time served, regardless of when it was served, except that total years served shall not include time served filling a vacancy on the Committee on Nominations.

The eight-year term limit for members and alternate members of the Committee on Nominations shall become effective as of the close of the 2015 annual meeting of the Society.

Notwithstanding the foregoing, each district society may, by a three-quarter vote by ballot at its annual meeting, extend eligibility of a member or alternate member of the Committee on Nominations of the Massachusetts Medical Society beyond eight total years.

3.22 Committee on Legislation Membership

Members of the Committee on Legislation of the Massachusetts Medical Society shall serve one-year terms with a maximum of nine consecutive years. Alternate members of the Committee on Legislation of the Massachusetts Medical Society shall serve one-year terms with a maximum of nine consecutive years.

Notwithstanding the foregoing, each district society may, by a three-quarter vote by ballot at its annual meeting, extend eligibility of a member or alternate member of the Committee on Legislation of the Massachusetts Medical Society beyond nine consecutive years.

• • •

CHAPTER 11 • Committees

11.01 Term and Qualifications of Committee Members

• • •

Committee members elected by districts shall serve for ~~one year~~ terms ~~with a maximum of nine consecutive years, unless otherwise specifically provided in these bylaws~~ set forth in 3.21 and 3.22.

• • •

11.0411 Committee on Legislation

The Committee on Legislation shall be composed of a chair and a vice chair, both appointed from among the committee members by the President-elect and one member and alternate from each district society as provided in 3.14 and 3.22. When an immediate decision is needed concerning legislative action, the decision shall be made by the President (or in the absence of the President, by the President-elect; or in the absence of the President and President-elect by the Vice President) in consultation with the committee chair (or in the absence of the committee chair with the vice chair) of the Committee on Legislation. The chair of the Committee on Legislation shall report this decision to all members of the committee.

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ITEM B:

CHAPTER 7 • Board of Trustees

• • •

7.08 Committee on Finance

The Board of Trustees shall have a Committee on Finance, which shall consist of nine members each of who shall have been a Regular member of the Society for at least five years. Of these nine members, at least five must be current trustees. In addition, the Secretary-Treasurer and the Assistant Secretary-Treasurer shall each be a member ex-officio of the Committee. In addition, one member of the Medical Student Section and one member of the Resident and Fellow Section shall be a member of the Committee, but neither shall be included in the determination of the number of members to which the Committee is entitled.

• • •

(D)

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	No Significant Impact

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	2
Code:	BOT Report I-19 C-2
Title:	Affiliate Membership for Commonwealth of Massachusetts Schools of Public Health Non-Physician Deans
Sponsor:	Board of Trustees Maryanne Bombaugh, MD, MSc, MBA, FACOG, Chair
Referred to:	Reference Committee C Tom Amoroso, MD, MPH, Chair

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Background

Massachusetts schools of public health serve as integral partners of the Massachusetts Medical Society. The MMS Strategic Plan FY2020–FY2024 includes a number of public health strategic initiatives, including access to care, social determinants of health, and care integration. To advance our goals, the Medical Society will be engaging more than ever with our robust public health community and collaborating with educators, researchers, and clinicians.

The MMS Bylaws, Chapter, 2, Membership, Section 2.104, provides the following regarding affiliate membership:

2.104 Affiliate Members. Affiliate membership consists of persons other than physicians who are involved in or associated with medicine and wish to participate in achieving the purposes of the Massachusetts Medical Society.

2.1041 Requirements. Affiliate membership is conferred by a majority vote of the House of Delegates at a stated meeting provided an application signed by five Regular members was submitted at a previously stated meeting and the application has been approved by the Committee on Membership as provided in 11.0427.

2.1042 Rights and Privileges. Affiliate members may attend and address meetings of the Society and may serve on committees, but shall not be granted other rights and privileges, except that Affiliate members may be elected as Delegates-at-large and, if so elected, shall have the right to vote in the House of Delegates.

Discussion

On August 22, 2019, the Committee on Membership approved a recommendation of affiliate membership for Michelle A. Williams, dean of the faculty, Harvard T.H. Chan School of Public Health, and Anna Maria Siega-Riz, PhD, dean of the School of Public Health and Health Sciences, University of Massachusetts, Amherst.

Historically, the MMS has provided delegate-at-large status to the physician deans of Massachusetts medical and public health schools. Previously, the former dean of the faculty of the Harvard T.H. Chan School of Public Health, a non-physician, was approved for affiliate membership and was elected delegate-at-large to the MMS House of Delegates.

At the September 25, 2019, Board of Trustees (BOT) meeting, the BOT voted to approve the following:

1. *That the Board of Trustees approves recommending to the House of Delegates at I-19 that MMS grant affiliate membership to non-physician deans of Massachusetts schools of public health, and further recommends*

2. *That the House of Delegates grant affiliate membership to Michelle A. Williams, Dean of the Faculty, Harvard T.H. Chan School of Public Health, and Anna Maria Siega-Riz, PhD, Dean of the School of Public Health and Health Sciences, University of Massachusetts, Amherst.*

Relevance to MMS Strategic Initiatives

An MMS strategic priority is MMS/7/Intermediate: Create strategies that will engage various member constituent groups and increase engagement, diversity, and trust in MMS.

Conclusion

It is recommended that the MMS approve granting affiliate membership to any non-physician deans of Massachusetts schools of public health and grant an affiliate membership to Deans Williams and Siega-Riz. Upon approval of affiliate membership, these deans will be eligible for appointment as delegates-at-large to the HOD as recommended by the BOT at the Annual Meeting.

Recommendations:

1. **That the MMS grant affiliate membership to non-physician deans of Massachusetts schools of public health.** ***(D)***

2. **That the MMS grant affiliate membership to Michelle A. Williams, dean of the faculty, Harvard T.H. Chan School of Public Health, and Anna Maria Siega-Riz, PhD, dean of the School of Public Health and Health Sciences, University of Massachusetts, Amherst.** ***(D)***

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	No Significant Impact

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	3
Code:	CSP Report I-19 C-3 [A-19 C-4, Section C, 8c]
Title:	MMS Committees Structure Principles Policy (Policy Sunset Process: Reaffirmed One Year at A-19 Pending Review)
Sponsor:	Committee on Strategic Planning David Rosman, MD, MBA, Chair
Report History:	OFFICERS Report A-19 C-4 (Section C, 8c)
Referred to:	Reference Committee C Tom Amoroso, MD, MPH, Chair

Background

At A-19, through the sunset policy review process, the following policy was reaffirmed for one year pending analysis for a potential new policy submission. The Board of Trustees referred this item to the Committee on Strategic Planning (CSP). The policy for review states:

MASSACHUSETTS MEDICAL SOCIETY ADMINISTRATION AND ORGANIZATION

Committees/Sections

The Massachusetts Medical Society (MMS) supports the following principles and recommendations:

MMS Committee Structure Principles

The CSP shall:

a) Review the MMS committee structure as warranted;

b) Develop a comprehensive action and communication plan for any committee structure changes;

The MMS shall:

c) Review committee productivity against committee action plans and current environmental/leadership needs, including the Society's strategic priorities;

d) Review a more comprehensive leadership and coaching process for the MMS leadership (including district, committee, and potential future leaders) regarding their responsibilities and leadership skills;

e) Explore, develop, and promote new methods for encouraging committee participation that will attract and retain members;

f) Prior to each Presidential Year, develop a comprehensive outreach communication plan to members and specific targeted populations to promote the work of the MMS committees.

(HP)

MMS House of Delegates, 5/13/05
Amended and Reaffirmed MMS House of Delegates, 5/19/12

Reference Committee Testimony

At the A-19 reference committee, no testimony was given, and the reference committee supported the officers' recommendation in their report to reaffirm this policy for one year, pending further review.

Relevance to MMS Strategic Initiatives
An MMS strategic initiative is MMS/3/Immediate: Reform governance to accomplish the strategic goals and objectives.

Discussion
The CSP met on September 10, 2019, and reviewed the policy. The CSP reviewed the MMS Strategic Plan with a particular focus on MMS/3/Immediate: Reform governance to accomplish the strategic goals and objectives. Much of that work will be undertaken by the CSP during the coming year with the assistance of Tecker International. It was noted that the committee chairs, vice chairs, and staff liaisons had been invited to an orientation to learn of the strategic initiatives and the need to align committee activities with them. It was also noted that with the new Strategic Plan in place and review of committees' action plans by the presidential officers and the Board of Trustees, the work of the CSP will be significantly different than the policy. A vote was taken to recommend that the policy be sunsetted. The CSP and a process for review of committee activities in alignment with the MMS Strategic Plan will continue.

Conclusion
The work of the CSP in alignment with the new Strategic Plan will be significantly different than the current policy would suggest, and the principles should be sunsetted.

Recommendation:
That the Massachusetts Medical Society sunset the MMS Committee Structure Principles policy amended and reaffirmed at A-12, which reads as follows:

MMS Committee Structure Principles

The CSP shall:

a) Review the MMS committee structure as warranted;
b) Develop a comprehensive action and communication plan for any committee structure changes;

The MMS shall:

c) Review committee productivity against committee action plans and current environmental/leadership needs, including the Society's strategic priorities;
d) Review a more comprehensive leadership and coaching process for the MMS leadership (including district, committee, and potential future leaders) regarding their responsibilities and leadership skills;
e) Explore, develop, and promote new methods for encouraging committee participation that will attract and retain members;
f) Prior to each Presidential Year, develop a comprehensive outreach communication plan to members and specific targeted populations to promote the work of the MMS committees.

(HP)

MMS House of Delegates, 5/13/05
Amended and Reaffirmed MMS House of Delegates, 5/19/12

Fiscal Note: (Estimated Expenses) — No Significant Impact

Estimated Staff Effort to Complete Directive(s): — No Significant Impact

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	4
Code:	BOT Report I-19 C-4
Title:	Special Committee Renewals and Continuance
Sponsor:	Board of Trustees Maryanne Bombaugh, MD, MSc, MBA, FACOG, Chair
Referred to:	Reference Committee C Tom Amoroso, MD, MPH, Chair

EXECUTIVE SUMMARY

As directed by the House of Delegates (HOD), all requests for approval of special committee continuance should include a brief written evaluation and recommendation by the Board of Trustees (BOT) as presented in the attached report. This report has detailed information, including background, history, and current requests from 17 of 22 special committees seeking renewal/continuance for three years; the evaluation process and request for data from special committees on how their work supports the strategic plan; review of data collected; observations/conclusions; and recommendations.

In support of the recommendations, the BOT recognizes the following points:

- The MMS must preserve the participatory, democratic nature of the organization, and the importance of member engagement.
- The MMS must ensure that key structures such as committees and processes support the MMS's longer-term vision and strategy as directed by the FY2020–2024 Strategic Plan approved at A-19.
- The structure for member engagement is changing, with current data indicating practicing physicians prefer short-term, focused project work over long-term commitments of serving on committees.
- In order to take advantage of future opportunities and respond to future challenges, there needs to be increased flexibility, responsiveness, nimbleness, and adaptability in the structure and processes by which work is done.
- Most special committees were created to advise on a specific topic, and be a resource, or provide counsel for targeted populations or specific subject matter. Most were not designed to produce concrete work products.
- Creating efficiencies in the way committees are structured will allow us to engage more members in specific work, increase work impact, increase responsiveness, increase communication and integration of group work, eliminate ongoing duplication of work and support the strategic initiatives.
- The BOT's fiduciary responsibility to the MMS is to oversee stewardship of both its financial and human resources.

In summary, the BOT recommends that beginning in FY21**, the work of all current FY20 special committees and any proposed future special committees be aligned within any future governance model which may include existing standing committees, task forces, sections, or member interest networks.**

The Board of Trustees trusts that the Medical Society would benefit from the adoption of the recommendations being made. The recommendations would change the structure of how strategically aligned work is planned and done, and therefore increase the impact towards achieving the MMS goals. **If approved by the HOD, the MMS leadership and the BOT will design an action plan with the special committee leadership and their committee members to transition the special committees' structure into a new model**.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	4
Code:	BOT Report I-19 C-4
Title:	Special Committee Renewals
Sponsor:	Board of Trustees Maryanne Bombaugh, MD, MSc, MBA, FACOG, Chair
Referred to:	Reference Committee C Tom Amoroso, MD, MPH, Chair

Background

To position the MMS to take advantage of future opportunities and respond to future challenges, we must also ensure that key structures, such as committees and processes, support the MMS's longer-term vision and strategy while preserving the participatory, democratic nature of the organization. To this end we have taken an objective and comprehensive look at our committee structure with specific focus on special committees that are up for renewal.

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 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 this information and providing recommendations to the BOT on special committee renewals.

The charge to the Officers included gathering the following information for special committees requesting term continuance and reporting their recommendation to the Board of Trustees for review, approval, and submission to the House of Delegates.

- 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 (MMS) for work performed
- Uniqueness of the committee (i.e., function not duplicated elsewhere in the Massachusetts Medical Society)

For reference, the MMS Bylaws state the following regarding special committees:
Special Committees. The House of Delegates may at any meeting establish special committees as provided in 11.051.

11.05 Special Committees
11.051 Special Committees Established by the House of Delegates
Special Committees may be established by the House of Delegates at any time. Unless the House of Delegates directs otherwise, the President shall appoint the committee members and the committee members shall elect the chair of each such committee.

Each special committee established by the House of Delegates shall exist for a term up to three (3) years as shall be designated by the House of Delegates and shall cease to exist at the end of the term unless the House of Delegates directs otherwise.

11.0511 Special Committee Members Appointed by the President-elect

The President-elect may, subject to approval by the House of Delegates, appoint special committees to serve during the term of office as provided in 8.053(3)(c). Each such committee member's term shall end at the close of the next Annual Session of the Society unless the then President-elect obtains approval by the House of Delegates to re-establish the committee. Each committee shall select its chair from among the members who have had at least one-year experience on the committee, except for new committees. The chair selection will occur at the first committee meeting of each presidential year.

11.052 Activities of Special Committees

Special committees may not be given assignments that conflict with or duplicate functions of any other committee of the Society.

History

In October 2018, the Officers' findings from the reports from eight (8) committees requesting renewal (Accreditation Review, Diversity in Medicine, Environmental and Occupational Health, Men's Health, Nutrition and Physical Activity, Sponsored Programs, Oral Health, and Senior Physicians) were presented to the Board of Trustees and approved for submittal to the House of Delegates. The report indicated at that time that the MMS was engaged on several fronts to review its strategic planning, governance, and future focus and anticipated that this work will encompass a review of committee purposes and alignment with other committees. To that end, they recommended a one-year continuance for these committees while this work was taking place and it was approved by the House of Delegates. The report also indicated that the recommendation was not a reflection on the value of the work of these committees.

Current Requests for Renewal

The following committees were renewed for one (1) year at I-18 for the period FY20 (June 2019–May 2020) and currently are seeking renewal for a three (3) year term beginning in June 2020 for FY2021–FY2023 (June 2020–May 2023)

1. Accreditation Review
2. Continuing Education Review (formerly Sponsored Programs)
3. Diversity in Medicine
4. Environmental and Occupational Health
5. Men's Health
6. Nutrition and Physical Activity
7. Oral Health
8. Senior Physicians

The following additional committees with three (3) year terms ending in May 2020 are seeking renewal for another three (3) year term beginning in June 2020 for FY2021–FY2023 (June 2020–May 2023).

9. Geriatric Medicine
10. History
11. Information Technology
12. LGBTQ Matters
13. Maternal and Perinatal Welfare
14. Senior Volunteer Physicians
15. Student Health and Sports Medicine
16. Violence Intervention and Prevention
17. Young Physicians

Process

In June 2019, the new fiscal year started with an education and training session for all committee chairs, vice chairs and staff liaisons to acquaint them with the new Strategic Plan (Attachment A) and its priority strategic initiatives. Committees were advised to review the plan and align their activities this year with priority initiatives identified as critical or immediate on the Strategic Initiative Priority Grid (Attachment B).

In preparation for this annual process, the Presidential Officers considered what additional data was needed to be collected from committees to objectively evaluate how their activities align with the new Strategic Plan. The template for the Committee Reports on Activities and Initiatives (Reports) was updated to include requests for the additional data to assist in the review process and to assess how the work of the committee is supporting the Strategic Plan. For those seeking continuance of their committee, additional information was requested on how their work aligns with the strategic plan and how the committee activities support MMS Strategic Initiatives 1–3 under Goal C: The Massachusetts Medical Society, as illustrated below.

GOAL C: The Massachusetts Medical Society
MMS will be the most trusted and respected leadership voice in health care, advancing medical knowledge and the medical profession to improve patient care and outcomes, maintaining a sound financial position and a diverse, engaged, and expanding membership.

Goal/ Beneficiary	Init #	Strategic Initiative	Priority
MMS	1	Evaluate impact and relevance of member-related products, services, and activities, and initiate a plan to discontinue those that do not offer strategic value to the membership.	Critical
MMS	2	Narrow focus and prioritize activities to align with our strategic plan.	Immediate
MMS	3	Reform governance to accomplish the strategic goals and objectives.	Immediate

At the President's Advisory Meeting on Wednesday, September 11, 2019, the Officers discussed the process for reviewing the data and developed objective criteria for evaluation of special committees seeking renewal. A Special Committee Renewal Decision Tree (Attachment C) was created addressing alignment with the strategic priorities, overlap or synergies with other committees, whether quorum was met for 2/3 of committee meetings, and affordability/cost to the MMS (direct expenses plus dedicated staff resources).

Recognizing the need for support with this task and its urgent timeline as requested renewals were imminent, the Officers reached out to Trustees to assist in this more comprehensive review process. At their meeting on September 18, the Presidential Officers and two Board volunteers reviewed the data collected from the 43 committees in preparation for the Board meeting on September 25. The charge for the working group was to review all Special Committee Requests for Renewal (17 committees) against the Special Committee Renewal Decision Tree and prepare draft recommendations for BOT approval and a report for submittal to the HOD at I-19. The charge also included a

review of all Committee Reports on Activities and Initiatives (43 committees) to determine alignment with the Strategic Plan.

Review of Data

MMS staff prepared a summary document (Attachment D) of the data collected from the Reports (special committee reports available at www.massmed.org/specialcomm/). The summary includes committee type, year established, renewal date for special committees, any assignments from strategic initiative plans for FY20, self-identified strategic initiatives, average attendance at meetings, number of meetings/number with a quorum, FY19 expense, FY20 budget, FY20 estimated cost of staff resources, total FY20 estimated expenses (FY20 budget plus staff), number of committee members in FY20, number of advisors, and estimated cost per member.

Conclusion

During the process of applying the Decision Tree to each of the special committees, it became clear, based on the objective data collected on the committees, that the special committees as structured did not meet the criteria to continue to serve in their current capacity and to be granted another three (3) year term.

Based on the data provided, the following observations were made:

- Most special committees were created to advise on a specific topic area, be a resource or provide counsel for targeted populations or a specific subject matter. Most were not designed to produce concrete work products.
- Six (6) of the 22 special committees were assigned work to support the current critical and immediate priority strategic initiatives, although each of the others did self-identify a strategic initiative for their activities.
- In some cases, the committees have been in existence for more than 30 years and up to 40+ years, with a small number of engaged members currently attending meetings [e.g., Maternal and Perinatal Welfare (est. 1988): 9 of 18 members on average attending meetings/Nutrition and Physical Activity (est. 1976): 7 of 12 members on average attending meetings.]
- Several committees failed to meet a quorum. (e.g., Diversity in Medicine: 0 of 5 meetings; Men's Health: 1 of 6 meetings). In the case of Men's Health, additional information was shared regarding challenges with engaging members and finding a volunteer to lead the committee.
- The estimated total cost to support the efforts of special committees is approximately $250,000 in FY20 (e.g., catering, staff resources, etc.)
- The average cost per member (289 members) assigned to all special committees is $865/member, with an average attendance of 59%, (not including 43 advisors). Note: The 289 members are not unique special committee members, there is member overlap among committees.
- Synergies with current standing committees, task forces, sections, and member interest networks:
    - There was agreement that most special committees could be categorized as serving in an advisory/counsel role to existing standing committees. Examples below:
        - Clinical/Medical Practice (CQMP)
            - (e.g., Information Technology, LGBTQ Matters, Maternal and Perinatal Welfare, Men's Health, Sustainability of Private Practice, Women's Health, Young Physicians)
        - Membership/Member Interest Networks
            - (e.g., Senior Physicians, Senior Volunteer Physicians, Young Physicians)

        - Public Health
            - (e.g., Global Health/Preparedness/Environmental and Occupational Health/Violence Intervention and Prevention)
        - Operational Function
            - [e.g., Accreditation Review and Continuing Education Review (formerly Sponsored Programs), provide an operational function that supports a core function of providing CME, History]
- Designated Representative Seats
  In some cases, it was agreed that designating a seat on a standing committee (as mentioned above) to represent a specific population or interest may serve the mission or goal of certain special committees without duplicating the efforts and associated expenses to support another committee structure. (e.g., Women's Health — Advisory to Committee on Quality of Medical Practice with a representative seat on Women Physician Section; LGBTQ Matters — Advisory to Committee on Quality of Medical Practice with representative seat on Minority Affairs Section, Committee on Quality of Medical Practice, and Committee on Public Health)
- Creating efficiencies in the way committees' function will allow us to engage more members in specific work and support the strategic initiatives to steward our human and financial resources.

Options (not mutually exclusive) for restructuring included the following:

- Subcommittees of Standing Committees
    - Serve under the umbrella of a standing committee.
    - Would have a budget and designated staff to support meetings and work products.
    - Results of Subcommittee work would be reported up through the standing committee.

- Advisory Panels to Standing Committees
    - Appointed experts serving as needed on a designated panel in advisory role to support the work of a standing committee.
    - Budget and staff resources allocated as needed.

- Ad Hoc Committees
    - Advisory panel members convened for a specific task.
    - Budget and staff resources allocated as needed.

- Task Forces
    - Appointment of members to address a specific task for a defined period. It was noted that in a recent MMS study conducted by Denneen & Company, our members prefer to engage on task-oriented groups for short periods of time, with a defined goal and measured results.
    - Budget and staff resources allocated as needed

- Member Interest Networks
    - For those committees offering networking and engagement around a specific topic of interest or similar demographic.

Restructuring of Special Committees would occur thoughtfully with input from all stakeholders. Examples of possible Special Committee synergies and realignment of work with standing committees, task forces, sections, member interest networks follow:

1. Accreditation Review (*Subcommittee of Committee on Medical Education*)
2. Continuing Education Review (*Subcommittee of Committee on Medical Education*)

3. Diversity in Medicine (*Minority Affairs Section*)
4. Environmental and Occupational Health (*Advisory Panel — Committee on Public Health*)
5. Geriatric Medicine (*Advisory Panel — Committees on Quality of Medical Practice and Public Health*)
6. Global Health (*Advisory Panel — Committee on Public Health*)
7. History (*Advisory Panel — Committee on Administration and Management*)
8. Information Technology (*Advisory Panel — Committee on Quality of Medical Practice)*
9. LGBTQ Matters (*Advisory Panel — Committee on Quality of Medical Practice, Representative Seat — Minority Affairs Section, Committee on Public Health)*
10. Maternal and Perinatal Welfare (*Advisory Panel — Committee on Quality of Medical Practice)*
11. Mental Health and Substance Use (*Task Force, Representative Seat — Committee on Quality of Medical Practice*)
12. Nutrition and Physical Activity (*Advisory Panel — Committee on Public Health*)
13. Oral Health (*Advisory Panel — Committee on Public Health*)
14. Physician Preparedness (*Advisory Panel — Committee on Public Health*)
15. Senior Physicians (*Member Interest Network*)
16. Senior Volunteer Physicians (*Member Interest Network*)
17. Student Health and Sports Medicine (*Advisory Panel — Committee on Public Health*)
18. Sustainability of Private Practice (*Subcommittee of Committee on Quality of Medical Practice)*
19. Violence Intervention and Prevention (*Advisory Panel — Committee on Public Health*)
20. Women's Health (*Advisory Panel — Committee on Public Health*)
21. Young Physicians (*Advisory Panel — Committee on Quality of Medical Practice, Member Interest Network)*

(*Men's Health not included — recommended for sunset.*)

The changes suggested in the report would provide benefits such as opportunities to increase member engagement and work impact, increase responsiveness, increase communication and integration of group work, eliminate ongoing duplication of work, and create efficiencies and work effort flexibility that are not currently present.

The Board of Trustees trusts the Medical Society would benefit from the adoption of the recommendations being made in place of recommending approval of special committee requests for renewal for three (3) years in their current structure. The BOT has been charged by the HOD through the approved strategic plan to align the work of committees with the strategic initiatives and goals in a manner that demonstrates stewardship of human and financial resources and optimizes the impact of MMS work efforts.

If approved by the HOD, MMS leadership and the BOT will design an action plan with all stakeholders to transition the special committees' structure into a new model.

In summary, the BOT, as the fiduciary of the Medical Society, after comprehensive and careful review of special committee data, thoughtful and extensive discussion, and consideration for transitions and communications, approved the following recommendations regarding special committees:

To recommend to the House of Delegates at I-19:

1. That beginning in FY21, the work of all current FY20 special committees and any proposed future special committees be aligned within any future governance model,

including the existing standing committees, task forces, sections, or member interest networks.

2. That the MMS sunset the following special committees requesting renewal at the end of FY20 (May 2020): Accreditation Review, Continuing Education Review, Diversity in Medicine, Environmental and Occupational Health, Geriatric Medicine, History, Information Technology, LGBTQ Matters, Maternal and Perinatal Welfare, Nutrition and Physical Activity, Oral Health, Senior Physicians, Senior Volunteer Physicians, Student Health and Sports Medicine, Violence Intervention and Prevention, and Young Physicians, and further recommends

   That the MMS sunset the following special committees at the end of FY20 (May 2020): Global Health, Mental Health and Substance Use, Physician Preparedness, Sustainability of Private Practice, and Women's Health.

3. That the MMS sunset the Committee on Men's Health, effective immediately, with gratitude for the past work and efforts of its members (12) currently serving on the committee.

<u>Recommendations</u>:

1. **That beginning in FY21, the work of all current FY20 special committees and any proposed future special committees be aligned within any future governance model including the existing standing committees, task forces, sections or member interest networks. *(D)***

2. **That the MMS sunset the following special committees requesting renewal at the end of FY20 (May 2020): Accreditation Review, Continuing Education Review, Diversity in Medicine, Environmental and Occupational Health, Geriatric Medicine, History, Information Technology, LGBTQ Matters, Maternal and Perinatal Welfare, Nutrition and Physical Activity, Oral Health, Senior Physicians, Senior Volunteer Physicians, Student Health and Sports Medicine, Violence Intervention and Prevention, and Young Physicians, and further recommends**

   That the MMS sunset the following special committees at the end of FY20 (May 2020): Global Health, Mental Health and Substance Use, Physician Preparedness, Sustainability of Private Practice, and Women's Health. *(D)*

3. **That MMS sunset the Committee on Men's Health, effective immediately, with gratitude for the past work and efforts of its members (12) currently serving on the committee. *(D)***

Fiscal Note: No Significant Impact
(Estimated Expenses)

Estimated Staff Effort
to Complete Directive(s): Item 1: One-Time Expense of $9,000

Attachments:
A) MMS Strategic Plan FY2020 – 2024
B) Strategic Initiatives Priority Grid
C) Special Committee Renewal Decision Tree
D) Special Committee Reports Summary

MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

MMS Strategic Plan FY2020-FY2024

March 2019

MMS Purpose, Mission, and Values

Taken together, core purpose, mission, and core values describe an organization's consistent identity that transcends all changes related to its relevant environment. **Core purpose** describes our reason for being. The **mission** describes who we are, what we do and how we do it. Our **core values** are the enduring principles that guide the behavior of the organization.

CORE PURPOSE:

To unite clinicians, support the medical profession and the practice of medicine, and improve patient care and outcomes through advocacy, member services, and the dissemination of medical knowledge.

MISSION STATEMENT:

"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*

CORE VALUES:

- Community
- Professionalism
- Quality
- Integrity
- Commitment

MMS Envisioned Future

Envisioned Future conveys a concrete, yet unrealized vision for the organization. It includes a description of how the world could be different for key stakeholders and a clear and compelling catalyst that serves as a focal point for effort. The Envisioned Future vividly depicts the intersection of what a group is passionate about, what they do best, and what they can marshal the resources to accomplish.

VIVID DESCRIPTION OF A DESIRED FUTURE

The Massachusetts Medical Society (MMS), the professional association for all physicians in the Commonwealth of Massachusetts, is the most trusted and respected leadership voice in health care, advancing medical knowledge and the medical profession to improve patient care and outcomes. We are a proactive organization that advocates for the shared interests of patients and our profession and takes a leadership role in the development of health care policy. We enhance and protect the physician-patient relationship and preserve the physician's ability to make clinical decisions for the benefit of patients. We encourage the development of standards for high quality care, and promote medical education, training, research, and the continuing education of physicians.

ASPIRATIONAL SHARED VISION (across MMS and NEJM Group)	The Massachusetts Medical Society is the most trusted and respected leadership voice in health care, advancing medical knowledge and the medical profession to improve patient care and outcomes.
IMPACT	The MMS is a leading voice in health care in Massachusetts. We lead collaboration to extend our reach across the region and have a strong voice at the national level to drive the betterment of medical practice and health of the population.
RELEVANCE	The MMS provides differentiated value to enhance clinical knowledge, collaboration, and professionalism for every clinician we serve, and to advance the interests of every institution we serve. We clearly communicate our strategy and our value, which are understood and supported by our key stakeholders.
SUSTAINABILITY	The MMS effectively monetizes products and services to support a financially independent advocacy and member relations operation with the ability to achieve a minimum financial threshold of break-even in perpetuity

Goals, Objectives & Strategic Initiatives

Goals will serve the organization for the next three to five years. They are outcome-oriented statements that represent what will constitute the organization's future success. The achievement of each goal will move MMS towards the realization of its vision. **Objectives** describe what we want to have happen with an issue. What would constitute success in observable or measurable terms? Objectives have a three to five-year timeframe and are reviewed every year by the Board. **Strategic Initiatives** describe how the association will commit its' resources to accomplishing the goal. They bring focus to operational allocation of resources and have a one to three-year timeframe reviewed every year by the Board.

Priority Levels (To Be Determined):

Critical: Work on this strategy must be completed in the coming year
Immediate: Work on this strategy must occur in the coming year
Intermediate: Work on this strategy should occur in the coming year if at all possible
Later: Work on this strategy can/should wait until subsequent year

GOAL A: PATIENTS

All people will achieve optimal health and wellbeing through patient engagement and improved health literacy, and equal access to timely, comprehensive, affordable, high-quality, integrated health care throughout their lives.

Objectives:

1. Advance patient health, wellbeing, and engagement, prioritizing the most critical individual and public health areas.
2. Increase patient access to appropriate care, with prioritized focus on vulnerable populations.
3. Increase the affordability of quality health care for patients.
4. Decrease the adverse impact of social determinants and health disparities.
5. Increase care integration to improve patient outcomes and experience.

Strategic Initiatives:

1. Advocate for technology and communication tools that improve health literacy, price transparency, and increase patient engagement. (Intermediate) (Objective 1)
2. Assess vulnerable populations and determine where the MMS can have the strongest impact on access to appropriate care, including social determinants of health and health disparities. (Critical) (Objective 2)
3. Advocate for affordability of care. (Intermediate) (Objective 3)
4. Evaluate the establishment of an MMS principle that declares health in all its dimensions, including health care, as a human right. (Critical) (All Objectives)
5. Enhance collaboration with patients; health care and technology organizations; community resources; and state, federal, and other stakeholders; with a focus on our patient-centered objectives. (Intermediate) (All Objectives)
6. Advocate for access, affordability, and quality of patient care to be the primary objectives of care integration. (Immediate) (Objective 5)

GOAL B: PHYSICIANS

Physicians will enjoy a satisfying career in medicine that is grounded in high-quality care, intellectual growth, and financial sustainability in an inclusive environment with minimal regulatory burden.

Objectives:

1. Reduce unnecessary regulations and administrative burdens.
2. Advance physician wellness, professional growth and satisfaction, and promote inclusive work environments.
3. Increase physicians' financial sustainability within the health care environment.
4. Increase the affordability of medical school education.

Strategic Initiatives:

1. Identify and implement three high-impact initiatives to advocate for the reduction of unnecessary regulations and administrative burdens. (Critical) (Objective 1 and 2)
2. Create a physician community that includes opportunities for networking. (Intermediate) (Objective 2)
3. Provide leadership development offerings for physicians and physician-led teams. (Immediate) (Objective 2)
4. Identify factors that contribute to satisfying work environments and advocate with stakeholders for action, where needed. (Intermediate) (Objectives 2 and 3)
5. Advocate for fair and equitable systems of compensation. (Intermediate) (Objectives 2 and 3)
6. Pursue options to increase medical school affordability, including the option of free medical education. (Immediate) (Objective 4)

GOAL C: THE MASSACHUSETTS MEDICAL SOCIETY

MMS will be the most trusted and respected leadership voice in health care, advancing medical knowledge and the medical profession to improve patient care and outcomes, maintaining a sound financial position and a diverse, engaged, and expanding membership.

Objectives:

1. Increase the alignment between products, services, and activities and the preferences of current and future members, eliminating offerings that do not demonstrate strategic value.
2. Reduce the extent to which funding for member-related activities is dependent upon NEJM Group revenue.
3. Increase dissemination of medical knowledge worldwide through NEJM Group.
4. Increase MMS brand recognition and profile, both regionally and nationally.
5. Increase physician utilization of MMS as a primary resource for professional support.
6. Increase physician engagement and diversity.
7. Increase engagement and collaboration with key stakeholder groups in support of MMS goals and objectives.

Strategic Initiatives:

1. Evaluate impact and relevance of member-related products, services, and activities, and initiate a plan to discontinue those that do not offer strategic value to the membership. (Critical) (Objectives 1 and 2)
2. Narrow focus and prioritize activities to align with our strategic plan. (Immediate) (Objectives 1 and 2)
3. Reform governance to accomplish the strategic goals and objectives. (Immediate) (Objectives 1 and 2)
4. Evaluate alternative sources of revenue in support of member-related areas to ensure MMS sustainability. (Intermediate) (Objective 2)
5. Ensure the financial strategy supports NEJM Group's sustainability. (Critical) (Objectives 2 and 3)
6. Develop a strategy to increase MMS brand recognition, profile, and communication with targeted audiences. (Intermediate) (Objective 4)
7. Create strategies that will engage various member constituent groups and increase engagement, diversity, and trust in MMS. (Intermediate) (Objectives 5 and 6)
8. Expand advocacy efforts in collaboration with key stakeholders on issues deemed critical to physicians and patients. (Immediate) (Objective 7)

APPENDIX

Environmental Scan – Building Foresight

CONDITIONS, TRENDS AND ASSUMPTIONS

These statements, developed by the Board of Trustees and Committee on Strategic Planning and informed by a comprehensive environmental scan, help to purposefully update the strategic plan on an annual basis. Since the outcome-oriented goals that will form the basis of the long-range strategic plan will be based on the vision of the future that appears in this section, an annual review of this vision will be an appropriate method of determining and ensuring the ongoing relevancy of the goals.

Care Delivery

1. Roles of advanced practice clinicians (e.g. NPs, PAs) as part of a team-based care model will continue to grow as health care costs rise and care access issues become more significant.
2. With changes in political leadership and increasing polarization in the health care space, federal legislative efforts will not quiet—care delivery at the system level will be ever-evolving.
3. The ongoing shifting demographics of practicing physicians in Massachusetts (e.g., active physician cohort trending older, percentage of female practicing physicians increasing, and Millennials making up most of the workforce) are changing the behaviors and the values of the workforce.
4. A majority of health care services in Massachusetts will be delivered by 3-4 large integrated health systems.
5. Consumers will be more engaged in their health overall, more heavily utilizing online medical content, direct-to-consumer medical products, online reviews of providers, etc., but will still largely rely on providers for decision-making.

Costs/Economic Climate

1. Health insurance regulations, Medicare/ Medicaid reimbursement, and other federal changes will continue to increase the cost burden for hospitals, health systems, and physician organizations, and squeeze overall budgets.
2. Physicians will almost exclusively be employed by integrated health systems or large physician organizations; physician-level economic trends are increasingly incentivizing practitioners to leave private practice for larger organizations.
3. Employers/ plan sponsors will aggressively seek to manage health care costs, pressuring payers and providers, and seeking alternative solutions.
4. Drug pricing—particularly specialty pharma—will remain a significant contributor to overall health spending.
5. Health care costs will continue to rise both nationally and in Massachusetts.
6. Both public and private payers will continue to squeeze reimbursement and drive the industry towards “value” to combat rising health care costs.
7. Physician reimbursement will be more variable, and increasingly based on outcomes and cost.

Technology & Science

1. Genomics and other scientific advances will lead to increasingly personalized treatment plans for complex care (e.g., cancer therapies).
2. Technology and decision tools (e.g. AI, machine learning) will assist in clinical diagnoses for routine procedures, reducing variation in care and improving outcomes.
3. Technology (e.g., AI) will enable the standardization of routine care.
4. AI and machine learning will be heavily leveraged to improve customer experience (e.g. adaptive learning and quizzing, personalized content/ curation).
5. AI and machine learning will be heavily leveraged to supplement human publishing expertise around content production (e.g., taxonomy creation, detection of data manipulation/ plagiarism/ other fraud)

Medical Societies

1. Member needs will shift as the demographic makeup of the physician workforce will shift, with the active physician cohort trending older, percentage of female physicians increasing, and Millennials making up most of the workforce.
2. Medical societies will see changing priorities of members, with increasing value placed on issues such as burnout and work-life balance.
3. Members will increasingly want to engage with peers, educational content, and advocacy through interactive digital channels, though the value of in-person collegiality will persist.
4. State medical societies will have increasing opportunities to expand engagement and collaboration with a variety of entities, including provider organizations and specialty societies.
5. Sustainability of medical societies' economic models will rely on increased alignment with institutions.

Academic Publishing

1. Trust, integrity, and quality will be significant differentiators in a world of over-information.
2. Pharmaceutical companies will increasingly demand metrics-based digital advertising (e.g., targeted access to specified clinicians, prescribing patterns).
3. The market share of different advertising media will continue to shift away from print.
4. Academic research will almost exclusively be distributed digitally.
5. Users will rarely browse journals to discover content, instead heavily utilizing digital content discovery platforms (e.g., Google Scholar) which will continue to become more advanced and precise.
6. Rather than sifting through journal articles, physicians focused on clinical tasks will primarily utilize practical tools embedded into the workflow (e.g., UpToDate) for determining the latest medical protocols.
7. Libraries will more aggressively negotiate subscription pricing for even the highest quality content.
8. Domestic and international university libraries will continue to see flat or decreasing budgets overall.

Key Drivers of Change

Key drivers of change are powerful forces that require MMS to develop strategic initiatives to address. They are conditions and dynamics in the relevant environment that will make tomorrow very different than today.

MMS KEY DRIVERS:

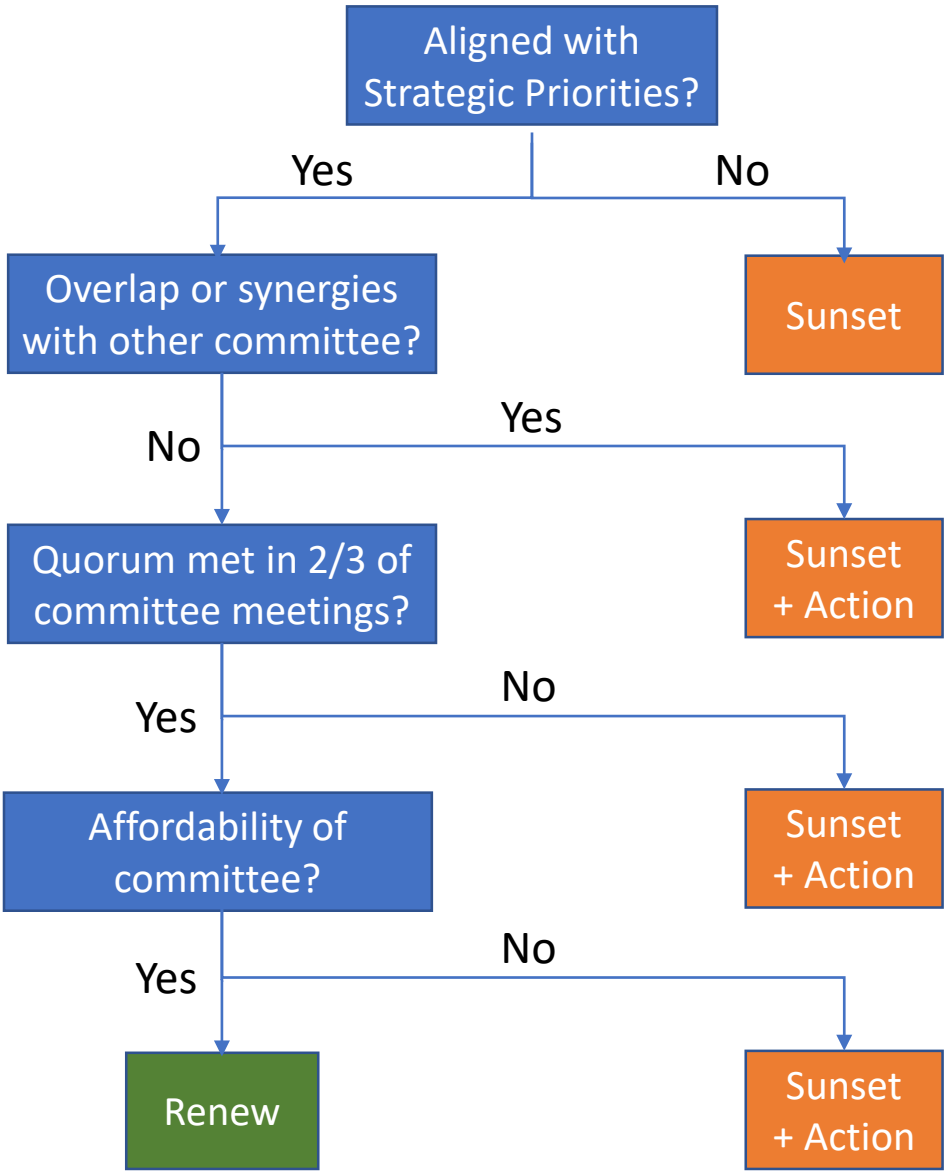
1. Rise of advanced practice clinicians and move towards “care team” (NPs and PAs with physician as leader)
2. Health care cost: Employers/ plan sponsors will aggressively seek to manage health care costs, pressuring payers and providers, and seeking alternative solutions (reimbursement limits, single payer)
3. Regulations/government mandates
4. Changing physician demographics (increase in females and millennials) shifting priorities toward work-life balance and wellness vs. burnout
5. Shift toward employed physicians
6. Changes in technology impact publishing, practice of medicine (AI, machine learning, robotics, patient engagement with digital technology), personalized medicine (genomics), EHRs, isolation
7. Consolidation/Regionalization
8. Increased consumer engagement in their own care
9. Medicare/Medicaid (increased administrative burden; decreased reimbursement)
10. Member priorities for advocacy more focused on improving the delivery of care and public health
11. Changes in the academic publishing environment (shifting ad revenues/users away from print); financial pressures across organization

Strategic Initiative Priority Grid

Critical: Work on this strategy must be completed in the coming year
Immediate: Work on this strategy must occur in the coming year
Intermediate: Work on this strategy should occur in the coming year if at all possible
Later: Work on this strategy can/should wait until subsequent year

Goal/ Beneficiary	Init #	Strategic Initiative	Priority
Patients	1	Advocate for technology and communication tools that improve health literacy, price transparency, and increase patient engagement.	Intermediate
Patients	2	Assess vulnerable populations and determine where the MMS can have the strongest impact on access to appropriate care, including social determinants of health and health disparities.	Critical
Patients	3	Advocate for affordability of care.	Intermediate
Patients	4	Evaluate the establishment of an MMS principle that declares health in all its dimensions, including health care, as a human right.	Critical
Patients	5	Enhance collaboration with patients; health care and technology organizations; community resources; and state, federal, and other stakeholders; with a focus on our patient-centered objectives.	Intermediate
Patients	6	Advocate for access, affordability, and quality of patient care to be the primary objectives of care integration.	Immediate
Physicians	1	Identify and implement three high-impact initiatives to advocate for the reduction of unnecessary regulations and administrative burdens.	Critical
Physicians	2	Create a physician community that includes opportunities for networking.	Intermediate
Physicians	3	Provide leadership development offerings for physicians and physician-led teams.	Immediate
Physicians	4	Identify factors that contribute to satisfying work environments and advocate with stakeholders for action, where needed.	Intermediate
Physicians	5	Advocate for fair and equitable systems of compensation.	Intermediate
Physicians	6	Pursue options to increase medical school affordability, including the option of free medical education.	Immediate
MMS	1	Evaluate impact and relevance of member-related products, services, and activities, and initiate a plan to discontinue those that do not offer strategic value to the membership.	Critical
MMS	2	Narrow focus and prioritize activities to align with our strategic plan.	Immediate
MMS	3	Reform governance to accomplish the strategic goals and objectives.	Immediate
MMS	4	Evaluate alternative sources of revenue in support of member-related areas to ensure MMS sustainability.	Intermediate
MMS	5	Ensure the financial strategy supports NEJM Group's sustainability.	Critical
MMS	6	Develop a strategy to increase MMS brand recognition, profile, and communication with targeted audiences.	Intermediate
MMS	7	Create strategies that will engage various member constituent groups and increase engagement, diversity, and trust in MMS.	Intermediate
MMS	8	Expand advocacy efforts in collaboration with key stakeholders on issues deemed critical to physicians and patients.	Immediate
		Totals	**5 Critical** **6 Immediate** **9 Intermediate** **20 Total**

Special Committee Renewal Decision Tree



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October 2019

Attachment D

Special Committee Reports Summary				2019-2020										
Committees	Type	Year Established	Renewal Date	Assigned Strategic Initiatives Critical Immediate Intermediate	Self-Identified Strategic Initiatives	Attendance	Quorum #met/ #mtgs	FY19 Expense	FY20 Budget	FY20 Est. Cost of Staff Resources	FY20 Total Estimated Expenses	FY20 # Members	FY20 # Advisors	FY20 Est. Cost/ Member*
Accreditation Review	Special	1997	I-18 (1 year)		MMS #5, #6, #7, #8	69%	4 of 4	$ 361	$ 2,032	$ 3,000	$ 5,032	10	1	$ 503
Continuing Education Review - formerly Sponsored Pgms	Special	1997	I-18 (1 year)		Patients #2 Phys #3 MMS #2, #5, #6, #7	62%	4 of 6	$ -	$ 1,000	$ 18,000	$ 19,000	8	1	$ 2,375
Diversity in Medicine	Special	1998	I-18 (1 year)	Patients #2	Phy #3	41% w/adv. 72.6% of those who attend	0 of 5	$ 1,408	$ 2,883	$ 6,000	$ 8,883	14	3	$ 635
Environmental and Occupational Health	Special	1997	I-18 (1 year)		Patients #2	60%	4 of 5	$ 928	$ 3,710	$ 4,500	$ 8,210	11	0	$ 746
Geriatric Medicine	Special	1980	I-19	Patients #2	Patients #4, 6 Physician #1	58%	3 of 5	$ 1,454	$ 4,315	$ 4,500	$ 8,815	11	2	$ 801
Global Health	Special	1999	I-20		Patients #2, 4 Physicians #2 MMS #1	60%	3 of 5	$ 1,199	$ 1,353	$ 8,000	$ 9,353	14	1	$ 668
History	Special	1995	I-19		Patients #2, 4 6 Physicians #2, 3, 6 MMS #1, 5, 8	78%	3 of 3	$ 1,440	$ 1,591	$ 2,250	$ 3,841	10	1	$ 384
Information Technology	Special	1998	I-19		Patients #1, 2,3 Physicians #2, 6 MMS #6, 8	50%	5 of 9	$ 17,553	$ 17,210	$ 6,750	$ 23,960	23	10	$ 1,042
LGBTQ Matters	Special	2007	I-19		Patients #2, 4	69%	3 of 3	$ 3,942	$ 2,919	$ 19,000	$ 21,919	11	3	$ 1,993
Maternal & Perinatal Welfare	Special	1988	I-19		Patients #2 Physicians #2 MMS #7, 8	55%	3 of 4	$ 1,068	$ 1,279	$ 7,500	$ 8,779	17	2	$ 516
Men's Health	Special	2003	I-18 (1 year)		Patients #2 Physicians #2 MMS #7	43%	1 of 6	$ 595	$ 1,821	$ 2,250	$ 4,071	12	0	$ 339
Mental Health and Substance Use **NEW	Special	2019	I-22								$ -	5	1	$ -
Nutrition and Physical Activity	Special	1976	I-18 (1 year)	Patients #2		63%	3 of 4	$ 585	$ 1,240	$ 6,000	$ 7,240	13	0	$ 557
Oral Health	Special	2013	I-18 (1 year)		Patients #2, 6	48%	2 of 5	$ 733	$ 1,214	$ 4,500	$ 5,714	10	6	$ 571
Preparedness	Special	2003	I-20		Patients #2	67%	4 of 4	$ 6,967	$ 6,000	$ 6,000	$ 12,000	19	6	$ 632
Senior Physicians	Special	2013	I-18 (1 year)		Physicians #2, 3, 4	67%	4 of 4	$ 3,001	$ 3,000	$ 8,500	$ 11,500	22	0	$ 523
Senior Volunteer Physicians	Special	1995	I-18 (1 year)		Patients #2, 3, 4, 6	48%	3 of 5	$ 2,186	$ 6,020	$ 10,000	$ 16,020	14	0	$ 1,144
Student Health & Sports Medicine	Special	1988	I-19		Patients #2, 6 MMS # 1, 2, 3	54%	3 of 5	$ 1,274	$ 1,427	$ 4,500	$ 5,927	9	0	$ 659
Sustainability of Private Practice	Special	2015	I-20	Physicians #1	Patients #6 Physicians #1, 4 MMS #6	80%	10 of 10	$ 5,983	$ 2,000	$ 7,500	$ 9,500	14	0	$ 679

** No Report Due. LIGHT SHADED BLOCKS: Renewal due in FY21

Committees	Type	Year Established	Renewal Date	Assigned Strategic Initiatives Critical Immediate Intermediate	Self-Identified Strategic Initiatives	Attendance	Quorum #met/ #mtgs	FY19 Expense	FY20 Budget	FY20 Est. Cost of Staff Resources	FY20 Total Estimated Expenses	FY20 # Members	FY20 # Advisors	FY20 Est. Cost/ Member*
Violence Intervention & Prevention	Special	1995	I-19	Patients #2	MMS #1, 2, 3	50%	2 of 5	$ 758	$ 1,231	$ 4,500	$ 5,731	11	4	$ 521
Women's Health	Special	1981	I-20		Patients #2, 4	63%	3 of 3	$ 457	$ 7,502	$ 30,000	$ 37,502	18	2	$ 2,083
Young Physicians	Special	1993	I-19	Physicians #3	Physicians #2, 3 MMS #5, 8	56%	3 of 5	$ 2,000	$ 3,000	$ 11,500	$ 14,500	13	0	$ 1,115
TOTALS						59% avg		$ 53,892	$ 72,747	$ 174,750	$ 247,497	289	43	

*Avg $865/mbr
($250k ÷ 289 members)

** No Report Due. LIGHT SHADED BLOCKS: Renewal due in FY21

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	5
Code:	OFFICERS Report I-19 C-5
Title:	Sunset Policy Review Process
Sponsor:	MMS Presidential Officers: Maryanne Bombaugh, MD, MSc, MBA, FACOG David Rosman, MD, MBA Carole Allen, MD, MBA, FAAP
	Reviewers: Various MMS Committees
Referred to:	Reference Committee C Tom Amoroso, MD, MPH, Chair

Background

Per the MMS Procedures of the House of Delegates, "a sunset mechanism with a seven-year time horizon shall exist for all Massachusetts Medical Society policy positions and statements established by the MMS House of Delegates… Policies are assigned to the appropriate standing committee/MMS section(s) (in consultation with appropriate special committees) to review whether to reaffirm, sunset, reaffirm for one year, or amend the policy and provide recommendations to the MMS presidential officers for final review and submission to the House of Delegates." The following policies were not included in the A-19 Sunset Policy Review Process Report, and now one policy, below, will be sunset, and the remaining are recommended for amendment and reaffirmed for seven years.

Policy Scheduled for Sunset

PRESCRIPTION AND NON-PRESCRIPTION DRUGS

Prescription Marketing

The Massachusetts Medical Society (MMS) supports the Board of Registration in Pharmacy's review of the practice of pharmacies sending confidential patient information to a computer data-base marketing specialist as a violation of patient confidentiality. (HP)

The MMS strongly supports legislation to curtail pharmacy disclosures of confidential patient information.

MMS House of Delegates, 5/8/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12

(Rationale: Pharmaceutical data: A 2017 Supreme Court decision (Sorrell v. IMS) ruled a Vermont law regulating the data exchange between pharmacies and pharmaceutical manufacturers was an unconstitutional violation restriction of commercial speech. We since have not seen any movement by states to regulate this practice.)

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

MEDICAL EDUCATION

1. Accreditation Council for Continuing Medical Education (ACCME)
The Massachusetts Medical Society adopts the Accreditation Council for Continuing Medical Education (ACCME)'s Accreditation Criteria and policies that include the Standards for Commercial Support: Standards to Ensure Independence in CME Activities℠ as amended from time to time, as a means to develop high-quality continuing medical education activities that are relevant, promote improvements in health care, and are independent of commercial influence. (HP)

MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12

PRESCRIPTION AND NON-PRESCRIPTION DRUGS

2. Opioids/Naloxone
That the MMS will educate physicians about current law allowing for the prescription and dispensing of ~~nasal~~ naloxone and encourage appropriate prescription for patients at risk for opioid overdose. (D)

MMS House of Delegates, 12/1/12

3. The MMS supports the use of ~~nasal~~ naloxone by medical first responders and trained non-medical personnel for the life-saving reversal of opioid overdose. (HP)

The MMS will advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose, and the use of ~~nasal~~ naloxone. (D)

MMS House of Delegates, 5/19/12

4. Limits on Medications and Testing or Treatment Supplies
The MMS supports the protection of the patient-physician relationship from interference by insurers' various utilization control mechanisms, including unreasonable medication limits and testing or treatment supply quantity limits. (HP)

MMS House of Delegates, 12/1/12

VIOLENCE

5. Hate Crimes
The Massachusetts Medical Society (MMS) recognizes that hate crimes pose a significant threat to the ~~public~~ health of individuals, families, communities, and society ~~and social welfare of the citizens of the Commonwealth of Massachusetts and the Nation~~ as a whole. (HP)

MMS House of Delegates, 11/7/98
Item 1 of Original: Reaffirmed MMS House of Delegates, 5/13/05
(Items 2-6 of Original Sunset)
Reaffirmed MMS House of Delegates, 5/19/12

6. Violence/against Physicians, Health Care Workers

The MMS deplores all forms of violence and terrorism against all members of society, and against the physicians and health care workers who provide ~~them~~ ~~with~~ medical services. (HP)

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	No Significant Impact

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	6
Code:	Resolution I-19 C-101
Title:	Making Options Consistent for all Policies Presented in the Sunset Policy Review Report
Sponsors:	Kenneth Peelle, MD Lee Perrin, MD
Referred to:	Reference Committee C Tom Amoroso, MD, MPH, Chair

Whereas, An MMS strategic initiative is MMS/3/Immediate: Reform governance to accomplish the strategic goals and initiatives; and

Whereas, The *MMS Procedures of the House of Delegates*, #19, Sunset Policy, states that:

A sunset mechanism with a seven-year time horizon shall exist for all Massachusetts Medical Society policy positions and statements established by the MMS House of Delegates.

• • •

Review/Report Process
Policies are assigned to the appropriate standing committee/MMS section(s) (in consultation with appropriate special committees) to review whether to reaffirm [for seven years], sunset, reaffirm for one year, or amend the policy and provide recommendations to the MMS presidential officers for final review and submission to the House of Delegates.

…

; and

Whereas, A portion of this procedure reads as follows:

Minor Amendments that Maintain the Original Intent of the Policy
The reviewing committee may propose amendments to any policy that maintain the original intent of the policy. Such policy amendments may only be adopted or not adopted by the House of Delegates. If a proposed policy amendment is not adopted, the original policy will be reaffirmed for one year and referred to the appropriate committee(s) for further analysis and potential submission of a new policy recommendation. Such items must be reported back to the House of Delegates within one year. (Adopted October 1993 & various amendments through 2016 Interim Meeting); and

Whereas, The current Sunset Policy Procedure has created confusion among delegates as to the available options for the disposition of the items submitted in the Sunset Policy Review Report to the House; and

Whereas, Once a minor amendment is proposed, under the current *Procedures of the House of Delegates*, the options change in that:

- Policies submitted for review with proposed minor amendments that are adopted will be reaffirmed for seven years
- Policies submitted for review with proposed minor amendments that are not adopted will be reaffirmed for one year and referred to the appropriate committee for further analsysis; and

Whereas, Once a minor amendment is proposed (whether adopted or not adopted), policies cannot be sunset; and

Whereas, The option to sunset policies should be permitted, even when a proposed minor amendment is proposed, as set forth in the "Review/Report Process" under The *MMS Procedures of the House of Delegates*, #19; and

Whereas, To expedite the sunset procedure and preserve the efficiency of the House, at the reference committee hearing and HOD meeting, additional amendments to any submitted policy in the Sunset Policy Review Report have been traditionally out of order, but this rule is not specifically stated in the Procedures; therefore, be it

1. **RESOLVED, That the MMS revise the *MMS Procedures of the House of Delegates*, #19, Sunset Policy, to provide that the House shall have the same options for disposition of items submitted for review under the Sunset Policy Procedure, regardless of any proposed recommended minor amendments; and, be it further *(D)***

2. **RESOLVED, That the MMS revise the *MMS Procedures of the House of Delegates*, #19, Sunset Policy, to provide that policies submitted pursuant to the "Review/Report Process" may not be amended, except for minor amendments that maintain the original intent of the policy, by the House and that this rule may not be suspended. *(D)***

Fiscal Note: (Estimated Expenses) — No Significant Impact

Estimated Staff Effort to Complete Directive(s): — No Significant Impact

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #:	7
Code:	Resolution I-19 C-102
Title:	Suggested Method for Expediting Referred Resolutions
Sponsor:	Ihor Bilyk, MD
Referred to:	Reference Committee C Tom Amoroso, MD, MPH, Chair

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Whereas, An MMS strategic initiative is MMS/7/Intermediate: Create strategies that will engage various member constituent groups and increase engagement, diversity, and trust in MMS; and

Whereas, The MMS has no official policy/House of Delegates (HOD) procedure regarding getting the input of the resolution sponsor when a resolution has been referred by the HOD to one or more specific committees for report back; and

Whereas, When a committee does not obtain the input of the referred resolution's sponsor to better understand the intent of the resolution and, if possible, how to make the resolution acceptable for presentation to the HOD, the committee may unintentionally make recommendations that may not fulfill the spirit of the resolution; and

Whereas, Not obtaining the input of the referred resolution's sponsor and rejecting the original resolution at the next "report back" creates inefficiencies in that time has been wasted and the same resolution will be visited 6 to 12 months later when the HOD meets again; and

Whereas, By obtaining the input of the referred resolution's sponsor, the committee may have a more informed discussion on whether the resolution may be truly pertinent, and if so, then how it can be amended for presentation at the next HOD meeting; therefore, be it

1. **RESOLVED, That the MMS amend the *Procedures of the House of Delegates* by adding a new procedure that requires that all committees evaluating a referred HOD resolution/report make a reasonable effort to contact the referred resolution's author for further input and, if appropriate, to work with the author on how to fulfill the spirit of the resolution acceptable for presentation to the HOD; and, be it further *(D)***

2. **RESOLVED**, **That the MMS amend the *Procedures of the House of Delegates* by adding language that requires that all committees evaluating a referred HOD resolution to include in their report back information on whether the referred resolution's sponsor was able to provide feedback. *(D)***

Fiscal Note: (Estimated Expenses)	No Significant Impact
Estimated Staff Effort to Complete Directive(s):	No Significant Impact

FISCAL NOTE COMPONENTS — REFERENCE COMMITTEE A

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

Educational Session regarding the decriminalizing of illegal drugs and the impact on the Commonwealth	**Cost**	**Notes**
Half-Day Recorded Educational Session	$8,000	One-Time Expense

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

POLST Adoption	**Cost**	**Notes**
Webinar	$6,000	One-Time Expense
Online Guide	$4,000	

ESTIMATED COST OF STAFF EFFORTS FOR DIRECTIVES

In an effort to provide as much data as possible to inform decisions on directives (identified with a "D" in resolves/recommendations), the estimated cost of staff efforts to complete a directive is ***indicated on the resolution/report.*** *The total is calculated using an estimate of the number of hours times an average hourly rate. Amounts less than $1,000 (approx. 15 hours or less) are not included.*

FISCAL NOTE COMPONENTS — REFERENCE COMMITTEE B

Item #: 8
Code: Resolution I-19 B-107
Title: Defining a Core Electronic Health Record
Sponsors: Michael Medlock, MD
Maximilian Pany

Defining a Core Electronic Health Record	Cost	Notes
Consultant to study and refine the specifications of a core electronic health record (EHR)	$20,000	One-Time Expense

FISCAL NOTE COMPONENTS — REFERENCE COMMITTEE C

(No Fiscal Notes)

ESTIMATED COST OF STAFF EFFORTS FOR DIRECTIVES

In an effort to provide as much data as possible to inform decisions on directives (identified with a "D" in resolves/recommendations), the estimated cost of staff efforts to complete a directive is ***indicated on the resolution/report.*** *The total is calculated using an estimate of the number of hours times an average hourly rate. Amounts less than $1,000 (approx. 15 hours or less) are not included.*