2018 Interim Meeting Informational Reports

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MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Code: BOT Informational Report I-18-01
Title: Summary of Official Actions
Sponsor: Board of Trustees
Alain Chaoui, MD, FAAFP, Chair

The Board of Trustees met on three occasions since the 2018 Annual Meeting of the House of Delegates: June 20, 2018, September 5, 2018, and October 10, 2018. The Board took action on the following items:

June 20, 2018

Summary of Votes

For Board Action:

- Approval of the minutes of the March 7, 2018, Board of Trustees meeting.

- Approval of Interim Committee Appointments for the Committees on: Accreditation Review, Bylaws, Communications, Ethics, Grievances, and Professional Standards, Geriatric Medicine, History, Information Technology, Membership, Preparedness, Nominations, Professional Liability, Public Health, the Quality of Medical Practice, Sponsored Programs, and Young Physicians; the Task Forces on Electronic Health Records Interoperability and Usability, Opioid Therapy and Physician Communication, and Physician Burnout; the Executive Council of the Arts, History, Humanism Member Interest Network; and the Board of Directors of the MMS and Alliance Charitable Foundation.

- Approval of the Annual 2018 Resolutions and Reports, Committee Referrals and Prioritization.

- Approval of the Committee on Membership Report: Deprivations of Members for Non-payment of 2018 Dues.

- Approval of the Members and Chair of the Committee on Finance.

- Approval of the Members and Chair of the Committee on Recognition Awards.

- Approval to combine the Board Committee on Member Services goals and activities with the Committee on Membership.

- Approval that Dr. Denise Faustman be invited to present the 2018 Oration addressing her research on Type 1 diabetes.

- Approval to extend the membership Group-within-a-Group pilot project for an additional five years (2023) and monitor results.

- Approval to amend the proposed criteria and composition of the Committee on Administration and Management to retain three (3) at-large Trustee members.

- Approval of the proposed amended criteria and composition of the Committee on Administration and Management.

- Approval of the proposed criteria and composition of the Committee on Strategic Planning.

- Approval to vote using the AMA multiple position procedure for the Committee on Administration and Management ballot.

- Approval of Drs. James B. Broadhurst, Christopher Garofalo, and Sarah F. Taylor to serve on the Committee on Administration and Management.

- Approval of the following regional Trustees to serve on the Committee on Strategic Planning:

  East Region: Paula Jo Carbone, MD
  West Region: Flora F. Sadri-Azarbayani, DO

- Approval that the following individuals are hereby elected directors of the corporation (PIAM):

Name	Term Expiration Date
George E. Ghareeb, MD	June, 2021
Kenneth J. Hekman, MD	June, 2021
Judd L. Kline, MD	June, 2021
Najmosama Nikrui, MD	June, 2021

  The term of office of the above named directors shall continue until the next annual meeting, or a special meeting in lieu thereof, of the year in which the term expires or until a successor is elected, unless the term shall subsequently be modified in accordance with the bylaws.

- Approval that the following three (3) resolutions required to allow the Society to enter into an agreement with Bank of America, N.A. and authorizes the Staff to prepare documents to execute the loan on substantially the terms indicated in the proposal, subject to approval by the Committee on Finance, using the fixed-rate option realizing the fixed rate could vary between now and closing:

  1. That, subject to approval of the terms and conditions by the Committee on Finance, the execution and delivery of documents evidencing a 10-year loan from Bank of America, N.A. in the principal amount of $15,000,000 and a promissory note evidencing same, as appropriate, (the “Loan Documents”), be and hereby are approved; and

  2. That, subject to approval of the terms and conditions by the Committee on Finance, the President and Secretary-Treasurer of the Corporation be and they are, and each of them acting singly is, hereby authorized and empowered, in the name and on behalf of the Corporation to execute and deliver each of the Loan Documents in such form as the officer so acting may

approve, the execution and delivery of the Loan Documents to be conclusive evidence that the same have been approved by the Board of Trustees; and

3. That, subject to approval of the terms and conditions by the Committee on Finance, the President, President-Elect, Vice President, Secretary-Treasurer and Assistant Secretary-Treasurer of the Corporation be and they are, and each of them acting singly is, hereby authorized and empowered from time to time, in the name and on behalf of the Corporation, to execute, make oath to, acknowledge and deliver any and all such orders, directions, certificates and other documents and papers, and to do or cause to be done any and all such other acts and things, as may be shown by his/her execution or performance thereof to be in his/her judgment necessary or desirable in connection with the consummation of the transactions contemplated by the Loan Documents or otherwise authorized by these resolutions, the taking of any such action to be conclusive evidence that the same has been approved by the Board of Trustees.

For Recommendation to the House of Delegates:

(None)

September 5, 2018

Summary of Votes

For Board Action:

- Approval to consider a new item of business.

- Approval of the minutes of the June 20, 2018, Board of Trustees meeting (as corrected).

- Approval of Interim Committee Appointments for the Committees on Administration and Management, Strategic Planning, Medical Education, Professional Liability, Public Health, Accreditation Review, Global Health, LGBTQ Matters, Maternal and Perinatal Welfare, Preparedness, Sponsored Programs, Violence Intervention and Prevention, Women's Health, and Young Physicians; the Task Forces on Opioid Therapy and Physician Communication and Physician Burnout; and the Boston Medical Library Trustees.

- Approval of the Committee Reports on Goals and Activities for the Committees on Finance, Recognition Awards, Legislation, Quality of Medical Practice, Sustainability of Private Practice, and Young Physicians; Medical Student and Resident and Fellow Sections; and the Arts, History, Humanism, and Culture Member Interest Network.

- Approval that the annual information technology award shall be increased from $3,000 to $5,000 for each of the two recipients.

For Recommendation to the House of Delegates:

(None)

October 10, 2018 (pending approval)

Summary of Votes

For Board Action:

- Approval of the minutes of the September 5, 2018, Board of Trustees meeting.

- Approval of Interim Committee Appointments for the Committees on Public Health, Strategic Planning, Accreditation Review, Diversity in Medicine, Nutrition and Physical Activity, Professional Liability, Senior Physicians, Sponsored Programs, and the Task Force on Opioid Therapy and Physician Communication.

- Approval of the Committee Reports on Goals and Activities for the Committees on Administration and Management; Strategic Planning; Bylaws; Communications; Ethics, Grievances, and Professional Standards; Interspecialty; Medical Education; Membership; Nominations; Professional Liability; Public Health; Publications; Accreditation Review; Diversity in Medicine; Environmental and Occupational Health; Geriatric Medicine; Global Health; History; Information Technology; Lesbian, Gay, Bisexual, Transgender and Queer Matters; Maternal and Perinatal Welfare; Men's Health; Nutrition and Physical Activity; Oral Health; Preparedness; Senior Physicians; Senior Volunteer Physicians; Sponsored Programs; Student Health and Sports Medicine; Violence Intervention and Prevention; Women's Health; and the International Medical Graduates, Minority Affairs, and Organized Medical Staff Sections.

- Approval that, subject to approval of the terms and conditions by the Committee on Finance, the execution and delivery of documents evidencing a renewal of the Line of Credit from Bank of America, N.A. in the maximum principal amount of $7,000,000 and a promissory note evidencing same, as appropriate, (the "Loan Documents"), be and hereby are approved; and

  That, subject to approval of the terms and conditions by the Committee on Finance, the President and Secretary-Treasurer of the Corporation be and they are, and each of them acting singly is, hereby authorized and empowered, in the name and on behalf of the Corporation to execute and deliver each of the Loan Documents in such form as the officer so acting may approve, the execution and delivery of the Loan Documents to be conclusive evidence that the same have been approved by the Board of Trustees; and

  That, subject to approval of the terms and conditions by the Committee on Finance, the President, President-Elect, Vice President and Secretary-Treasurer of the Corporation be and they are, and each of them acting singly is, hereby authorized and empowered from time to time, in the name and on behalf of the Corporation, to execute, make oath to, acknowledge and deliver any and all such orders, directions, certificates and other documents and papers, and to do or cause to be done any and all such other acts and things, as may be shown by his/her execution or performance thereof to be in his/her judgment necessary or desirable in connection with the consummation of the transactions contemplated by the Loan Documents or otherwise authorized by these resolutions, the taking of any such action to be conclusive evidence that the same has been approved by the Board of Trustees.

- Approval to temporarily recess the meeting of the Board of Trustees and call to order the Annual Meeting of Physician Health Services, Inc.

- Approval that the Board of Trustees, acting for and on behalf of MMS in its capacity as sole voting member of PHS, approve Dr. Alexa Boer Kimball, Dr. Mary Kraft and Dr. Stephen Tosi each for a three-year term on the PHS Board of Directors.

- Approval that the Board of Trustees, acting for and on behalf of MMS in its capacity as sole voting member of PHS, approve Mr. Michael J. Farrell as Treasurer of Physician Health Services, Inc.

- Approval to adjourn the Annual Meeting of Physician Health Services, Inc. and resume the meeting of the Board of Trustees.

<u>For Recommendation to the House of Delegates:</u>

- Approval that the MMS support the renewal of the following special committees for one year: Accreditation Review, Diversity in Medicine, Environmental and Occupational Health, Men's Health, Nutrition and Physical Activity, Sponsored Programs, Oral Health, and Senior Physicians. (D)

Fiscal Note: (Out-of-Pocket Expenses):	Average Annual Expense per Committee (for 1 year beginning FY20): $3,000 per committee, for a total of $24,000
FTE: (Staff Effort to Complete Project)	Existing Staff

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Code:	CME Informational Report I-18-02 [I-17 B-203]
Title:	Conference on Universal Health Care
Sponsor:	Committee on Medical Education Michael Rosenblum, MD, Chair
Report History:	Resolution I-17 B-203

Background

At I-17, the House of Delegates adopted as amended Resolution I-17 B-203, Conference on Universal Health Care. The Board of Trustees referred this item to the Committee on Medical Education in consultation with the MMS Departments of: Advocacy, Government & Community Relations; Health Policy and Public Health; and Practice Solutions & Economics for implementation and an informational report at I-18. The resolution directs:

That the Massachusetts Medical Society conduct a comprehensive educational conference on Universal Health Care. *(D)*

Fiscal Note: (Out-of-Pocket Expenses)	One-Time Expense of $50,000
FTE: (Staff Effort to Complete Project)	Existing Staff

Discussion

On October 3rd, 2018, the Massachusetts Medical Society (MMS) held a conference at the MMS headquarters in Waltham, on Universal Health Care. 149 learners attended the Conference at MMS while 304 joined online. The conference also included a networking lunch for attendees, where they were encouraged to socialize and meet new colleagues. CME credits were awarded to physicians and Certificates of Attendance were provided to other health care professionals.

To plan the conference, staff members from NEJM Group Education consulted with the MMS General Counsel/Vice President of Advocacy and Member Relations, the Director of Health Policy and Public Health, and the Director of Practice Solutions and Economics as part of the planning and development process for this educational activity. In addition, members of the Committee on Medical Education and the Committee on Sponsored Programs also made recommendations. Meetings were held over the course of the development process with these key stakeholders as well as several of the original authors of Resolution I-17 B-203 to ensure that a robust conference on universal health care was presented.

The audience engaged with the speakers via a polling option and submitted questions that were asked to the speakers individually and as a panel. 61% of those who were engaged with polling indicated that they were physicians; while others identified as clinicians, students, or academics. 51% of those who responded to a poll indicated that they supported the Affordable Care Act (ACA), while 32% replied that they did not because it's too market oriented/too incremental/prefer a single-payer approach; 15%

indicated that they did not because it involves too much government involvement/intrusion. Justice, broken, and complicated — the three most repeated words submitted by the audience when asked what one word comes to mind when you think of universal health care and the US health care system.

The conference covered the relative merits and political viability of various approaches to achieving universal health coverage in the United States. Speakers also presented data on the impact of the ACA and other relevant policy and legislation thus far, and looked at Massachusetts as a model for achieving near-universal health coverage on the national level.

Below, please find a summary of the speakers' remarks, as well as their titles and institutions:

President Alain Chaoui, MD, was joined by moderator Nancy C. Turnbull, Senior Lecturer on Health Policy and Senior Associate Dean for Professional Education, Harvard School of Public Health, for the **Welcome & Introductions**. Dr. Chaoui emphasized the importance of considering the issue of Universal Health Care (UHC) at the present moment, as well as the MMS's history of advocacy and engagement on ensuring that all patients have access to health care. He also urged participants to use the conference as an opportunity to meet and get to know one another. Nancy C. Turnbull asked the audience various questions about their preconceptions of UHC, and set the agenda for the day.

Health care economist Jonathan Gruber, PhD, Ford Professor of Economics at the MIT Department of Economics, gave a talk entitled, **Health Care Access and Financing: A Status Report.** Dr. Gruber described both the policy and political impacts of the ACA's passage, and contextualized his comments with a brief history of the law. He then provided an update on subsequent legal and regulatory changes to the ACA, and a forecast of what we can expect moving forward. With regards to moving the country towards UHC, he described high health care costs, and particularly, high unit prices, and opposition from the health insurance industry, as the major obstacles in the way of providing equitable care to all Americans.

Benjamin D. Sommers, MD, PhD, Associate Professor of Health Policy and Economics, Harvard T.H. Chan School of Public Health, presented on **The Real World Effects of the Affordable Care Act**. He shared data on the impact that the ACA has visibly had on American patients, and unpacked which aspects of the law were most pivotal in achieving that impact. His research showed that Medicaid Expansion has been very effective in those states that have elected it, such that their uninsurance rates have dropped significantly. He also found demonstrated, measurable improvements to the public health of states that expanded Medicaid, including, but not limited to, higher rates of: patients reporting an ongoing relationship with a PCP; patients with chronic diseases, such as diabetes, receiving ongoing care; and patients with acute and severe illnesses, such as appendicitis or threatened limbs due to cardiovascular issues, receiving prompt care resulting in safer appendectomies and salvaged limbs. His research also showed higher self-reported satisfaction, and better self-reported health, for patients in states that expanded Medicaid. He then described efforts under the Trump administration to repeal and, short of that, to erode the ACA, and explained the ways in which the GOP has succeeded in those efforts.

James A. Morone, PhD, John Hazen White Professor of Political Science, Public Policy, and Urban Studies, of Brown University, gave a talk entitled, **A Single-Payer Option.** Dr. Morone made a case for single-payer, based on the continuing rise of health care costs in the United States, which he contrasted with the successfully controlled health care costs of countries that have elected single-payer. He argued that, in our current system, the government is already the largest payer, so a single-payer system would not be an overwhelmingly significant shift; and switching to single-payer would curtail the high costs of the private insurance industry, which currently account for a third of American health care costs.

Matthew Fiedler, PhD, Fellow at USC-Brookings Schaeffer Initiative on Health Policy, Economic Studies Program, of the Brookings Institution, presented a talk entitled, **Other Health Reform Options.** In contrast to Dr. Morone, Dr. Fiedler made the case for an incremental approach to achieving UHC, by building on the ACA rather than switching to single-payer. He presented a five-step plan for enrolling all Americans in UHC, and then took up the question of the means by which to finance such a plan. He also compared his approach to single-payer, through the lenses of both policy and politics; through both, he held that an incrementalist approach would function better than single-payer.

Sarah Kliff, Senior Policy Correspondent at Vox, spoke about **Health Care & The Elections.** She explained the extent of the impact that congressional and gubernatorial elections can have on health policy in the US. She also provided data on public opinion of health policy: the public is significantly misinformed on many important issues—40% of Republican voters believe that Trump has repealed Obamacare—and public opinion of these issues can change quickly and easily with the introduction of very little information.

Amy Rosenthal, Executive Director of Health Care For All, gave a talk entitled, **A Patient's Perspective**. Representing a patient advocacy perspective, she spoke about the work that Health Care For All does to support patients in the Commonwealth and the country. She also discussed various state and federal legislative proposals to move towards UHC, explaining that states often serve as "labs" prior to the federal implementation of innovative policy approaches.

Next, the speakers sat on a panel for a **Moderated Discussion—The Next Five Years: What's in Store for Massachusetts and Beyond.** They discussed innovative health policies being considered and/or implemented at the state and federal levels, such as soda taxes, and cost transparency legislation. Moderator Nancy C. Turnbull asked them what one policy change they would make, if they could magically implement a single one. Several speakers agreed that they would compel the remaining states to expand Medicaid; also mentioned were improvements to grassroots advocacy methods, transparency of medical bills sent to patients, and making the House of Representatives less partisan.

Finally, Nancy C. Turnbull gave a **Recap and Wrap-Up,** which included additional poll questions to ask the audience whether they felt more or less optimistic about the implementation of UHC following the conference. She encouraged attendees to continue learning about and engaging in this issue, through the MMS as well as other venues. As of October 11, 2018, MMS received 61 responses from learners who attended the live activity. 99% rated the Conference excellent or good. 72% responded that

participating in this conference will affect change in their view of the current state of the US health care system or its policy directions.

Please see appendix for the conference agenda and speaker bios.

Conclusion

The conference was a success, as described above, and the educational goals were achieved.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Code:	TFPB Informational Report I-18-03
Title:	Physician Burnout: A Status Report on the Work of the MMS-MHA Joint Task Force on Physician Burnout
Sponsor:	Alain Chaoui, MD, FAAFP, Co-Chair Steven Defossez, MD, Co-Chair

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EXECUTIVE SUMMARY

The Massachusetts Medical Society (MMS) and the Massachusetts Health and Hospital Association (MHA) Joint Task Force on Physician Burnout was established in late fall of 2017 and began meeting monthly in January 2018. Chairs Alain Chaoui, MD, FAAFP, president, Massachusetts Medical Society, and Steve Defossez, MD, vice president of Clinical Integration, Massachusetts Health and Hospital Association, and Maryanne Bombaugh, MD, MSc, MBA, FACOG, vice chair and MMS president-elect — united with a total of 8 representatives from each organization* — to raise awareness about the root causes of physician burnout and to review and promote evidence-based solutions to mitigate its occurrence and effects on the physician workforce. Burnout is "a syndrome characterized by emotional exhaustion, depersonalization (i.e., cynicism), and loss of work fulfillment." With physician burnout being more common among physicians than among other US workers and physician suicide twice as likely in the physician community than the general population, the MMS and the MHA Physician Hospital Integration Collaborative have made this issue a priority.

The Task Force has met 9 times and has identified root causes by career category (medical student, residency, early-career physician, private practice physician, and employed physician — see page 14, have begun to review evidence-based solutions, other findings and has held meetings with a variety of key stakeholders.

The root causes of burnout are multifactorial and dependent on career stage, gender, age, specialty, and practice location. While individual residents and physicians are encouraged and supported in some institutions with managing their stress that can lead to burnout, it is now widely understood that burnout is an organizational issue that can negatively impact physician retention and health care quality — meaning institutions employing or working with physicians have a significant stake in taking ownership to implement strategies and interventions that address this issue.

Forward looking institutions are beginning to survey their physicians, identify physician burnout levels, and are starting to apply remedies. Evidence-based solutions for physician burnout are still in their infancy despite the fact that medical student and residency program solutions have been in effect for a longer period of time. Organizations are implementing solutions and reporting on outcomes. This report shares much of that recent literature.

We are pleased to present this informational report:

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The members of the Task Force include:

Dr. Alain Chaoui,	MMS
Dr. Steve Defossez,	MHA
Dr. Maryanne Bombaugh,	MMS
Dr. Steve Adelman,	PHS
Dr. Karim Awad,	Atrius
Dr. Andrew Chandler,	Tufts Medical Network
Dr. Jatin Dave,	New England Quality Care Alliance
Dr. Barbara Spivak,	MCIPA and Chair, CQMP
Dr. John Burress, Chair,	MMS Public Health Committee
Mr. Travis Hallett,	Resident
Dr. Tonya Hongsermeier,	Lahey
Dr. Susannah Rowe,	Boston Medical Center
Dr. Khuloud Shukha,	MBA candidate
Dr. James Wang,	Baystate
Dr. Bruce Bertrand,	
Dr. Marcela Del Carmen,	Mass. General Hospital
Ms. Spurthi Bhatt	Medical Student/Resident

MMS Staff: Yael Miller, Carly Redmond, and Cheena Yadav
MHA staff: Deb Ryan, Pat Noga

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

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A. History of the Study of Burnout — When Did It Become Prevalent and Where Is It Now? A Chronological Review

The term "burnout" was coined in the 1970s by the American psychologist Herbert Freudenberger. He used it to describe the consequences of severe stress and high ideals experienced by people working in helping professions. Thousands of studies and papers have resulted from this discovery and furthered our understanding of the issue of burnout in the ensuing several decades.[1] A key revelation exposed the heightened presence of burnout among those in the health field. In 1999, the Institute of Medicine (now known as the National Academy of Medicine) published "To Err is Human: Building a Safer Health System" — the famous report that discusses medical errors and why the system is largely to blame. Following this publication, the Agency for Healthcare Research and Quality launched the Patient Safety initiative, which funded studies that linked work conditions to patient outcomes. Efforts promoting patient safety continued for the next decade, and evidence that burnout impacts patient outcomes continued to grow.

More recently, Christina Maslach, an American social psychologist, known for her research on occupational burnout, co-authored the Maslach Burnout Inventory and the Areas of Worklife Survey. The Maslach Burnout Inventory (MBI) is the most commonly used survey instrument to measure burnout. The MBI — as described on the NAM website — "is a 22-item survey that covers 3 areas: Emotional Exhaustion (EE) Depersonalization (DP) and Low sense of personal accomplishment (PA). There are multiple questions for each of these subscales and responses are in the form of a frequency rating scale." In 2011, the Maslach Burnout Inventory reported that 45.5% of US physicians were experiencing at least one symptom of burnout. In 2014, the same assessment identified this rate at 54.4%, exposing that this rate is growing.[2]

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[1] Morse G, Salyers MP, Rollins AL, Monroe-Devita M, Pfahler C. Burnout in Mental Health Services: A Review of the Problem and Its Remediation. Administration and Policy in Mental Health and Mental Health Services Research. 2011;39(5):341-352. doi:10.1007/s10488-011-0352-1

[2] Shanafelt TD, Hansan O, Dyrbye LN, et al. Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014. *Mayo Clinic Proceedings*. 2015;90(12):1600-1613. doi: https://doi.org/10.1016/j.mayocp.2015.08.023

In 2014–15, the American Medical Association having completed several studies on this topic and finding a need to respond promoted implementation of surveys and practice transformation initiatives to help physicians cope with this growing epidemic. The AMA Steps Forward initiative was launched.[3] In 2017, the Institute for Healthcare Improvement, recognizing the rising epidemic of work force burnout, developed and disseminated its white paper titled "Framework for Improving Joy in Work."

In 2016, Health Affairs printed a significant article written by 11 CEOs of major health systems referring to physician burnout as a public health crisis.[4] The group identified 11 key issues that require attention and action in health systems, thus acknowledging physician burnout was not solely an individual issue but a system issue as well. The authoring CEOs have committed to addressing each issue on their list and invite other health care CEOs to do the same. Examples of these commitments include incorporating measures of physician well-being to institutional performance dashboards, supporting the use of research and data to direct policies and interventions, and continuing to educate other CEOs and stakeholders on the importance of reducing burnout.[5]

In January 2017, the National Academy of Medicine (NAM) created the "Action Collaborative on Clinician Well-being and Resilience" in "response to the burgeoning body of evidence that burnout is endemic and affects patient outcomes."[6] The Action Collaborative is a network of more than 60 organizations committed to reversing the trends in clinician burnout.[7] The Collaborative has three goals:

- 1. Raise the visibility of clinician anxiety burnout, depression, stress, and suicide.
- 2. Improve baseline understanding of challenges to clinician well-being.
- 3-Advance evidence-based, multidisciplinary solutions to improve patient care by caring for the care giver.

As stated on their website, "The Action Collaborative is composed of five working groups that will meet over the course of four years to identify evidence-based strategies to improve clinician well-being at both the individual and

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[3] Linzer M, Guzman-Corrales L, Poplau S. Preventing Physician Burnout - STEPS Forward. STEPSforward.org. https://www.stepsforward.org/modules/physician-burnout.

[4] Noseworthy J, Madara J, Cosgrove D, et al. Physician Burnout Is A Public Health Crisis: A Message To Our Fellow Health Care CEOs. Health Affairs. https://www.healthaffairs.org/do/10.1377/hblog20170328.059397/full/. Accessed March 28,

[5] Ibid.

[6] Brigham T, Barden C, Dopp AL, et al. A Journey to Construct an All-Encompassing Conceptual Model of Factors Affecting Clinician Well-Being and Resilience. National Academy of Medicine. https://nam.edu/journey-construct-encompassing-conceptual-model-factors-affecting-clinician-well-resilience/. Published September 12, 2018

[7] Clinician Resilience and Well-being. National Academy of Medicine. https://nam.edu/initiatives/clinician-resilience-and-well-being/.

systems levels. Products and activities of these five working groups include an online knowledge hub, a series of NAM Perspectives discussion papers, and an all-encompassing conceptual model that reflects the domains affecting clinician well-being". Dr. Defossez participated in the fifth and most recent closed-door session of the Collaborative with regards to Interoperability, in October 2018.

The NAM is in the process of developing a consensus paper on burnout equivalent in scope to "Crossing the Quality Chasm" and "To Err is Human" efforts, which put Quality and Patient Safety into the health care lexicon and caused institutions to act. Much the same may be expected here.

Many local health systems as well as CRICO and Coverys have clinician well-being committees and/or dedicated staff known as Chief Wellness Officers, Associate Chief Medical Officers, or other similar titles. Examples of institutional committees include the Massachusetts General Physicians Organization (MGPO), which has formed a committee, the "Frigoletto Committee" formally incorporated into its bylaws and approved by the Board to address wellness for the organization.

B. What Is Burnout?

Burnout is defined as "a syndrome characterized by emotional exhaustion, depersonalization (i.e., cynicism), and loss of work fulfillment." As described by Stalker and Harvey, "The dimension of *emotional exhaustion* refers to feelings of being depleted, overextended, and fatigued. *Depersonalization* (also called cynicism) refers to negative and cynical attitudes toward one's consumers or work in general. *A reduced sense of personal accomplishment* (or efficacy) involves negative self-evaluation of one's work with consumers or overall job effectiveness."[8]

Gentry and Baranowsky described burnout as "the chronic condition of perceived demands outweighing perceived resources."[9]

In the Lancet article, West et al. wrote, "Physician burnout has reached epidemic levels, as documented in national studies of both physicians in training and practicing physicians."[10]

C. Contributing Factors to Burnout

See Appendix A: "Drivers of burnout and engagement in physicians" table.

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[8] Morse G, Salyers MP, Rollins AL, Monroe-Devita M, Pfahler C. Burnout in Mental Health Services: A Review of the Problem and Its Remediation. Administration and Policy in Mental Health and Mental Health Services Research. 2011;39(5):341-352. doi:10.1007/s10488-011-0352-1

[9] Brigham T, Barden C, Dopp AL, et al. A Journey to Construct an All-Encompassing Conceptual Model of Factors Affecting Clinician Well-Being and Resilience. National Academy of Medicine. https://nam.edu/journey-construct-encompassing-conceptual-model-factors-affecting-clinician-well-resilience/. Published September 12, 2018.

[10] West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. The Lancet. 2016;388(10057):2272-2281. doi:10.1016/s0140-6736(16)31279-x

We further provide a review of burnout by career category.

I. Medical Student

- While the mental health of matriculating medical students is better than that of the general population, burnout has been found to be prevalent in medical students. In a study of over 4,000 medical students across seven different schools, nearly 50% reported burnout, and more than 10% reported suicide ideation within the past year. Further studies with medical students revealed that when burnout was addressed, and students recovered, the rates of suicidal ideation decreased.[11]
- A literature review on burnout during residency reveals that burnout is prevalent in medical students at a rate of anywhere from 28% to 45%, and research has found that distress experienced during medical school can lead to burnout that persists into residency and beyond.[12]
- According to a report published by the Association of American Medical Colleges, it again has been suggested that burnout takes root in medical school — studies show that mental health begins to deteriorate as early as a student's first year, and only persists from that point. Reasons for this decline include academic pressure and workload, financial concerns, sleep deprivation, exposure to death and suffering (via patients), student abuse, and structural cynicism.[13]
- Additional studies have shown that the presence of even one symptom of burnout can result in negative effects in medical students that not only interfere with their learning process but also cause issues such as "drowsiness, fatigue, eating disorders, migraine, emotional instability, and even the use of illicit drugs."[14]

II. Residents

- In the literature review on burnout during residency, the reasons for burnout were studied. Residents reported causes such as "time demands, lack of control over time management, work planning, work organization, inherently difficult job situations, and interpersonal relationships" as prominent stressors. Data collected in a 2006 study found rates of burnout at the beginning of intern year at 4.3% (measured by the MBI), which jumped to 55.3% by the end of that same year. More detailed studies have reported 61% of residents admitting to increased levels of

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[11] Dyrbye LN, Thomas MR, Massie FS, et al. Burnout and Suicidal Ideation among U.S. Medical Students. Annals of Internal Medicine. 2008;149(5):334. doi:10.7326/0003-4819-149-5-200809020-00008

[12] IsHak WW, Lederer S, Mandili C, et al. Burnout During Residency Training: A Literature Review. Journal of Graduate Medical Education. 2009;1(2):236-242. doi:10.4300/JGME-D-09-00054.1.

[13] Dyrbye LN, Thomas MR, Huntington JL, et al. Personal Life Events and Medical Student Burnout: A Multicenter Study. Academic Medicine. 2006;81(4):374-384. doi:10.1097/00001888-200604000-00010

[14] Boni RADS, Paiva CE, Oliveira MAD, Lucchetti G, Fregnani JHTG, Paiva BSR. Burnout among medical students during the first years of undergraduate school: Prevalence and associated factors. Plos One. 2018;13(3). doi:10.1371/journal.pone.0191746

cynicism, and 23% claiming to have become less humanistic during training.[15]

- Potential interventions can be both workplace-driven and individual-driven. Workplace interventions include education about burnout, workload modifications, increasing the diversity of work duties, stress management training, mentoring, emotional intelligence training, and wellness workshops. Individual-driven behavioral, social, and physical activities include promoting interpersonal professional relations, meditation, counseling, and exercise. [16]
- There is reason to be concerned about burnout among residents. Residency is a key, hands-on stage in the education process of working toward becoming a practicing physician, yet the demands leading up-to and throughout this point take a major toll on the student. A variety of factors including but not limited to, long duty hours seems to contribute to burnout (exhaustion, depersonalization) and research to determine what can be done to combat this is necessary.[17]

III. **Early Career Physicians**

- In a large national study of medical students, residents/fellows, and early-career physicians were surveyed to assess burnout, symptoms of depression and suicidal ideation, quality of life, and fatigue (response rates: medical students = 35.2% [4,402/12,500], residents/fellows = 22.5% [1,701/7,560], early-career physician = 26.7% [7,288/27,276]). After controlling for relationship status, sex, age, and career stage, it was discovered that being a resident/fellow was associated with increased odds of burnout, being a medical student with increased odds of depressive symptoms, and that early-career physicians had the lowest odds of high fatigue. This study also obtained a population control sample to compare these measurements to rates in other careers. When compared to controls, medical students, residents/fellows, and early-career physicians were more likely to be burned out and medical students and residents/fellows were more likely to exhibit symptoms of depression, but the groups were not more likely to have experienced recent suicidal ideation.

- This study has concluded that medical training is the peak time for distress among physicians, but differences in the prevalence of burnout, depressive symptoms, and recent suicidal ideation when comparing training and practice are relatively small. What is clear is that among the US population, burnout is highly prevalent among physicians as opposed

[15] IsHak WW, Lederer S, Mandili C, et al. Burnout During Residency Training: A Literature Review. Journal of Graduate Medical Education. 2009;1(2):236-242. doi:10.4300/JGME-D-09-00054.1.
[16] Ibid.
[17] Thomas NK. Resident Burnout. Jama. 2004;292(23):2880. doi:10.1001/jama.292.23.2880

to other areas of work and results in lacking levels of competency and quality of care.[18]

- MMS polling data highlighted the following reasons for burnout in this career stage. It included:
    1. Being overwhelmed by work-life balance resulting in not feeling fully engaged with work while also feeling overworked and expecting to see too many patients
    2. That “the ideal vision” of what starting a career should be isn’t always the reality experienced
    3. Lack of mentoring- making it more difficult to have work-life balance

IV. Private Practice Physicians

- Rates of burnout have already proven to vary within the realm of physician specialties — those in specialties at the front line of care being at greater risk — but it also appears to vary by practicing environment, as one study has found that surgeons (one of the specialties at highest risk for burnout) working in a private practice had higher distress parameters and lower career satisfaction when compared to academic surgeons. This study revealed that there were even differing factors associated with burnout between the two settings.[19]
- Research within the MMS that surveyed members found that EHRs, clerical/administrative burdens, and quality measurement requirements were all key contributors to burnout among private practice physicians.
- Physicians in private practice may shoulder stress of being in a competitive environment and therefore being "taken advantage of" due to being a "small potato" and either not knowing about something or falling prey to larger institutions. Some practices are forming larger groups, joining a group practice without walls or other arrangements to have collective means of vetting vendors and even bargaining for better rates/prices.

V. Employed Physicians

- In the 2017 the Massachusetts General Physician Organization-wide physician survey, 46% of physicians rated high on two of the three Maslach scales and were reported and having burnout. Administrative tasks, such as pre-authorization forms, medication refills, and the electronic health records, were

[18] Dyrbye LN, West CP, Satele D, et al. Burnout Among U.S. Medical Students, Residents, and Early Career Physicians Relative to the General U.S. Population. Academic Medicine. 2014;89(3):443-451. doi:10.1097/acm.0000000000000134

[19] Balch CM, Shanafelt TD, Sloan JA, Satele DV, Freischlag JA. Distress and Career Satisfaction Among 14 Surgical Specialties, Comparing Academic and Private Practice Settings. Annals of Surgery. 2011;254(4):558-568. doi:10.1097/sla.0b013e318230097e

identified as areas contributing to burnout. A total of 1,882 of 2,031 (96.6%) eligible physicians completed the survey.

- Leadership has been proven to play a key role in burnout rates. In a multi-dimensional survey involving the use of a 5-point scale to rate the leadership qualities of their immediate supervisor as well as validated tools to assess burnout and professional satisfaction of physicians, after adjusting for age, sex, duration of employment at Mayo Clinic, and specialty, it was found that a 1-point increase in composite leadership score was associated with a 3.3% decrease in the likelihood of burnout and a 9.0% increase in the likelihood of satisfaction of the physician.[20]
- Research within the MMS that surveyed members found that EHRs, extra hours of work at night (at home), and the feeling of a broken system were the major factors contributing to burnout among otherwise employed physicians.

D. Scope of the Problem

The US Department of Health and Human Services have predicted a shortage of up to 90,000 physicians by the year 2025. One of the underlying drivers of this shortage will be loss of practicing clinicians due to burnout.[21] According to the article "Changes in Burnout and Satisfaction with Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014," physician burnout is increasing and has contributed to a 1% reduction in physicians' professional work effort. This reduction roughly equates to losing the number of graduates in a given year from seven medical schools — and that estimate is not accounting for other outcomes of burnout such as early retirement or leaving the profession all together in pursuit of alternative careers.[22]

Rates of burnout symptoms that have been associated with adverse effects on patients, the health care workforce, costs, and physician health exceed 50% in studies of both physicians-in-training and practicing physicians. This problem represents a public health crisis with negative impacts on individual physicians, patients, and health care organizations and systems.[23]

Those in "front-line" specialties, including general internal medicine, family medicine, emergency medicine, and neurology, are at the highest risk.[24]

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[20] Shanafelt TD, Gorringe G, Menaker R, et al. Impact of Organizational Leadership on Physician Burnout and Satisfaction. Mayo Clinic Proceedings. 2015;90(4):432-440. doi:10.1016/j.mayocp.2015.01.012

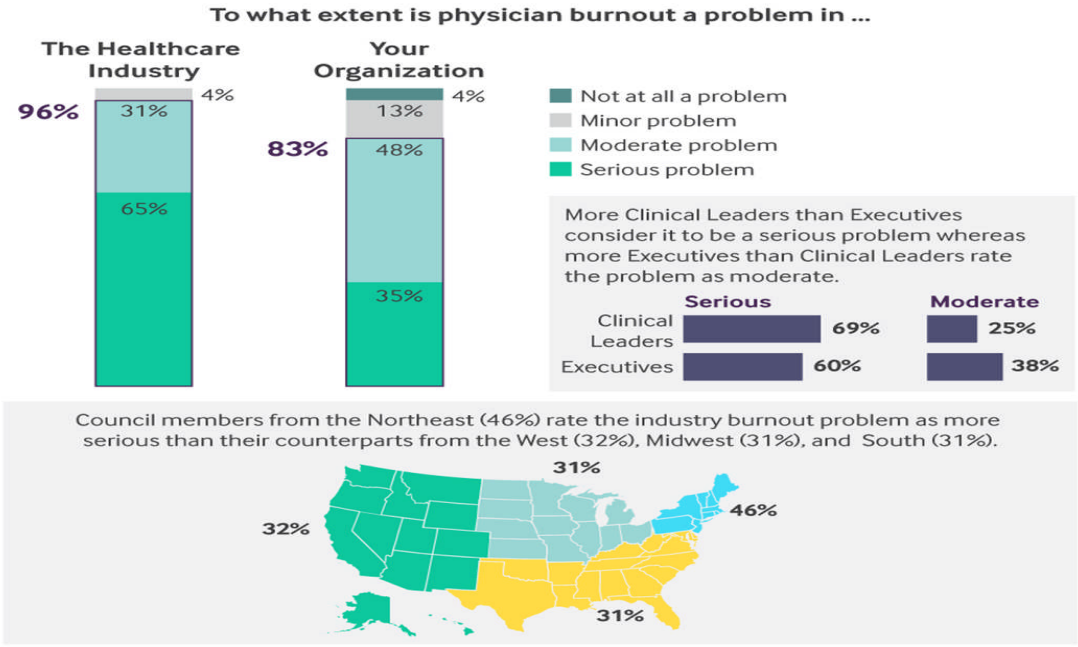
[21] Shanafelt TD, Dyrbye LN, West CP, Sinsky CA. Potential Impact of Burnout on the US Physician Workforce. Mayo Clinic Proceedings. 2016;91(11):1667-1668. doi:10.1016/j.mayocp.2016.08.016

[22] Ibid.

[23] West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. Journal of Internal Medicine. 2018;283(6):516-529. doi:10.1111/joim.12752

[24] Berger E. Physician Burnout. Annals of Emergency Medicine. 2013;61(3). doi:10.1016/j.annemergmed.2013.01.001

The Physician Burnout Problem Is Perceived to Be Larger Outside of One's Organization



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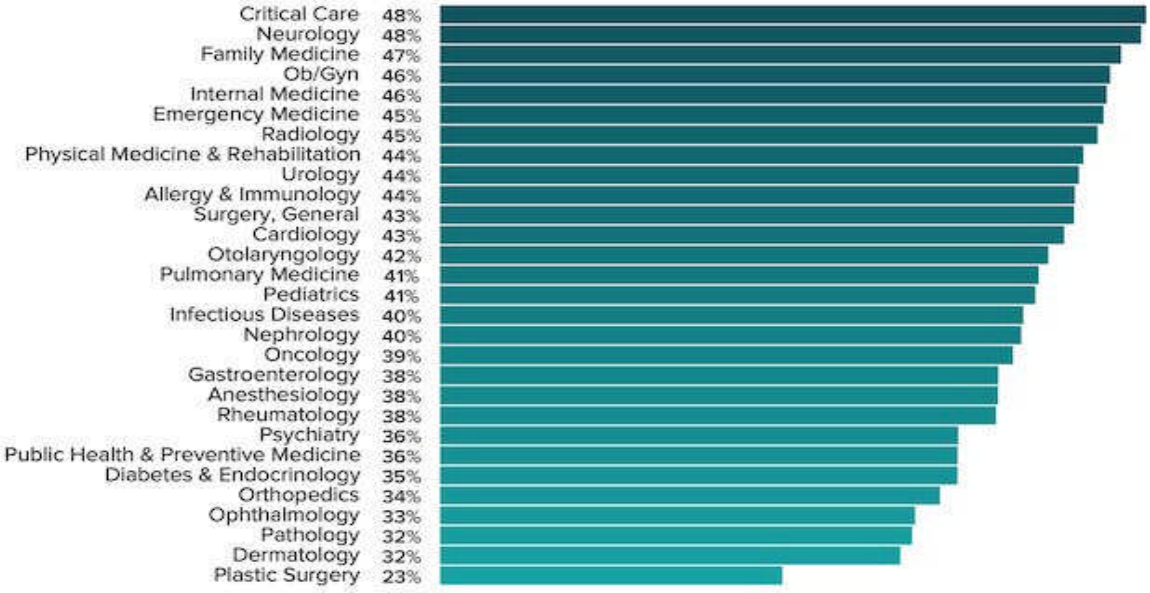
1

Which Physicians Are Most Burned Out?



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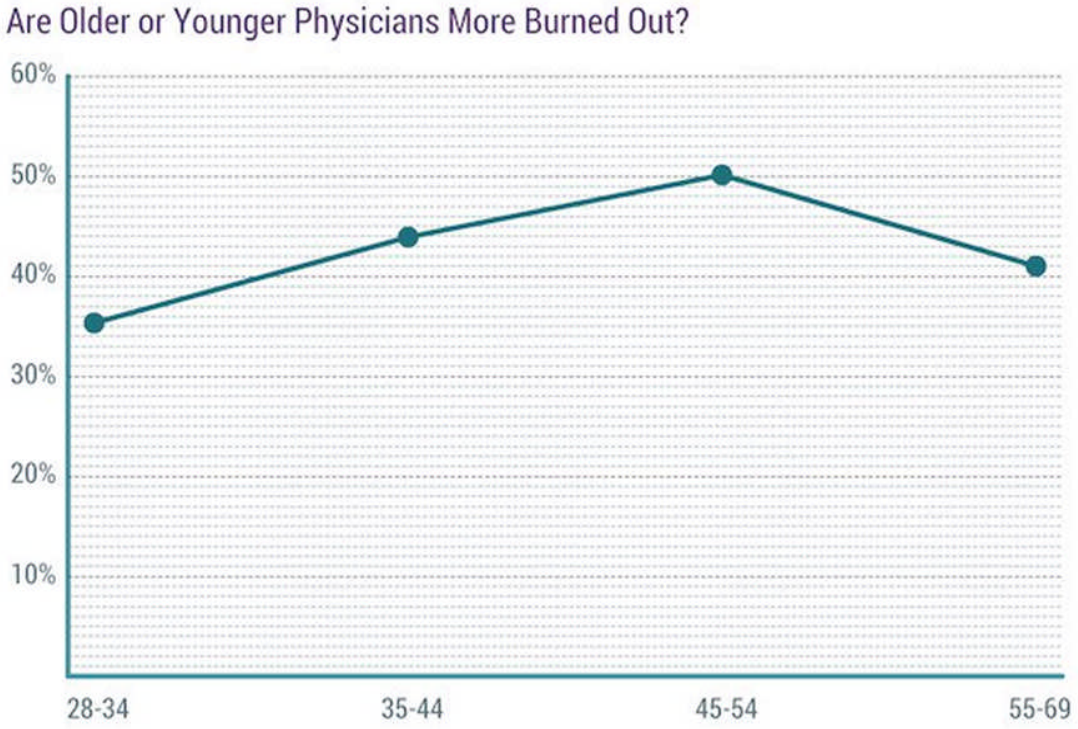
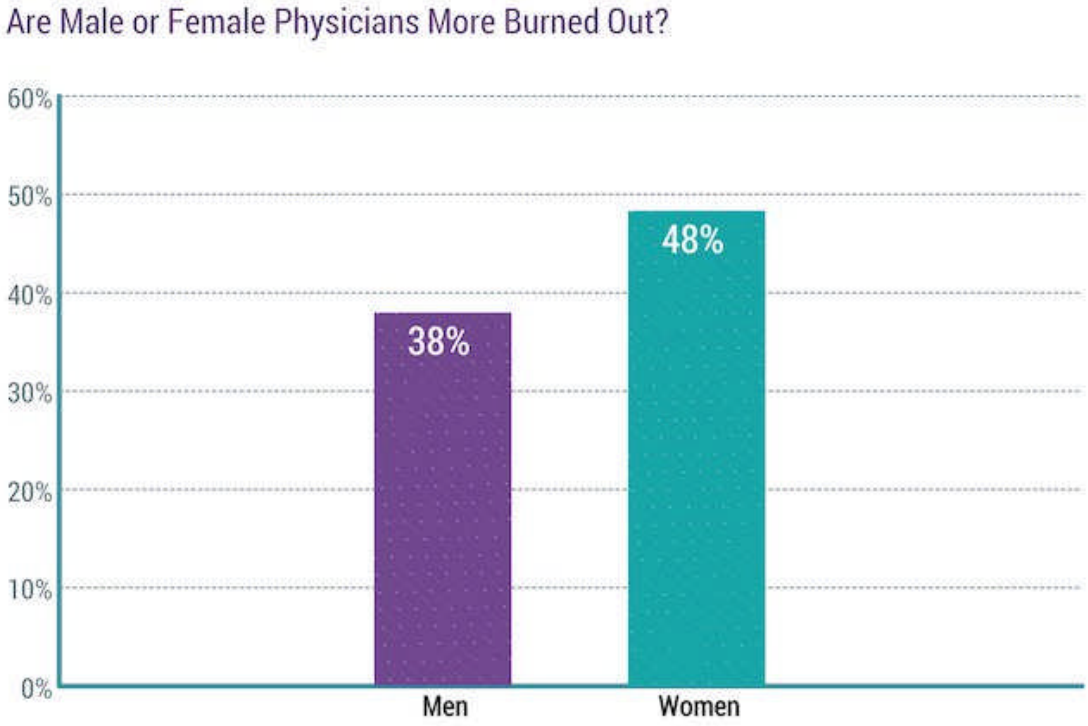
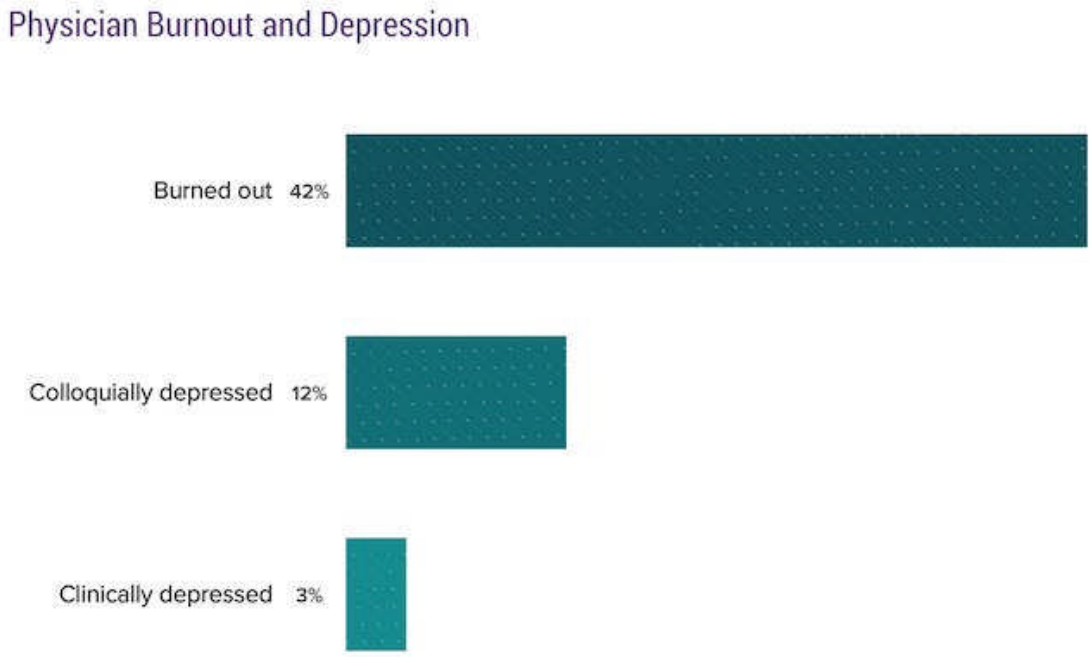




"Increasing clerical burden is one of the biggest drivers of burnout in medicine. Time-motion studies show that for every hour physicians spend with patients, they spend one to two more hours finishing notes, documenting phone calls, ordering tests, reviewing results, responding to patient requests,

prescribing medications, and communicating with staff. Little of this work is currently reimbursed. Instead, it is done in the interstices of life, during time often referred to as 'work after work' — at night, on weekends, even on vacation."[25]



E. What Are the Associated Consequences and Costs of Such a Crisis?

- Burnout has both personal and professional consequences. On the Personal side, research has shown broken, relationships, Alcohol and substance use, Depression and even Suicide. On the Professional side burnout is beginning to be linked to Decreased quality of care, Decreased patient satisfaction, and Decreased productivity and professional effort.

[25] Wright AA, Katz IT. Beyond Burnout — Redesigning Care to Restore Meaning and Sanity for Physicians. New England Journal of Medicine. 2018;378(4):309-311. doi:10.1056/nejmp1716845

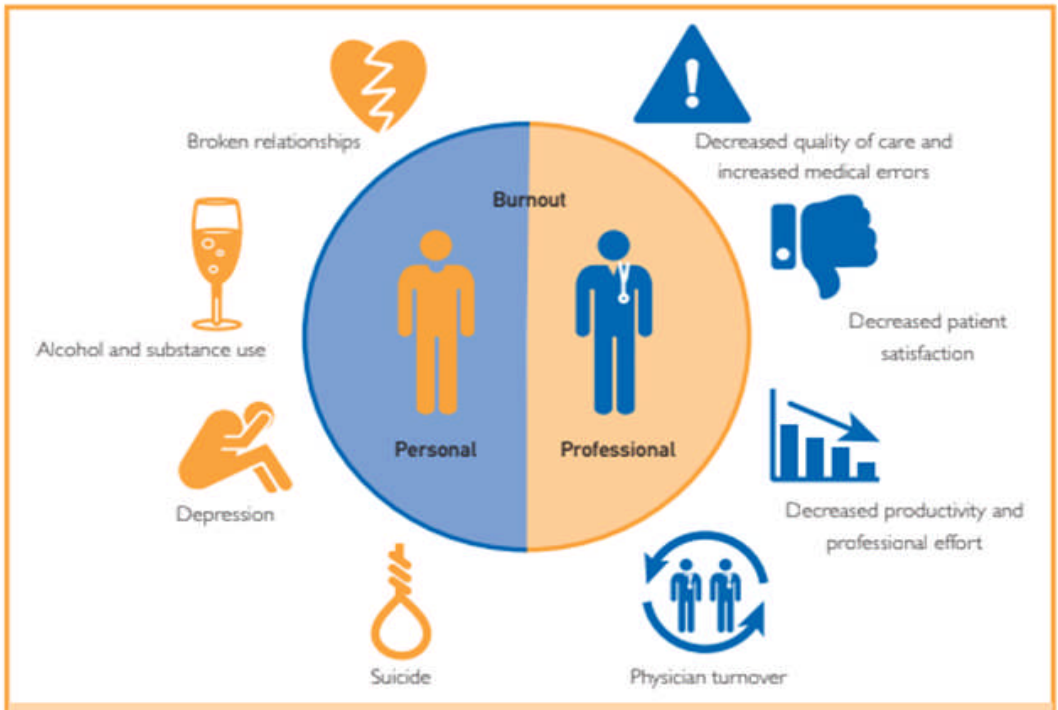


FIGURE 1. Personal and professional repercussions of physician burnout.

- MMS is talking with CRICO and Coverys about these concerns and seeing how we can work together.

- Further research on these professional findings are below:

  - **Decreased Quality and Increased Medical Errors have been found in the following studies:**
    - BMJ Review: "The relationship between physician burnout and quality of health care in terms of safety and acceptability" found moderate evidence that burnout is associated with safety-related quality of care."[26]
    - NHS Study: "Employee engagement and NHS performance", finding that more engagement is associated with less MRSA in hospitals."[27]
    - Mayo Clinic: "Medical errors may stem more from physician burnout than unsafe health care settings" finding that

[26] Dewa CS, Loong D, Bonato S, et al The relationship between physician burnout and quality of healthcare in terms of safety and acceptability: a systematic review BMJ Open 2017;7:e015141. doi: 10.1136/bmjopen-2016-015141

[27] West MA, Dawson JF. The King's Fund. Employee engagement and NHS performance. 2012.

"(P)hysician burnout is at least equally responsible for medical errors as unsafe medical workplace conditions."[28]

- **Decreased Productivity and Professional Effort has been found in the following studies:**
  - Mayo Clinic Proceedings' "Longitudinal Study Evaluating the Association Between Physician Burnout and Changes in Professional Work Effort" explains that every one-point increase in burnout (on a seven-point scale) is associated with a 30–40 percent increase in the likelihood that physicians will reduce their hours in the next two years.[29]

- **Decreased Patient Satisfaction is demonstrated by the following study:**
  - Journal of Clinical Psychology in Medical Settings' "Physician Burnout and Patient Satisfaction with Consultation in Primary Health Care Settings": Evidence of Relationships from a one-with-many Design "found that "Patients of physicians with high-exhaustion and high-depersonalization had significantly lower satisfaction scores, compared with patients of physicians with low-exhaustion and low-depersonalization, respectively."[30]

- **Physician Turnover:**
  - JAMA Network's "The Business Case for Investing in Physician Well-being" has found that "multiple large, national studies of U.S. physicians have indicated that burnout is one of the largest factors determining whether or not physicians intend to leave their current position over the next 24 months." Additionally, JAMA referenced data finding the lost revenue per full time-equivalent physician to be $990,000 and the costs of recruiting and replacing a physician to range from $500,000 to $1,000,000.[31]

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[28] Tawfik DS, Profit J, Morgenthaler TI, et al. Physician Burnout, Well-being, and Work Unit Safety Grades in Relationship to Reported Medical Errors. Mayo Clinic Proceedings. 2018. doi:10.1016/j.mayocp.2018.05.014

[29] Shanafelt TD, Mungo M, Schmitgen J, et al. Longitudinal Study Evaluating the Association Between Physician Burnout and Changes in Professional Work Effort. Mayo Clinic Proceedings. 2016;91(4):422-431. doi:10.1016/j.mayocp.2016.02.001

[30] Anagnostopoulos F, Liolios E, Persefonis G, Slater J, Kafetsios K, Niakas D. Physician Burnout and Patient Satisfaction with Consultation in Primary Health Care Settings: Evidence of Relationships from a one-with-many Design. Journal of Clinical Psychology in Medical Settings. 2012;19(4):401-410. doi:10.1007/s10880-011-9278-8

[31] Shanafelt T, Goh J, Sinsky C. The Business Case for Investing in Physician Well-being. JAMA Internal Medicine. 2017;177(12):1826. doi:10.1001/jamainternmed.2017.4340

Who else suffers negative consequences from physician burnout?

Our Patients
Rushed appointments
Lack of continuity of care
Miscommunication
Delayed care
Compassion fatigue
Medical errors

F. Possible Solutions to Mitigate Burnout Reflected in Literature and from the Task Force [see Appendix B: Solutions the Taskforce Reviewed for Your Consideration]

As previously mentioned, drivers of physician burnout are multifactorial and are dependent on the individual and on the institution in which the physician works. Therefore, the solutions will vary. Further, institutions often measure the solution in context of return on investment needing to cover the cost and or a percentage more. Given the negative relationship between burnout and physician retention, and the estimated costs to replace a physician (prior studies have quoted $500K–$1 million), it seems fiscally responsible to consider many options to reduce burnout.

This segment provides a brief overview of some evidence-based solutions for consideration and discussion. Another section highlights advancing discussion papers and other health leader findings and recommendations.

It is likely that physician burnout will not be eliminated or even fully reduced with the implementation of any one solution. Rather, the system must invest in measuring the problem and involving those affected in problem solving and resolution. Then piloted solutions need to be implemented and burnout needs to be measured again, taking on a dedicated, continuous improvement processes.

Recognizing solutions are in their infancy and will continue to evolve, we share possible solutions in Appendix B, Page 31.

G. What are We — the MMS and the Task Force and Others — Doing?

Task Force and MMS Activities to date:

- The Task Force is actively engaged in meeting with key stakeholders to advocate for change in the health care system.
- The Task Force has met with the four largest Health Plan's Medical Director's to raise awareness about burnout and seek a reduction in the number of Prior Authorization requirements and Quality reporting requirements.
- The Task Force has met with state agencies working on the Massachusetts Quality Measurement Alignment Task Force (QAT) including the Health Policy

Commission and MassHealth, who are responsible for making recommendations on the quality metrics used in the MassHealth ACO program and to be voluntarily adopted by health plans. Recently, the QAT, through a deliberative process, moved to reduce 151 quality and outcome measures to 33 measures. The MMS-MHA Task Force on Physician Burnout is calling for additional refinement of the 33 measures down to 14. Further, the Task Force proposed that the QAT include a physician well-being metric in the Menu Measures and for the reduced measures to apply to all products not just Alternative Payment Models products.

- The MMS Officers have met with the BORIM to propose adoption of the recommendations recently published by the Federation of State Medical Board. These recommendations seek to support and protect physicians who pursue treatment, had impairments in the way past, and invite boards to explicitly emphasize the importance of physician health, self-care, and treatment while also maintaining patient safety.[32] MHA members have also talked with the BORIM. The MMS and the MHA will continue dialogue with the Board in this regard.
- The MMS also submitted comment to Centers for Medicare and Medicaid Services (CMS) with regards to the Medicare Physician Fee Schedule and in support of reducing the administrative burden invoked by regulatory rules for documentation and coding. The MMS called for CMS to work with a multi-faceted work group to design a more efficient Evaluation and Management coding and document system.
- The MMS and the MHA submitted comments directly to the QAT seeking a reduction in quality measures and the addition of a physician well-being metric as well.
- The Task Force is also working with the Harvard School of Public Health to develop a report/op-ed to bring even further attention to this issue including referencing it as a public health crisis and providing some context and targeted solutions.
- The issue of burnout is prevalent. At the Massachusetts Health Policy Commission meeting on Tuesday, October 16, 2018, a question was raised about burnout and the connection to Electronic Health Records (EHRs) and what institutions are doing to reduce this trend. Each hospital and clinic acknowledged the concern and mentioned their practices to reduce the administrative burden including scribes (local and outsource), practice flow, template agreement, and other solutions.
- The Task Force will continue its dialogue with key state stakeholders to reverse the debilitating trend of burnout and will also convene stakeholders who are actively engaged in this work at the state-level.

[32] Physician Wellness and Burnout. Federation of State Medical Boards; 2018. http://www.fsmb.org/globalassets/advocacy/policies/policy-on-wellness-and-burnout.pdf.

To continue its efforts the Task Force will focus on the following:

1. MMS-MHA will **work on creating a <u>statewide measurement</u> of physician burnout** with systematic comparative methods over the next 6–10 months.
2. MMS-MHA will **advocate for the reduction of <u>documentation burdens</u>** by 2020 (a certain percentage to be proposed).
3. MMS-MHA will **advocate to <u>reduce the number of quality measures</u>** primary care physicians are held accountable by 20% by 2020.

    - o

The MMS and the MHA will also advocate for physicians by Career Category

- **Medical Students**
    - o **Calling on Medical Schools to:**
        - Continue to provide counseling services, but do so with sufficient staff and during “off hours” for easy access
        - Continue to add Mindfulness and self-care into curriculum but also “value it” and “mentor it” (model this behavior)
        - Provide continued Financial Support — we applaud NYU’s free tuitions and mindfulness training
- **Residents & Fellows**
    - o **Calling on Residency Programs**
        - Counsel residents and faculty about signs and symptoms of burnout and promote and support self-care and counseling
        - Value Work-Life balance and support coverage for predictable life events and model it
        - Organize and Prioritize Scope of work for MDs
        - Prioritize time with Colleagues to discuss tough issues and to socialize
- **Early-Career MDs**
    - o Systems and Provider Organizations should:
        - Promote wellness
        - Be implementing strategies with a commitment to improvement
        - Hire a VP of Physician/Clinician Wellness (Chief Wellness Officer)
    - o Find alternatives to EMR documentation (Group approved Templates, Scribes, Dragon, etc.).
    - o Encourage involvement in the MMS and/or other Social/Networking for mentoring.
    - o Help colleagues to understand that your first job may not be the vision you expected — that’s not uncommon.

- **Private Practice MDs**
    - o Seek Practice Redesign for Ease and Satisfaction (PPRC)
    - o Find alternatives to EMR documentation (Group-approved Templates, Scribes, Dragon, etc.).
    - o Systems and Provider Organizations should:
        - Promote wellness
        - Be implementing strategies with a commitment to improvement

- Hire a VP of Physician/ Clinician Wellness (Chief Wellness Officer)

- **Employed MDs**
  - MD-focused work and team-based care, and sufficient support staff.
  - Leaders matter.
  - Meet and Socialize with Colleagues.

  - Systems and Provider Organizations should:
    - Promote wellness
    - Be implementing strategies with a commitment to improvement
    - Hire a VP of Physician/ Clinician Wellness (Chief Wellness Officer)
  - Find alternatives to EMR documentation (Group-approved Templates, Scribes, Dragon, etc.):

The MMS and MHA outlined the following advocacy collaboration opportunities:

The Board of Registration in Medicine (BORIM) to adopt the Federation of State Medical Board Recommendations as presented in the *Physician Wellness and Burnout: Report and Recommendations of the FSMB Workgroup on Physician Wellness and Burnout Adopted as policy by the Federation of State Medical Boards, April 2018, Journal of Medical Regulation Vol. 104, NO2, 37-48):*

- Recognize "Burnout" as complex issue; recognize the importance of "Quadruple Aim"; recognize need for broad approach.
- FSMB 2018 Policy Acknowledges: *
  - Physicians are reluctant to seek help.
  - Physicians feel stigmatized seeking help.
  - SMBs' inadvertently discriminates Mental illness, Substance abuse disorders, Burnout.
- FSMB 2018 Policy Points:
  - Clarify burnout investigation is not discipline.
  - Eliminate stigma of reporting/remove care barriers.
  - Encourage State Medical Boards to maintain a relationship with Physician Health Services.
  - Support use of Physician Health Services data in board decision making (excludes identifiable PHI).
  - Differentiate between illness and impairments.
  - Consider "safe havens" for non-reporting.
  - Emphasize health, self-care and treatment.

The Task Force has and will continue to work on and explore the following:

a) Raising Awareness of Physician Burnout:

- Presentations at District meetings and other venues

- Convene stakeholders at MMS Annual Education Program at the MMS 2019 Annual Meeting, May 3

b) Advocating for Institutions to Hire: Chair for Physician or Clinician Wellness, Directors of Physicians Wellness, and/or Associate Medical Directors.

c) Physician wellness to be added to Board Dashboard along with other quality and patient safety metrics.

d) Partnering with Key Organizations:

- **National Academy of Medicine** — "Action Collaborative on Clinician Well-being" redesigns the digital heath environment to promote the well-being of health care professionals including the vision for a person-centered health information system and streamlined documentation through simplified E/M guidance.
- Share organizational commitment statement from the MMS and the MHA task force to the **NAM Action Collaborative on Clinician Well-Being and Resilience.**[33]
- Join in advocating for initiatives that minimize non-value added administrative and clerical task burdens while advancing team-based care models to optimize top-of-license task allocation.
- **Continue conversations with CRICO and Coverys.**
- **MMS/Physician Health Services**[34] has conducted a multitude of burnout presentations across the commonwealth. It has also created MedPEP, a podcast series that provides a personal look at a physician at risk of burnout and the tools available to help her succeed.[35]

- **American Medical Association** invited President to speak about alternative practice models for February 2 event. More information to follow.

- **Health Information and Management Systems Society (HIMSS):** Will invite New England Chapter president to discuss ways to advance effective configuration and EHR operationalization practices that can mitigate the administrative task burdens that may be amplified by ineffective EHR implementation.

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[33] Commitment Statements on Clinician Well-Being. National Academy of Medicine. https://nam.edu/initiatives/clinician-resilience-and-well-being/commitment-statements-clinician-well-being/.

[34] Physician Health Services. phshome. http://www.massmed.org/phshome/#.W9NqL5NKiUl. Accessed 0AD.

[35] ABOUT MedPEP. MedPEP. https://www.medpep.org/.

e) Working with Harvard School of Public Health/MMS/MHA Paper and Op-ed — Burnout is a Public Health Crisis, Backgrounder and Recommendations — **Underway**

f) Identifying Root Causes and Evidence-Based Solutions — [via this report]

g) Board/CEO Call to Action — Something to consider in Massachusetts — Shanafelt/Noseworthy/Health Affairs Article. The Task Force supports the principles listed in the article with minor amendments. See Appendix B for details. Health Affairs Blog (dated March 28, 2017): *"The issue of burnout is a matter of absolute urgency" (see solutions page **31**).*

h) Physician Suicide: Advocate for the state medical examiner to specifically report any physician or medical student suicide to the appropriate authority that accurate numbers can be maintained and monitored.

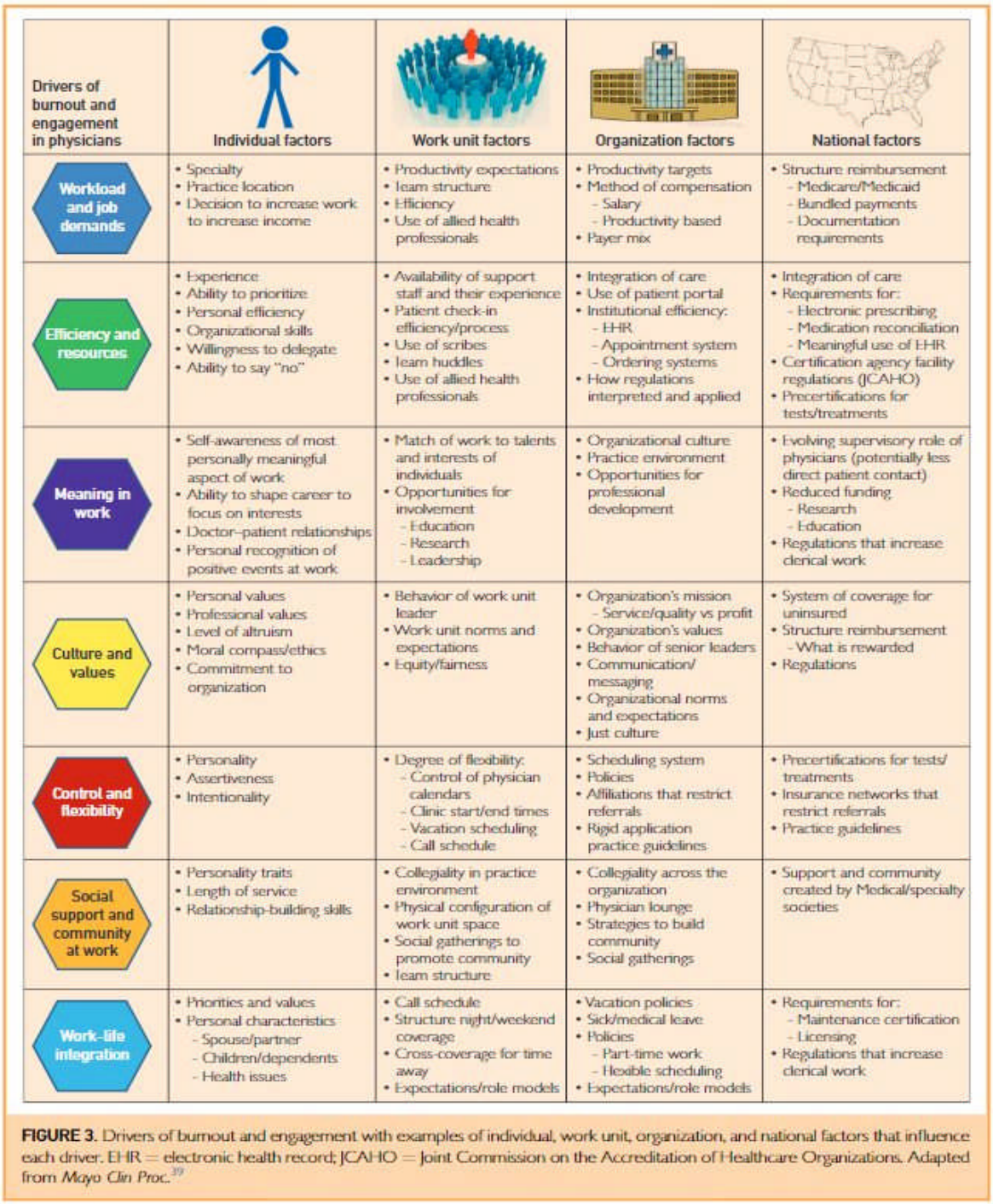
*****Organizations already engaged to remedy Burnout:**

- **CRICO**
- **COVERYS**
- **Boston Medical Center**
- **ATRIUS**
- **Brigham and Women's**
- **Mass. General Hospital**
- **Tufts Medical Network**

H. Conclusion

The MMS will continue its work with the Task Force and report back on its efforts at the Annual meeting.

Appendix A



Drivers of burnout and engagement in physicians	Individual factors	Work unit factors	Organization factors	National factors
Workload and job demands	• Specialty • Practice location • Decision to increase work to increase income	• Productivity expectations • Team structure • Efficiency • Use of allied health professionals	• Productivity targets • Method of compensation – Salary – Productivity based • Payer mix	• Structure reimbursement – Medicare/Medicaid – Bundled payments – Documentation requirements
Efficiency and resources	• Experience • Ability to prioritize • Personal efficiency • Organizational skills • Willingness to delegate • Ability to say "no"	• Availability of support staff and their experience • Patient check-in efficiency/process • Use of scribes • Team huddles • Use of allied health professionals	• Integration of care • Use of patient portal • Institutional efficiency: – EHR – Appointment system – Ordering systems • How regulations interpreted and applied	• Integration of care • Requirements for: – Electronic prescribing – Medication reconciliation – Meaningful use of EHR • Certification agency facility regulations (JCAHO) • Precertifications for tests/treatments
Meaning in work	• Self-awareness of most personally meaningful aspect of work • Ability to shape career to focus on interests • Doctor–patient relationships • Personal recognition of positive events at work	• Match of work to talents and interests of individuals • Opportunities for involvement – Education – Research – Leadership	• Organizational culture • Practice environment • Opportunities for professional development	• Evolving supervisory role of physicians (potentially less direct patient contact) • Reduced funding – Research – Education • Regulations that increase clerical work
Culture and values	• Personal values • Professional values • Level of altruism • Moral compass/ethics • Commitment to organization	• Behavior of work unit leader • Work unit norms and expectations • Equity/fairness	• Organization's mission – Service/quality vs profit • Organization's values • Behavior of senior leaders • Communication/ messaging • Organizational norms and expectations • Just culture	• System of coverage for uninsured • Structure reimbursement – What is rewarded • Regulations
Control and flexibility	• Personality • Assertiveness • Intentionality	• Degree of flexibility: – Control of physician calendars – Clinic start/end times – Vacation scheduling – Call schedule	• Scheduling system • Policies • Affiliations that restrict referrals • Rigid application practice guidelines	• Precertifications for tests/ treatments • Insurance networks that restrict referrals • Practice guidelines
Social support and community at work	• Personality traits • Length of service • Relationship-building skills	• Collegiality in practice environment • Physical configuration of work unit space • Social gatherings to promote community • Team structure	• Collegiality across the organization • Physician lounge • Strategies to build community • Social gatherings	• Support and community created by Medical/specialty societies
Work-life integration	• Priorities and values • Personal characteristics – Spouse/partner – Children/dependents – Health issues	• Call schedule • Structure night/weekend coverage • Cross-coverage for time away • Expectations/role models	• Vacation policies • Sick/medical leave • Policies – Part-time work – Flexible scheduling • Expectations/role models	• Requirements for: – Maintenance certification – Licensing • Regulations that increase clerical work

FIGURE 3. Drivers of burnout and engagement with examples of individual, work unit, organization, and national factors that influence each driver. EHR = electronic health record; JCAHO = Joint Commission on the Accreditation of Healthcare Organizations. Adapted from *Mayo Clin Proc.*[39]

[36]

[36] Shanafelt TD, Mungo M, Schmitgen J, et al. Longitudinal study evaluating the association between physician burnout and changes in professional work effort. Mayo Clin Proc. 2016; 91 (4):422-431

Appendix B: Solutions the Task Force Reviewed for their Consideration

1. Evidence-Based:

   - 1.1: Support for use of Validated Surveys[37]
     - Burnout:
       - Maslach Burnout Inventory — Human Services Survey for Medical Personnel
       - Oldenburg Inventory
       - Physician Work-Life Study's Single-Item
       - Copenhagen Burnout Inventory
     - Composite Well-Being:
       - Stanford Professional Fulfillment Index
       - Well-Being Index
     - Depression and Suicide Risk:
       - The Patient Health Questionnaire-9 (PHQ-9)

(See "Commonly Used Burnout and Composite Well-Being Measures by Pragmatic Characteristics" on next page.)

[37] Valid and Reliable Survey Instruments to Measure Burnout, Well-Being, and Other Work-Related Dimensions. National Academy of Medicine. https://nam.edu/valid-reliable-survey-instruments-measure-burnout-well-work-related-dimensions/

Table 2 | **Commonly Used Burnout and Composite Well-Being Measures by Pragmatic Characteristics**

	Burden	Actionable	Sensitivity to Change	Broadly Applicable	Psychometrics
Burnout Measures					
Maslach Burnout Inventory-HSS (22 item) (MBI-HHS)	• 22 items • Moderately complex to analyze • Fee for use	• National benchmark data • Robust data showing scores correlate with outcomes of interest such as medical error, malpractice, and turnover	• Longer time frame • Can detect meaningful effect sizes from interventions	HCPs	• Strongest construct validity evidence in physicians and other HCPs
Maslach Burnout Inventory-HSS (2 item) (2 single-item MBI-HHS)	• 2 items • Relatively simple to analyze • Fee for use	• Data showing scores correlate with outcomes of interest such as medical error, malpractice, and turnover	• Longer time frame	HCPs	• Strong construct validity evidence in U.S. physicians • No construct validity evidence in other HCPs
Copenhagen Burnout Inventory (CBI)	• 16 items • Moderately complex to analyze • Free [a]	• No national benchmark data • Limited data showing scores correlate with outcomes of interest	• No time frame • Unknown if sensitive to change	Any occupation	• No construct validity evidence in U.S. physicians or other HCPs • Limited construct validity evidence in non-U.S. physicians and other HCPs
Oldenburg Burnout Inventory (OBI)	• 19 items • Moderately complex to analyze • Free [a]	• No national benchmark data • Limited data showing scores correlate with outcomes of interest	• No time frame • Unknown if sensitive to change	Any occupation	• No construct validity evidence in U.S. physicians or other HCPs • Limited construct validity evidence in non-U.S. physicians and other HCPs
Physician Worklife Survey (mini-Z) (PWLS)	• 1 item • Simple to analyze • Free [a]	• No national benchmark data • Limited data showing scores correlate with outcomes of interest	• No time frame • Unknown if sensitive to change	Any occupation [b]	• Limited construct validity evidence in U.S. physicians • No construct validity evidence in other HCPs; too brief to have strong psychometrics
Composite Well-Being Measures					
Well-Being Index (WBI)	• 7-9 items • Simple to analyze • Free [a]	• National benchmark data • Moderate data showing scores correlate with outcomes of interest	• Moderate time frame • Unknown if sensitive to change	Any occupation [b]	• Moderately strong construct validity evidence in U.S. physicians and other HCPs
Stanford Professional Fulfillment Index (PFI)	• 16 items • Moderately complex to analyze • Free [a]	• No national benchmark data • Limited data showing scores correlate with outcomes of interest	• Short time frame • May be sensitive to change	HCPs	• Limited construct validity evidence in U.S. physicians • No construct validity evidence in other HCPs

SOURCE: Dyrbye et al., "Pragmatic Approach for Organizations to Measure Health Care Professional Well-being," National Academy of Medicine.

NOTE: HCP = health care professional.[a] Free for research use and for use in quality improvement efforts by nonprofit organizations.
[b] Although called "Physician Worklife Survey," this item does not specifically refer to physicians or patients and thus could be used for other occupations; however, no validity data exist for use in other occupations.

- **1.2: "Tools and Interventions to Combat and Prevent Physician Burnout — Examples from the Literature, such as the CHARM Annotated Bibliography"**

Medical School/Residency

<u>Curriculum Changes Incorporating Mindfulness and Resilience Training</u>

Incorporating mindfulness-based practices and assessments into first year medical student curriculum led to a reduction in depression and hostility and improvement in quality of life.

Monash University in Australia developed its Health Enhancement Program (HEP) for their first-year medical students in 2002, implemented during the second half of the first semester for the 315 medical students in each class. The curriculum includes mindfulness and mind-body techniques and the "ESSENCE" model for a healthy lifestyle (including of education, stress management, spirituality, exercise, nutrition, connectedness, and environment). The eight core lectures are supplemented by six two-

hour tutorials and self-directed learning. Students keep a journal and meet regularly with a tutor and in small groups. These elements are integrated into other elements of the core curriculum through lecture series, case-based learning, and assessment integrated into assessment of other components of the curriculum and the OSCE. Overall, the HEP curriculum is a significant portion of the first-year curriculum, accounting for 10% of the total assessment load. Data before and after the intervention were available for 148 (55%) of students. Ninety percent reported applying mindfulness practice, and there were statistically significant improvements in the depression, hostility, and General Severity Index of the Symptom Checklist-90, and in the psychological domain of the World Health Organization Quality of Life scale.

Medical Students MBI Screening/Education during Medical School

This study encourages Medical Schools to educate medical students about burnout screening methods the same way that they are educated about PHQ-9 and GAD-7, and then to screen students for burnout to identify at risk students and link them to care before they have concerns for litigation as practicing physicians.

> In this scheme, emotional exhaustion scores of 27 or greater, depersonalization scores of 10 or greater and personal accomplishment scores of 33 or less are considered indicative of high levels of burnout in each domain for physicians. Other options include the Copenhagen Burnout Inventory and the Oldenburg Burnout Inventory. However, despite ongoing efforts to refine burnout instruments, the MBI remains the current "gold standard" for burnout assessment.

Integrating Professional Development and Wellness into Curriculum

Revising the four-year curriculum to include wellness education, reflection time, and exposure to psychiatry services to reduce the stigma of seeking medical care for mental health.

The authors describe a new four-year professional development and wellness curriculum at Northwestern University's Feinberg School of Medicine, consisting of required monthly 90-minute sessions in small groups of eight students and one faculty member from within the students' college. Students prepare for each session by reviewing a learning guide and completing written exercises on a blog to stimulate reflection and narrative, then meet in small groups to process the exercise. Topics cover personal and educational goals and relationships with peers, positive psychology techniques, psychological struggles common in the profession of medicine such as perfectionism and impostor syndrome, and professional identity formation. Quantitative evaluations in the first two years included satisfaction measures by small group leaders and students (N=140). The majority of students felt more prepared to transition to medical school and more self-aware and reported being willing to seek help if they need it. Some students were not comfortable discussing personal topics in small groups, and the facilitation of the faculty leader impacted group dynamics. The authors comment that an unintended effect of exposure to psychiatry faculty may have been to decrease stigma in seeking mental health care. There was no comparison group.

Changes at Saint Louis University School of Medicine

Incorporating changes such as a pass/fail system for pre-clinical years, reducing required facetime, and allowing for career exploration and mentorship, and fostering peer support led to a reduction in depression and anxiety scores and an increase in USMLE Step 1 scores.

Curricular changes were first instituted in the 2009–2010 school year, using person-in-context primary prevention model to proactively target contextual elements within the curriculum that could contribute to poor mental health. Changes were made based on data from 2008 indicating that 57% of students had moderate-high anxiety and 27% had moderate-severe depression; volume and level of detail of material and competition were identified as drivers and were the impetus for changes. Curricular changes included (1) a pass/fail grading system for preclinical courses, replacing the honors/near honors/pass/fail grading system; (2) a reduction in contact hours across the first two years of curriculum by 10% and reducing unnecessary detail in courses through course-specific faculty development; (3) the institution of longitudinal electives to allow students more time to explore their interests, to create mentorship relationships, and to engage in service and/or research with more continuity; and (4) the establishment of learning communities composed of students and faculty who share common interests and passions beyond the classroom. In 2010–2011, a six-hour Resilience and Mindfulness program based in positive psychology was added to the first-year clinical skills course. In 2011–12 anatomy was rescheduled to later in the year and exam design was changed. Students took an annual Center for Epidemiological Studies Depression Scale, Spielberger State-Trait Anxiety Inventory, Perceived Stress Scale, and Perceived Cohesion Scale. Post change classes, compared to the historical cohort of pre-change classes, exhibited lower rates of moderate to severe depression symptoms and a substantial decrease in mean anxiety scores, as well as a non-statistically significant decrease in the mean stress levels. Mean group cohesion and student satisfaction with the program scores were higher in the post-intervention cohorts. USMLE Step 1 scores also rose significantly for the class of 2014, compared with the previous classes that did not receive the Resilience/Mindfulness program, social events, and the reversal of anatomy and cell biology.

Residents/Fellows Reduced Work Hours

Studies have shown benefit from reducing physician hours in intensive care units and on teaching rotations. These approaches align with excessive workload as a driver of burnout. Locally developed practice changes to promote efficiency and satisfaction have also been shown to offer benefit.

Shift Lengths

Shorter shifts were associated with decreased medical errors, motor vehicle crashes, and percutaneous injuries.

Sixty-four studies were included. Most studies used single-institution, observational designs and many were felt to be methodologically weak, with a high risk for bias. However, 73% of the studies that examined shift length showed that shorter shifts were associated with decreased medical errors, motor vehicle crashes, and percutaneous injuries. While heterogeneous, this body of evidence appears to support reducing shift length; however, optimal shift duration was not adequately addressed. Other recommendations about protected sleep time and night float were limited by the quality

of the methodology used in the original studies and unclear generalizability for most outcomes.

Counseling and Faculty Training

Increasing individual counseling for students and increasing faculty mental health response education led to a substantial decrease in suicidal ideation.

The University of Hawaii John A. Burns School of Medicine, Honolulu, Hawaii, found high rates of depression and suicidal ideation in a confidential survey of third-year medical students. The purpose of this study was to develop an intervention that would reduce depressive symptoms and suicidal ideation in their third-year students. The intervention was multi-pronged and consisted of (1) increased individual counseling for students, (2) faculty education about recognizing and responding to student depression, and (3) a specialized curriculum for students, including lectures and a student handbook. Focus was made on having anonymous counseling available to students. The Center for Epidemiologic Studies Depression Scale and a question about suicidal ideation from the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire were used to measure depressive symptoms both before and after the intervention. Investigators saw a 35% reduction in depressive symptoms and a 27% reduction in suicidal ideation.

Narrative Medicine Courses

Narrative medicine electives incorporated for fourth-year electives led to improved communication skills, enhanced empathy, and self-reported increase in the importance of personal development.

This study used a grounded theory approach to understand the impact of narrative medicine on both the process of training and its influence on clinical skills. Twelve fourth-year medical students volunteered to participate in a one-month narrative medicine elective. The impact of the elective was evaluated by initially by a survey using open-ended questions (response rate was 11/12, 91%). These answers were used to generate exploratory questions for a focus group (6/12, 50% of the enrolled students participated). Lastly, a few open-ended questions were sent at 18 months to all participants (response rate 3/12, 25%). Through iterative thematic analysis, five themes emerged: students perceived that attending the sessions (1) helped them develop and improve specific communication skills; (2) enhanced their capacity to collaborate, empathize, and deliver patient-centered care; (3) emphasized that regular self-reflection and reflection about the practice of medicine was valued and felt to be important for personal and professional development; (4) demonstrated that learning narrative medicine methodology was critical to their positive experience; and (5) helped them realize that narrative medicine training is misunderstood by others and perceived as counter-culture.

Behavioral Change Plans

Six-week courses on healthy habits such as exercise, mindfulness, and prioritizing emotional and mental health led to less than 50% of student feeling like they reached their goals by the end of the program, but 81.9% of students reported that they would like to try the program for longer and could see a perceived benefit in the training.

A one-group post-test design was used to evaluate the BCPs of 343 second-year students at Northwestern University School of Medicine. Students in the classes of 2010 and 2011 participated in a six-week, 12-hour Healthy Living course, during which they

completed the BCP activity. The activity targeted exercise, nutrition, sleep, personal habits/hygiene, study/ work habits, or mental/emotional health. Of the students, 87.2% elected to modify exercise, nutrition, or sleep behavior. After self-monitoring behavior for six weeks, 40.5% of students indicated that they achieved their goal, 49.6% of students failed to achieve their goal, and 9.9% of students were uncertain about whether they met their goal. Overall, 79.9% of students felt that they were healthier after implementing the BCP, and 81.9% of students noted that they would use a BCP to monitor and set goals for individual behavior change in the future.

Audio Mindfulness Interventions

Using guided mindfulness audio CDs for training students led to a significant decreased in perceived stress that was maintained at an eight-week follow-up.

This study was a multicenter, randomized controlled trial with intention-to-treat analysis in three medical schools attached to the University of Tasmania in Hobart, Tasmania. Sixty-six students were randomized to either usual care or the intervention group. The intervention group received an audio CD of guided mindfulness practice and were instructed to use the CD daily over eight weeks. The impact of the intervention was measured by the Perceived Stress Scale (PSS) and Depression, Anxiety and Stress Scale (DASS). The intervention group had a significant decrease in perceived stress (on the PSS) and anxiety (on the DASS). A borderline significant effect was observed on the stress component of the DASS ($p = 0.05$). The significant effects were maintained at eight weeks follow-up. This study contributed significantly to literature on mindfulness and stress among medical students. First, the study confirmed that medical students experience higher rates of stress than their age matched peers. Second, it is the first randomized controlled trial to examine an audio CD mindfulness intervention for stress management. This intervention requires less time and fewer resources than traditional mindfulness-based stress reduction, and is self-guided by students, making it more accessible for their schedules. The randomized structure also strengthens this study.

Informal Peer Support Groups

Loss of physician lounges and safe spaces for informal interactions has led to an erosion of peer support. Historically, such interactions happened somewhat organically during discussing interesting/challenging cases or spending time together in the physicians' lounge. In our experience, these interactions have been an unintended casualty of increasing productivity expectations, documentation requirements, and clerical burden. Well-intentioned efforts to create a more egalitarian environment have also led many organizations to eliminate formal spaces for physicians to interact (e.g., physicians' lounge or dining room) without recognizing the important role that this dedicated space played in fostering interpersonal connections among physicians. Collectively, these changes have led to an erosion of peer support. The Balint Group and COMPASS (Colleagues Meeting to Promote and Sustain Satisfaction) are recent alternatives to this change. (See below.)

Balint Group

A Balint group is a purposeful, regular meeting among family physicians, with a trained facilitator or leader, to allow discussion of any topic that occupies a physician's mind outside of his or her usual clinical encounters. Most family medicine residency programs in the United States have Balint groups as part of the training experience. There is much evidence in the literature that participation in a Balint group increases a participant's coping ability, psychological mindedness, and patient-centeredness.

COMPASS

A follow-up trial, at Mayo Clinic, evaluated a revised format to make these COMPASS (Colleagues Meeting to Promote and Sustain Satisfaction) groups more cost-effective and scalable. Participating physicians signed up with a group of 6 to 7 colleagues, shared a meal together at a restaurant in town once every two weeks, and spent the first 20 minutes of that gathering discussing a question that explored the virtues and challenges of being a physician. Funds to cover the cost of the meal were provided by Mayo Clinic. The randomized trial again found that these meetings with colleagues led to an improvement in both meaning in work and burnout for participants.

ACGME and CRCR — Five Recommendations

Based of 2015 discussions at ACGME and CRCR in response to two resident suicides in August 2014. When asked what the ACGME and CRCR can do to foster these changes, Five recommendations emerged. The first entailed increasing awareness of the risk of depression during residency, thereby destigmatizing it. Approaches may include program and institutional outreach about mental health problems and acknowledging and discussing depression and suicide in trainees. The second recommendation was to create a confidential approach to treat depression in trainees. The third recommendation was to develop a more formal approach to mentoring by senior peers and faculty. Promoting a more supportive culture in training programs was the fourth recommendation, including team building and resident retreats. The final recommendation was to encourage additional study of resident wellness to better understand problem areas and highlight best practices.

Increasing Belonging

Simply reading anecdotes from older residents about their struggles during early years in training led to increased feelings of belonging and increased self-reported likelihood of finishing residency when compared to reading about challenging medical ethical dilemmas without peer reflections.

Junior residents from seven surgical specialties took a baseline survey of attitudes and beliefs and were then randomized into either a belonging treatment or control condition. The intervention group spent 15–20 minutes reading anecdotes from senior residents describing challenging early residency experiences, while the control group read descriptions of challenging ethical dilemmas. Attitudes and beliefs were surveyed as a proxy for likelihood of leaving residency, and burnout was measured using the Maslach Burnout Inventory. Residents reporting feelings of belonging were more likely to report feeling they would complete residency ($P<0.01$). Mean scores for burnout items on the MBI post-intervention were lower in the intervention arm compared to the control arm ($P<0.05$), driven by decrease in emotional exhaustion, without significant change in depersonalization or accomplishment (personal communication with author A. Salles).

Web-Based CBT for Trainees

Interns participating in wCBT were 60% less likely to endorse SI during the entire year (RR 0.40; 95% CI 0.17–0.91; P=0.03). Effect size was 1.97. The NNT was 11, meaning that for every 11 interns, taking part in the intervention would prevent one intern from having SI. This protective effect was sustained over the entire year.

This RCT was performed in two large academic centers (Yale University and University of Southern California) and enrolled interns in many different disciplines (internal medicine, surgery, obstetrics/gynecology, pediatrics, psychiatry, neurology, emergency

medicine, and medicine/pediatrics). Interns were randomized to the wCBT group (n=100) or an Attention Control Group (n=99); randomization was successful. The intervention group were directed via email each week for four weeks to the intervention website http://moodgym.anu.edu./au to complete a CBT module each week. The control group received an email once weekly for four weeks with information about the symptoms of mental illness and where to obtain local mental health treatment. Brief refresher emails were sent at months 2, 5, 8, and 11: the wCBT participants were asked to return to the website and review a module of their choice, while the control group was sent the same email as before. SI was measured using the question from the PHQ-9 "thoughts that you would be better off dead or hurting yourself." The response was considered positive if the intern responded to frequencies of "several days," "more than half the days," or "nearly every day" over past two weeks. Results showed that uptake of the intervention was good: 88% (88/100) completed at least one wCBT module; 78% completed two; 65% completed three; 51% completed all four modules; and 82% went back and reviewed at least one module. The wCBT interns were 60% less likely to endorse SI during the entire year (RR 0.40; 95% CI 0.17–0.91; P=0.03). Effect size was 1.97. The NNT was 11, meaning that for every 11 interns, taking part in the intervention would prevent one intern from having SI. This protective effect was sustained over the entire year.

Medical Home for Trainees

Locations with comprehensive medical and mental health care, with dedicated coordination staff, should be offered for all house officers.

This paper alerts programs to the unmet or partially met health care needs of many residents and suggests a solution: the medical home. Several practical interventions to increase residents' access to care and use of services are described. Authors concluded that a critical step toward improving health and wellness in residents is to apply the relevant, evidence-based, and patient-centered principles of the primary care field to the well-being of those who train within it. Appointment of a care coordinator (ideally someone separated from any supervisory or promotional role involving trainees) was the main cost identified by authors. The coordinator position could be 0.2–0.5 full time equivalents (FTE), depending on program size and anticipated resident needs. Medical and mental health care providers could be hired specifically for trainee health care. Alternately, some FTE share could be added to existing providers (e.g., within an employee health clinic, medical student clinic, primary care clinic, or another medical home).

Need for Protected Reflection Time

Bimonthly meetings with psychotherapists to discuss several themes — such as death and dying, coping, difficult patients — did not lead to reduced stress and improved resiliency because residents were required to keep pagers on and deal with other tasks at the same time.

Incoming first year internal medicine residents were randomly assigned to intervention or control groups (total n=51; 39 of whom completed both surveys). The intervention groups were designed to be one-hour meetings twice per month for nine months. The groups were facilitated by psychotherapists with expertise in facilitating group discussion; self-development psychotherapy, however, was not part of the intervention. Sessions were not held in place of existing educational meetings; rather, they were in addition to the daily work expectation for each randomized participant and interns still

carried their pagers and could be interrupted. Each session was organized around a theme (e.g., death and dying, coping mechanisms, difficult patients, etc.). The primary outcome was burnout (Maslach Burnout Inventory) and secondary outcomes included items related to suboptimal patient care, professional behavior and fatigue (Epworth Sleepiness Scale). Results showed that there was no significant improvement in any of the outcomes at the study conclusion. Informal feedback from many of the residents noted that they had ongoing clinical responsibilities during this time and that it did not eliminate their other daily requirements, which increased their stress level.

Culture Transformation

Pilot program to foster an emotionally intelligent learning community showed that although quantitative measures of well-being did not change, themes from the qualitative analysis highlighted the positive culture and experiences with emotional awareness, self-care and reflection.

This paper describes a pilot study of a curriculum implemented in the Lehigh Valley Health Network Family Medicine Residency Program anchored on the concept of an emotionally intelligent learning community. That framework aimed to cultivate wellness through provision of time and space for self-care/reflection; safety through promoting vulnerability, asking for help, and admitting mistakes without fear of retribution; and development of interpersonal skills. Investigators used a mixed-methods evaluation strategy to examine data from 34 residents who were enrolled in the pilot program from 2007 to 2012. The measurements included the Fordyce Emotions Scale, Satisfaction with Life Scale, the Arizona Integrative Outcomes Scale, analysis of transcripts of "closing ritual statements" from resident assessment meetings, and analysis of transcripts from resident focus groups. Although quantitative measures of well-being did not change, themes from the qualitative analysis highlighted the positive culture and experiences with emotional awareness, self-care, and reflection. The authors suggest that their results reflect that the intervention did not change the nature of the work, but rather normalized challenges of professional identity development. The authors hypothesize that existing psychometric tools may not be sensitive enough to capture valuable contributions from such interventions.

Practicing Physicians

Practicing Physicians Emergency Medicine Reflection Rounds

EMRR is a one-hour monthly small group meeting where residents were encouraged to share ethically and/or personally difficult clinical encounters.

These support groups were facilitated by faculty members, and the curriculum evolved based on verbal feedback from the initial nine resident participants. At the conclusion of the intervention, a survey of four questions was distributed to gain feedback about the program. In survey evaluation of the EMRR program, all participating residents felt that the intervention provided a safe space to discuss challenging issues and that participation in the groups improved their well-being.

Failure Bow

In an exercise called the Failure Bow, popularized in Schwartz Rounds, each person stands, shares an error, omission, or challenge from the previous weeks, then leans in and takes a bow. And as team member after team member steps into a space of vulnerability, their colleagues meet them with empathy and compassion — a virtual trust

fall. BIDCO Outpatient clinics implemented monthly peer groups to discuss housekeeping, difficult cases, and a community-building exercise.

COMPASS

A follow-up trial at Mayo Clinic evaluated a revised format to make these COMPASS (Colleagues Meeting to Promote and Sustain Satisfaction) groups more cost-effective and scalable. Participating physicians signed up with a group of six to seven colleagues, shared a meal together at a restaurant in town once every two weeks, and spent the first 20 minutes of that gathering discussing a question that explored the virtues and challenges of being a physician. Funds to cover the cost of the meal were provided by Mayo Clinic. The randomized trial again found that these meetings with colleagues led to an improvement in both meaning in work and burnout for participants.

Courses for Practicing Physicians

Physicians participating in Mindfulness Based Stress Reduction (MBSR) exercises for eight weeks had significant reductions in burnout, as well as increases in mindfulness and meaningfulness among clinicians after MBSR. They also found that patients' perceptions of clinical encounters improved, suggesting that patient-centered care improved after MBSR.

This longitudinal study was conducted at the Pitié-Salpêtrière Hospital in Paris from September to December 2014. The full eight-week MBSR course was the intervention provided. The authors used pre- and post-intervention validated questionnaires to measure burnout (Maslach Burnout Inventory, MBI), depression (Beck Depression Inventory II, BDI), stress (Perceived Stress Scale, PSS), meaningfulness (Sense of Coherence), and mindfulness (Five Facet Mindfulness Questionnaire, FFMQ) in physicians. The authors also asked patients to evaluate their physicians' communication pre- and post-intervention, using the Rochester Communication Rating Scale. Lastly, several patient encounters were audio-recorded, transcribed, and analyzed using a Roter Interaction Analysis System (RIAS) to provide qualitative analysis of patient-physician encounters. This study included providers from multiple disciplines: physicians, psychologists, nurses, dieticians, an osteopath, and a research coordinator participated. Two people dropped out, leaving 25 participants in the data analysis. The communication evaluation included 18 participants, due to poor patient follow-up. The physicians who participated were from different specialties: cardiology, addiction medicine, internal medicine, oncology, pediatric psychiatry, and family medicine. The authors found significant reductions in burnout, as well as increases in mindfulness and meaningfulness among clinicians after MBSR. They also found that patients' perceptions of clinical encounters improved, suggesting that patient-centered care improved after MBSR.

Peer Support vs. Time off

Study showed that one hour of protected peer small group sessions every other week, when compared with similar amounts of unstructured time off or no intervention, led to decreased rates of depersonalization, emotional exhaustion, and overall burnout.

A total of 74 academic Internal Medicine physicians were randomized to participate in a facilitated small group session or unstructured protected time. All participants received one hour of protected time every other week. Outcome measures included the Physician Job Satisfaction Scale, the Empowerment at Work Scale, the Medical

Outcomes Study Short-Form Health Survey (which measures mental and physical health), the Maslach Burnout Inventory, the Perceived Stress Scale, the 2-item PRIMEMD (which screens for depression), and the Jefferson Scale of Physician Empathy. Quality of life and fatigue were measured by a single-item linear analog scale. In addition to study participants, 350 physicians not participating in the intervention were also surveyed in the same interval. The intervention group showed significant improvement in empowerment and engagement at work. Rates of high depersonalization also decreased. The proportion of participants strongly agreeing that their work was meaningful also increased whereas the proportion decreased in the control and non-study cohorts, a finding that was statistically significant. These changes were evident by three months after the study and persisted at 12 months. There were no statistically significant changes in stress, symptoms of depression, quality of life, or job satisfaction among the intervention group, control group, and non-participants. Interestingly, rates of depersonalization, emotional exhaustion, and overall burnout decreased substantially in the trial intervention arm, decreased slightly in the trial control arm, and increased in the non-participants, all of which were statistically significant findings.

Communication Skills Training

Communication skills training led to improvements in emotional support, confidence, and burnout, persistent at three months following the two-day intervention.

Patient preferences were explored related to (1) the appropriate environment for bad news discussions, (2) various approaches on how to deliver bad news, (3) important additional information to discuss, and (4) how to best provide reassurance and emotional support. The two-day CST workshop consisted of lectures, role playing with simulated patients, and group discussions with other physicians. The program evaluation used pre- and post-CST consultation with a simulated patient. The authors observed the communication preferences, behaviors, and utterances of the providers at the simulated patient encounter before and after the CST in order to evaluate confidence with news delivery. The authors also evaluated burnout (Maslach Burnout Inventory), subjective confidence, and helpfulness with pre-, post-, and three-month post-CST surveys. The authors found significant improvement in emotional support and consideration for how to deliver information after the two-day CST intervention. They also found improvements in confidence and reduction of burnout, persistent at three months post-CST.

Time Banking

Time banking, Stanford Medicine 's time bank, was part of a two-year, $250,000 pilot funded largely by the Sloan Foundation, and showed big increases in job satisfaction, work-life balance and collegiality, in addition to a greater number of research grants applied for and a higher approval rate than Stanford faculty not in the pilot.

And for the first time, in that pilot year, there were no openings for new fellows in the Department of Emergency Medicine. Volunteering to cover shifts on short notice nearly doubled, to 83 percent, and people reported feeling more collegiality. Fewer postponed or avoided taking care of their health or put off vacation. The proportion of faculty who had time to discuss science with their colleagues jumped from 9 to 55 percent. And the share of female faculty members who felt Stanford supported their career development rose from 29 to 57 percent. After the pilot, Stanford Medicine adapted the program to meet its individual needs.

Female physicians may be at highest risk, particularly those with heavy clinical loads. A survey of Stanford School of Medicine faculty found that few female faculty members reported "feeling supported" in their career development. The survey prompted the administration to consider novel ways to improve work–life integration and prevent burnout. Stanford piloted a "time bank" to ensure that faculty were rewarded for activities that are rarely recognized by medical centers, such as serving on committees. This program allowed faculty to trade time spent on these activities for in-home support, such as meal delivery and cleaning services, or support at work, including assistance with grant writing, and submission. Though this initiative was meant for all physicians and basic scientists, women used these services more frequently than men, and the number of female faculty members who reported "feeling supported" had nearly doubled by the end of the pilot program.[38]

Burnout in Primary Care

Study looked at interventions targeting communication vs. workflow vs. QI and their effect on burnout. Lower burnout scores were specifically associated with workflow interventions and targeted QI projects, while improved satisfaction was associated with improved communication and workflow.

This cluster randomized trial evaluated 166 primary care physicians who were recruited from 34 Midwest and New York City practices and represented a mix of urban, rural, and suburban environments at academic and non-academic centers. Interventions were grouped into three categories: (1) improving communication; (2) changes in workflow; and (3) quality improvement (QI) projects addressing clinician concerns. An office work life survey that evaluated time pressure, work chaos, and workplace control was completed before and after the intervention. Physician burnout (modified MBI), satisfaction, and intention to leave were also evaluated. The study used tools adapted from the Physician Worklife (PWS) and Minimizing Error, Maximizing Outcome (MEMO) studies to measure outcomes at baseline and at 12–18 months. Response rate was 81.3% (135/166). Significantly more physicians who participated in the intervention had improved burnout and satisfaction. Lower burnout scores were specifically associated with workflow interventions and targeted QI projects, while improved satisfaction was associated with improved communication and workflow. Data were presented in aggregate and did not specify whether there were differences in outcomes comparing environments (e.g., urban vs. rural; academic vs. non-academic).

Interrupted vs. Continuous Schedules for Intensivists

Intensivists experienced significantly higher burnout, work-home-life imbalance, and job distress working under the continuous schedule. ICU and hospital length of stay and mortality for patients did not differ significantly between the two work schedules.

A prospective, cluster-randomized, alternating trial of two intensivist staffing schedules was undertaken in five medical intensive care units (ICUs) in four academic hospitals. Daily coverage by a single intensivist in half-month rotations (continuous schedule) was compared with weekday coverage by a single intensivist, with weekend cross-coverage

[38] Wright AA, Katz IT. Beyond Burnout — Redesigning Care to Restore Meaning and Sanity for Physicians. New England Journal of Medicine. 2018;378(4):309-311. doi:10.1056/nejmp1716845

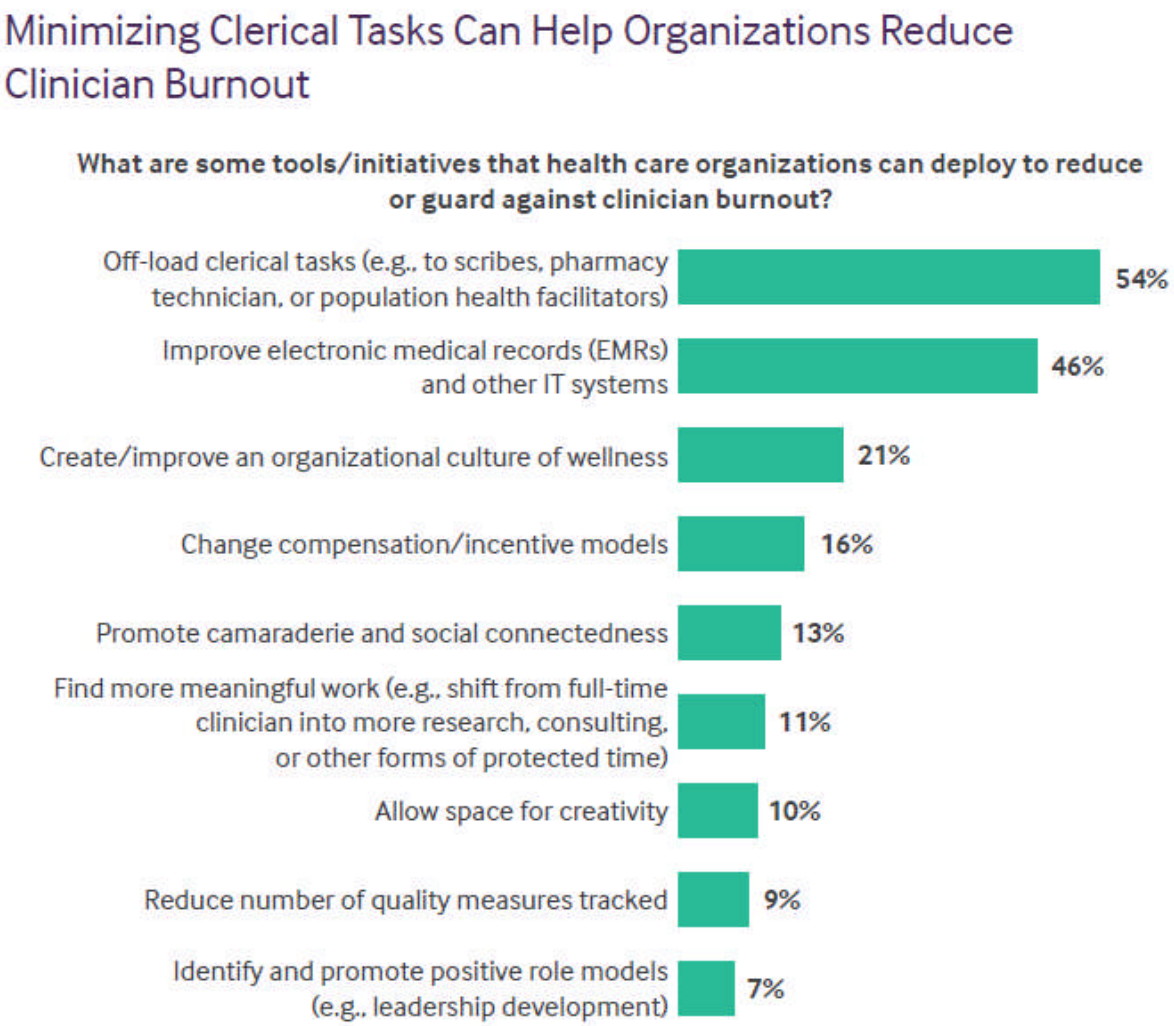
by colleagues (interrupted schedule). A total of 45 intensivists and 1,900 patients participated in the study. The impact of the intervention was measured on intensivist outcomes such as burnout, work home life imbalance, and job distress and patient outcomes including ICU length of stay, hospital length of stay and mortality. Intensivists experienced significantly higher burnout, work home life imbalance, and job distress working under the continuous schedule. ICU and hospital length of stay and mortality for patients did not differ significantly between the two work schedules. Continuity of care was significantly higher in the continuous work schedule.

Integrating Medical Assistants to Improve Workflow

"Whereas past efforts to address burnout have focused on bolstering individuals' resilience skills, there's a growing recognition that organizations also need to redesign the way that clinical care is delivered. In 2015, the Department of Family Medicine at the University of Colorado health system instituted a team-based model called ambulatory process excellence, or APEX. Under this system, medical assistants gather data, reconcile medications, set the agenda for patient visits, and identify opportunities to increase preventive care. After they complete this structured process, they share this information with a physician or nurse practitioner and remain in the room to document the visit. When the clinician leaves, the medical assistant provides patient education and health coaching. This arrangement allows physicians and midlevel clinicians to focus on synthesizing data, performing the physical exam, and making medical decisions without distractions."[39]

"(T)he implementation succeeded because of flexibility and teamwork: 'Providers have to be willing to give up a little control to get the support they need so that they can build better connections with patients without technology interfering.'"[40]

[39] Ibid.
[40] Ibid.



AMA STEPS Forward — Practice Transformation Processes

Health care is changing rapidly. Physicians are transforming their practices into organizations that can achieve the Quadruple Aim: better patient experience, better population health, and lower overall costs with improved professional satisfaction. To navigate this environment, we leveraged the findings from the AMA-RAND study: "Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy," to develop the STEPS Forward™ practice transformation series.[41]

Selecting leaders based on their ability to manage a team rather than their ability to deliver target metrics is very important.

[41] Linzer M, Guzman-Corrales L, Poplau S. Preventing Physician Burnout - STEPS Forward. STEPSforward.org. https://www.stepsforward.org/modules/physician-burnout.

After adjusting for other factors, 11% of the variation in burnout and 47% of the variation in satisfaction between work units was explained by the aggregate leadership rating of the work unit supervisor as assessed by their physician reports.

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https://nam.edu/valid-reliable-survey-instruments-measure-burnout-well-work-related-dimensions/

2: Health Leader Recommendations and System Recommendations National Academy of Medicine Discussion Papers

- **2.1: The Task Force Supports, with Minor Amendments, the 11 Principles from a March 2017 *HealthAffairs* Article**
  "The issue of burnout is a matter of absolute urgency."

1. Regularly measure the well-being of our physician workforce at our institutions using one of several standardized, benchmarked instruments.
2. Include measures of physician well-being in our institutional performance dashboards along with financial and other performance metrics.
3. Evaluate and track the institutional costs of physician turnover, early retirement, and reductions in clinical effort.
4. Emphasize the importance of leadership skill development for physicians and managers leading physicians throughout our organization.
5. Understand and address more fully the clerical burden and inappropriate allocation of work to physicians that is contributing to professional burnout.
6. Support collaborative, team-based models of care where physician expertise is maximally utilized for patient benefit, with tasks that do not require the unique training of a physician delegated to other skilled team members.
7. Encourage government/regulators to address the increasing regulatory burden that is driving inefficiency, redundancy, and waste in health care and to proactively monitor and address new unnecessary and/or redundant regulations.
8. Encourage and support the AMA and other national organizations to work with regulators and technology vendors to align technology and policy with advanced models of team-based care and to reduce the burden of the EHR on all users.
9. Encourage and support the AMA and other national organizations in developing further initiatives to make progress in this area by compiling and sharing best practices from institutions that have successfully begun to address burnout, profiling

case studies of effective well-being programs, efficient and satisfying changes in task distribution, and outlining a set of principles for achieving the well-being of health professionals.

10. Educate CEOs as well as other stakeholders in the health care ecosystem about the importance of reducing burnout and improving the well-being of physicians as well as other health care professionals.
11. Support and use organizational research to determine the most effective policies and interventions to improve professional well-being among our physicians and other health care professionals.

➢ 2.2: Executive Leadership and Physician Well-Being — Nine Organizational Strategies to Promote Engagement and Reduce Burnout

- Strategy 1: Acknowledge and Assess the Problem
  Acknowledging the problem of burnout and demonstrating that the organization cares about the well-being of its physicians is a necessary first step toward making progress. Naming the issue and being willing to listen demonstrates that the problem is recognized at the highest level of the organization and creates the necessary trust for physicians and leaders to work in partnership to make progress. Once the problem is acknowledged, it is necessary to measure physician well-being as a routine institutional performance metric.

- Strategy 2: Harness the Power of Leadership
  Although the importance of leadership for organizational success is obvious, its direct effect on the professional satisfaction of individual physicians is underappreciated. Recent evidence suggests that the leadership behaviors of the physician supervisor play a critical role in the well-being of the physicians they lead. A 2013 study of more than 2,800 physicians at Mayo Clinic found that each 1-point increase in the leadership score (60-point scale) of a physician's immediate supervisor (division/department chair) was associated with a 3.3% decrease in the likelihood of burnout

- Strategy 3: Develop and Implement Targeted Interventions
  Using the framework of the existing organizational structure in combination with strategy 1 (assessment) and strategy 2 (leadership) can overcome this dilemma.

- Strategy 4: Cultivate Community at Work
  Physicians deal with unique challenges (e.g., medical errors, malpractice suits) and have a professional identity and role that is distinct from other disciplines. Peer support has always been critical to helping physicians navigate these professional challenges. This support can be formal or informal and encompasses a wide range of activities, including celebrating achievements (e.g., personal and professional milestones), supporting one another through challenging experiences (e.g., loss of a patient, medical errors, a malpractice suit), and sharing ideas on how to navigate the ups and downs of a career in medicine.

- Strategy 5: Use Rewards and Incentives Wisely
  People can be motivated by rewards. To harness this principle, many health care organizations have linked physicians' financial compensation to productivity

- Strategy 6: Align Values and Strengthen Culture
  Most health care organizations have an altruistic mission statement that centers on serving patients and providing them the best possible medical care. An organization's culture, values, and principles in large part determine whether it will achieve its mission. It is critical for organizations to (1) be mindful of factors that influence culture, (2) assess ways to keep values fresh, and (3) periodically take stock of whether actions and values are aligned.

- Strategy 7: Promote Flexibility and Work-Life Integration
  Two aspects particularly important to physician well-being are policies related to flexibility and work-life integration. Approximately 45% of physicians work more than 60 hours per week compared with less than 10% of US workers in other fields. Providing physicians with the option to adjust professional work effort (with a commensurate reduction in compensation) allows them to tailor their work hours to meet both personal and professional obligations.

- Strategy 8: Provide Resources to Promote Resilience and Self-Care
  Providing individual physicians with tools for self-calibration, resources to promote selfcare, and training in skills that promote resilience are three tangible ways that organizations can help individuals care for themselves

- Strategy 9: Facilitate and Fund Organizational Science
  The Mayo Clinic Program on Physician Well-Being, founded in 2007, was launched precisely to provide such evidence. These efforts have included developing new metrics, establishing national benchmarks, implementing practice analytics, and conducting intervention studies and randomized trials, which have resulted in approximately 100 peer-reviewed publications.
  Other leading institutions, such as the Stanford University School of Medicine/Medical Center, have recently made a major institutional investment in launching a similar program.

➢ 2.3: Dr. Larry Garber — Presentation "From a Liability to an Asset to Reduce Physician Burnout

Reliant realized improving their EHR/workflows could improve their physician experience and the patient experience. They implemented a technology-facilitated, physician-led, team-based care process.

- Key innovation: Reliant subscribes to information on all their patients from their affiliated hospitals, home health agencies, and soon, ambulance services. If a patient has a Reliant physician listed, the hospital will send all laboratory, X-ray, transcribed notes, and CCDs directly into Reliant's Epic EHR. Reliant can also query hospital the EHR systems directly through Care Everywhere (Epic to Epic) or Care quality for Athena Health and eClinicalWorks.

- Connected to health plans: Claims data on their patients from outside offices as far away as Florida or California will flow into Reliant's EHR. The physician knows about activity at other sites, such as whether the patient had necessary and required preventative procedures such as mammography at another system, based on claims

data. This automatically satisfies health maintenance requirements for pay for value plans regarding quality metrics for preventive health such as immunizations, mammography, and Pap smears, even if they were done at outside institutions.

- Key innovation: The laboratory or X-ray data which flows into Reliant's epic EHR are indistinguishable within the EHR from Reliant's own data. For example, when a Reliant physician looks up mammography reports, they see a list of all the mammography reports on this patient regardless of where the mammogram was performed. (However, they only see X-ray reports from outside institutions. X-ray images are not included.)

- Key innovation; inbox management: Systems were put in place to make it faster to process in basket messages and reduce the number of physician inbox messages, included rerouting notes to associated staff that previously first went to physicians. Reliant developed guidelines for staff to help decompress the physician's in basket without having to check with the physician first.
  For example:
    - Not all inpatient hospital labs will automatically be sent to the PCP's inbox.
    - Hospital labs that were in the hospital EHR at the time of the patient's discharge (and were presumably reviewed by the hospitalist) are filed silently into the Reliant EHR without Reliant physician inbox notification.
    - Hospital inpatient lab results that come in after the patient was discharged will go to the PCP's inbox.
    - Incidental findings on X-rays are highlighted in the physician's inbox.
        - Discharge summaries and emergency room visit notes are first reviewed by a nurse. If they are unremarkable, they will go into the EHR, but they will not go to the physician's inbox. If the nurse is concerned, they go to the physician's inbox.
        - Many routines consult notes, such as Ophthalmology and podiatrist notes, no longer automatically go to the PCP's inbox.
        - Staff members monitor physician in baskets and use guidelines to automatically send out letters or patient portal messages for normal test results.
        - For chronic medications, there will be automatic medication renewal protocols. In the meantime, the EHR gathers medication-specific information to assess appropriate medication monitoring and suggests to a Medical Assistant how many refills are appropriate and what monitoring tests, if any, need to be ordered. The physician can then assess and sign the renewals with one click and no scrolling.
        - This system changes increased trust between physicians and staff and resulted in a 25% reduction in physician in basket message volume over an 18-month period.

- Key innovation; no-show recalls without physician inbox notification: No-show policies now maximize effort to contact the patient without notifying the physician until after a month of trying to reschedule the patient.

    - If a patient does not show at a specialist's office, it is now the specialist's office staff's responsibility to rebook the patient, not the referring primary care physician's.
    - If a patient does not show up for an appointment for a relatively minor ailment, such as a dermatology appointment for acne, there is no notification to the PCP's inbox. However, if they don't show up at the dermatologist for a suspected melanoma, a PCP inbox notification is sent.

- Key innovation: Staff place draft orders on behalf of physicians, prior to appointments, so that appropriate patient specific labs are available at the time of the physician appointment, based on the patient's age, gender, diagnosis, medications, and prior laboratory results. The scheduling staff sends these draft orders for these tests to the physician and the provider can edit or cancel if they disagree.

- Key innovation; Flagging truly significant lab results to facilitate rapid resolution:
    - Critically high or low results are always flagged in the doctor's inbox.
    - "Fairly high or low results" that are significant changes are also flagged in the doctor's inbox.
    - Chronic or minimally abnormal results are not flagged in the physician's in basket.

- Key innovation; provider-specific guidelines/orders for triage staff to handle phone calls: Staff take a phone call from the patient; if it fits a standard clinical scenario, such as sinusitis, a tick bite, poison ivy, etc., the staff follows templated documentation and advice, and if appropriate pends the prescription; the physician approves it or changes it in a timely and efficient manner.

- Central anticoagulation clinic: Automatic alerts are sent to anticoagulation staff if:
    - Someone has prescribed an antibiotic to one of the patients.
    - Patient misses a scheduled follow-up INR testing.
    - Dose of anticoagulant during renewal doesn't match what anticoagulant clinic has recorded.

- Key innovation; offload physician work, patient rooming:
    - Medical assistant rooms the patient and enters the EHR (based on individual physician preferences and appointment type):
        - Chief Complaint(s)
        - Allergies/Medications (including OTC)
        - Preferred Pharmacy
        - Pends medications that need renewals
        - Full Social and Family History
        - Vital signs
        - Rooming note
        - Screening questions (e.g., fall risk or depression)
        - Review of Systems and starts MD's note

- Key innovation; incidental radiology findings: EHR automatically populates registries to track radiology incidental findings.

- EHR interacts directly with the patients to reduce physician/staff clerical work:
    - Patient portal alerts patients to health maintenance and disease management reminders, and if they have overdue labs that have been ordered already.
    - Patients automatically receive a “Happy Birthday” letter each year reminding them of due or overdue health maintenance and disease management tests/procedures (e.g., on the patients’ 50 birthdays for colon cancer screening).
    - Automated interactive voice response phone calls to patients to remind them of upcoming lab tests just prior to the expected date.
    - Letters are automatically sent to patients who no-show at labs.

- Reduce risk during transitions of care:
    - Patient summaries are automatically sent to local ERs when a Reliant patient registers there. Soon this will be available for EMS, VNA, and SNF.
    - Patients started on high-risk meds at time of hospital discharge triggers an alert for a pharmacist to contact the patient.
    - Patient started on new meds in the hospital automatically triggers a message to PCP if lab monitoring is missing or dosage of other meds needs adjustment.
    - Automatic message for appointment staff to schedule a PCP appointment three days after hospital discharge if a follow-up appointment has not already been scheduled.

- One clicks radiology orders improve efficiency and reduce radiology department phone calls with requests for more clinical information or study changes — for example, instead of just clicking “CT the abdomen and pelvis,” prescribers have a choice of CT of the abdomen and pelvis with appropriate contrast for:
    - Kidney stone
    - Hematuria
    - Unexplained weight loss
    - Cancer staging, etc.

- Key innovation; limit physician documentation in the EHR (in order of preference):
    - The computer (last note, history, results, keyboard macros)
    - The patient (patient portal or forms)
    - The nurse triaging problem on phone
    - The medical assistant that rooms patient
    - The doctor assisted by speech recognition
    - The doctor assisted by transcriptionist
    - A scribe typing
    - The doctor typing

➢ **2.4: MMS/MHA Task Force on Physician Burnout Provided the Following Comments to the State Quality Alignment Task Force Recommendations — Calling on a Reduction in Measures**

i) Support a reduction of the total number of quality metrics an Alternative Payment Model (APM)/Accountable Care Organization (ACO) can utilize at

no more than 14 measures consistent across payers. If measures are added beyond the 14, their results should be gathered by the plan without interference of the physician

ii) That a single quality metric reflecting physician well-being be added to the "Core Measure" set and

iii) That the Task Force consider adopting the "Core Measures" set and the "Menu Measure" sets for all types of products, not just those which utilize APM/ACO methodology"

- **2.5: Why Are Doctors Burned Out? Our Health Care System Is a Complicated Mess**

By Steven Adelman and Harris A. Berman, December 15, 2016

1. Improving electronic health records and related technologies to enhance the experience of patients and their clinicians
2. Restructuring physician work-life to promote better self-care and work-life balance, especially for physician parents in dual-career families
3. Reorganizing the funding of medical education to diminish burdensome debt for early-career physicians
4. Placing more emphasis on identifying emotional intelligence in medical school admissions
5. Modifying systemic factors (e.g., reimbursement, medical malpractice) that impede genuine, multidisciplinary team-based care that will unburden physicians
6. Rebalancing the funding and focus of graduate medical education to produce more primary care physicians and fewer hospital-based specialists
7. Enhancing the reimbursement of physicians who focus on health maintenance and primary care
8. Accelerating migration away from utilization-driven fee-for-service care to so-called "value-based care"

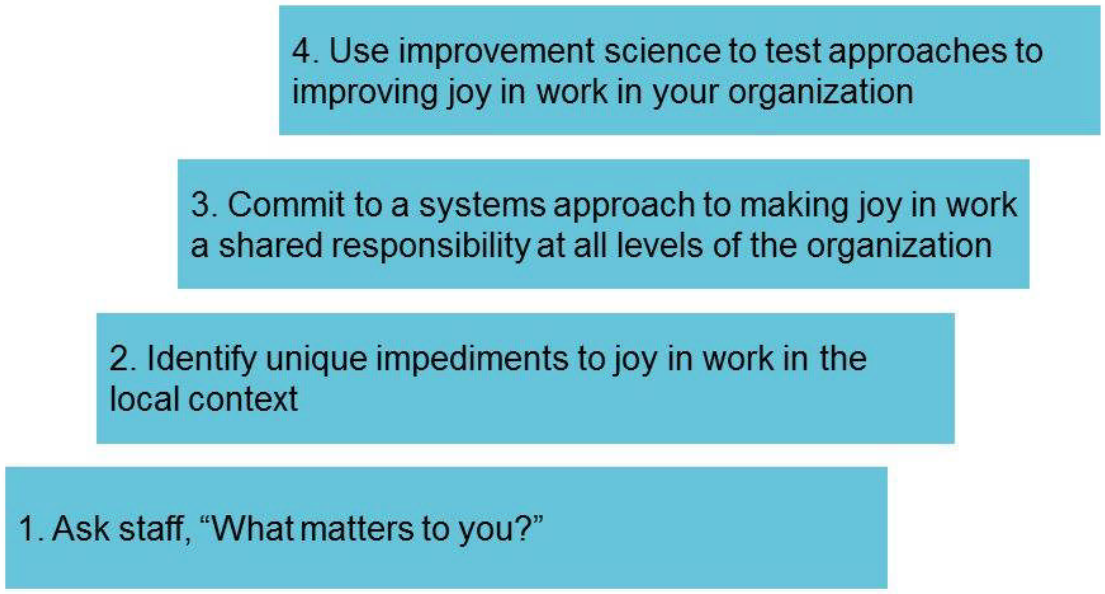
- **2.6: From *Leadership Survey — Immunization Against Burnout***

By Stephen Swensen, MD, MMM, FACR, Intermountain Healthcare; Steven Strongwater, MD, Atrius Health; Namita Seth Mohta, MD, NEJM Catalyst

- Off-load clerical tasks (e.g., to scribes, pharmacy technician, or population health facilitators)

- Create/improve an organizational culture of wellness
- Change compensation/incentive models
- Improve electronic medical records (EMRs) and other IT systems
- Promote camaraderie and social connectedness
- Find more meaningful work (e.g., shift from full-time clinician into more research, consulting, or other forms of protected time)
- Reduce number of quality measures tracked
- Identify and promote positive role models (e.g., leadership development)

➢ **2.7: Seeking Solutions to Physician Burnout ROUNDTABLE REPORT from NEJM Catalyst**



➢ **2.8: Task Force Comments on Solutions**

Solutions from the February 21, 2018, meeting:

- Before any payer, public or private, can require us to measure a specific metric, EHRs must be made to do this automatically, as part of their certification. A template should be included in the EHR to create and follow a new metric, prior to its introduction. If measurement of a metric is mandated, it should be embedded in each EHR, or that EHR should be not be certified.

- Quality metrics should be uniform across plans and reasonable in number.
- Quality metrics should be kept up to date. Provider should not be penalized for providing up-to-date care that does not coincide with out of date metrics.
- Unionization of physicians might be useful.
- Medical students or medical staff members who are harassed should be able to report it to someone other than their supervisor (ideally an independent agent).
- As hospitals are increasingly becoming employers of physicians, guidelines should be developed as to how hospitals should care for their providers. (Should the same be true of physician groups?)
- Frame the discussion to the public as physician burnout is a public health crisis that affects patient care. Patients are better off being treated by physicians who are not burnt out. (Physicians cannot provide the kind of care they want to if they're tired and burnt out.)
- Administrative simplification is needed.
- Structured peer support might be offered (question mandated) at times of emotional crisis, such as the death of a patient, suicide of a colleague, medical malpractice suit, etc.

➢ 2.9: NAM Discussion Papers

- *A Vision for a Person-Centered Health Information System*[42]

  "The person-centered health information system (PCHIS) of the future leverages information technology enhanced by artificial intelligence (AI) to support better, safer, and more affordable health care. The vision presented in this paper describes a system that has less cognitive and administrative burden than current systems and that provides seamless usability for patients and the multidisciplinary teams that care for them. Further, the PCHIS vision presented in this paper supports the evolving definition of high-value care, which includes the simultaneous provision of acute, chronic, and preventive care and promotion of patient wellness.

  "The system in this vision makes health information technology easily accessible and clinical data easily understood by the clinician and patient, while making administrative tasks and billing secondary functions. The PCHIS revolutionizes how health care is delivered and information is used. It provides a customizable interface for each clinician and patient and gives each the ability to collect and use the same data. In short, the system leverages knowledge from the entire care team, including the patient, to improve care."

- *A Pragmatic Approach for Organizations to Measure Health Care*

[42] Horvath K, Sengstack P, Opelka F, et al. A Vision for a Person-Centered Health Information System. National Academy of Medicine. https://nam.edu/a-vision-for-a-person-centered-health-information-system/. Published October 1, 2018.

Professional Well-Being[43]

"There is a high prevalence of burnout, depression, and suicide among health care professionals (HCPs) [1-5]. Compromised well-being among HCPs is associated with medical errors, medical malpractice suits, health care associated infections, patient mortality, lower interpersonal teamwork, lower patient satisfaction, job dissatisfaction, reduction in professional effort, and turnover of staff [2]. In addition, burnout among physicians is an independent predictor of suicidal ideation and substance abuse and dependence [6-9]. As burnout is adversely affecting quality, safety, and health care system performance, as well as the personal lives of HCPs, there is a need for organizations to add measures of HCP well-being to their routine institutional performance measures (e.g., patient volume, quality metrics, patient satisfaction, financial performance) [10, 11]. Institutional performance measures, including measurements of HCP well-being, hold the potential to substantially improve health care systems. However, putting measures in place without sufficient thought and care (e.g., insufficiently valid data) may result in the misdirection of resources, a false sense of the scope of the problem, and delay in improvement. The successful evaluation of HCP well-being depends on a series of strategic decisions, including who to survey (e.g., all employees or only a subset), how to survey (electronic or paper survey, local administration or external vendor), when to survey (timing and frequency), and what to include on the survey (i.e., items)."

- *Implementing Optimal Team-Based Care to Reduce Clinician Burnout*[44]

"Team-based health care has been linked to improved patient outcomes and may also be a means to improve clinician well-being [1]. The increasingly fragmented and complex health care landscape adds urgency to the need to foster effective team-based care to improve both the patient and team's experience of care delivery. This paper describes key features of successful health care teams, reviews existing evidence that links high-functioning teams to increased clinician well-being and recommends strategies to overcome key environmental and organizational barriers to optimal team-based care in order to promote clinician and patient well-being."

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[43] Dyrbye LN, Meyers D, Ripp J, Dalal N, Bird SB, Sen S. A Pragmatic Approach for Organizations to Measure Health Care Professional Well-Being. National Academy of Medicine. https://nam.edu/a-pragmatic-approach-for-organizations-to-measure-health-care-professional-well-being/.

[44] Smith CD, Balatbat C, Corbridge S, et al. Implementing Optimal Team-Based Care to Reduce Clinician Burnout. National Academy of Medicine. https://nam.edu/implementing-optimal-team-based-care-to-reduce-clinician-burnout/. Published September 17, 2018.

- *Burnout Among Health Care Professionals: A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care*[45]
  "The US health care system is rapidly changing in an effort to deliver better care, improve health, and lower costs while providing care for an aging population with high rates of chronic disease and co-morbidities. Among the changes affecting clinical practice are new payment and delivery approaches, electronic health records, patient portals, and publicly reported quality metrics—all of which change the landscape of how care is provided, documented, and reimbursed. Navigating these changes are health care professionals (HCPs), whose daily work is critical to the success of health care improvement. Unfortunately, as a result of these changes and resulting added pressures, many HCPs are burned out, a syndrome characterized by a high degree of emotional exhaustion and high depersonalization (i.e., cynicism), and a low sense of personal accomplishment from work"

- *Nurse Suicide: Breaking the Silence*[46]

  "The purpose of this paper is to raise awareness of and begin to build an open dialogue regarding nurse suicide. Recent exposure to nurse suicide raised our awareness and concern, but it was disarming to find no organization-specific, local, state, or national mechanisms in place to track and report the number or context of nurse suicides in the United States. This paper describes our initial exploration as we attempted to uncover what is known about the prevalence of nurse suicide in the United States. Our goal is to break through the culture of silence regarding suicide among nurses so that realistic and accurate appraisals of risk can be established, and preventive measures can be developed."

- *A Journey to Construct an All-Encompassing Conceptual Model of Factors Affecting Clinician Well-Being and Resilience*[47]

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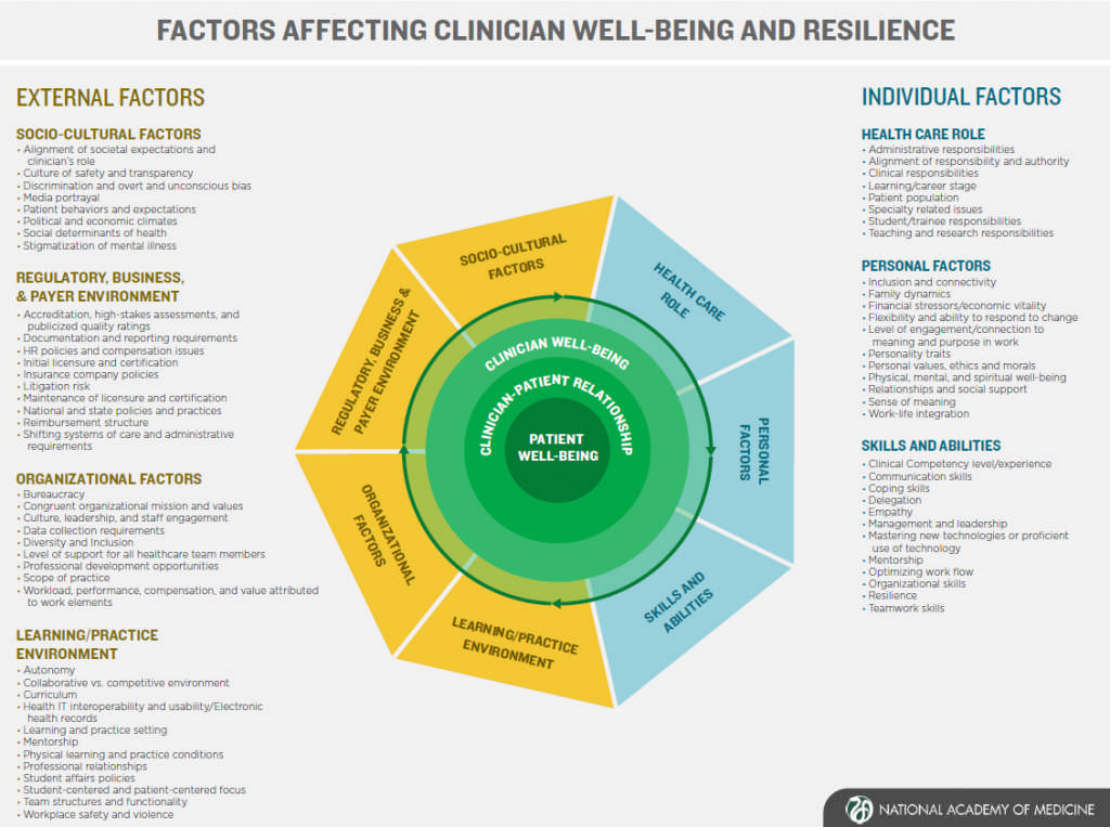
[45] Dyrbye LN, Shanafelt TD, Sinsky CA, et al. Burnout Among Health Care Professionals: A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care. National Academy of Medicine. https://nam.edu/burnout-among-health-care-professionals-a-call-to-explore-and-address-this-underrecognized-threat-to-safe-high-quality-care/. Published August 20, 2018.

[46] Davidson J, Mendis J, Stuck AR, DeMichele G, Zisook S. Nurse Suicide: Breaking the Silence. National Academy of Medicine. https://nam.edu/nurse-suicide-breaking-the-silence/. Published August 17, 2018.

[47] Brigham T, Barden C, Dopp AL, et al. A Journey to Construct an All-Encompassing Conceptual Model of Factors Affecting Clinician Well-Being and Resilience. National Academy of Medicine. https://nam.edu/journey-construct-encompassing-conceptual-model-factors-affecting-clinician-well-resilience/. Published September 12, 2018.



- *Care-Centered Clinical Documentation in the Digital Environment: Solutions to Alleviate Burnout*[48]

  "A range of factors drives clinician burnout, including workload, time pressure, clerical burden, and professional isolation. Clerical burden, especially documentation of care and order entry, is a major driver of clinician burnout. Recent studies have shown that physicians spend as much as 50 percent of their time completing clinical documentation. Nurses similarly spend up to half their time fulfilling clinical documentation requirements and data entry for other demands such as quality reporting and meeting accreditation standards. In the outpatient setting, patients will often describe clinical team members going through mundane questioning and computer documentation, often duplicative, and spending little time making eye contact and talking to them or performing physical examination. With the exception of improving medication safety, nurses and other clinicians report dissatisfaction with the design and cumbersome processes of electronic documentation. Many clinicians feel they are compelled to first satisfy the demands of documentation in the clinical record. After caring for patients, many clinicians

[48] Ommaya AK, Cipriano PF, Hoyt DB, et al. Care-Centered Clinical Documentation in the Digital Environment: Solutions to Alleviate Burnout. National Academy of Medicine. https://nam.edu/care-centered-clinical-documentation-digital-environment-solutions-alleviate-burnout/. Published August 17, 2018.

devote significant amounts of time to nonclinical activities, which often carry on into afterhours. This paper explores the relationship between clinical documentation, the electronic systems that support documentation, and clinician burnout, and provides recommendations for addressing these issues."

Box 1 | Recommendations

- Clinicians should be responsible only for essential primary data entry that is required to support the care of a patient.
- EHR developers should increase the development of capabilities that allow clinicians to understand the previous medical, health, and social history of the patient.
- CMS should deemphasize documentation requirements as a condition of payment for health care services.
- CMS should clarify that elements of the HPI drafted by an assistant, and confirmed with the patient by the provider, should count for reimbursement.
- An authoritative body, such as the NAM, should initiate a study focused on redesigning clinical documentation suited to the modern digital age, with a primary focus on informing clinical management and improving patient outcomes and health.

SOURCE: Ommaya et al., "Care-Centered Clinical Documentation in the Digital Environment: Solutions to Alleviate Burnout," National Academy of Medicine.

- **2.10: Make Medical School Free**
  - ***NYU Makes Medical School Tuition Free***[49]

"New York University School of Medicine said that it will pay the tuition of all its students regardless of merit or financial need, becoming the first major American medical school to do so

[49] Adams S. NYU Makes Medical School Tuition Free. Forbes. https://www.forbes.com/sites/susanadams/2018/08/16/nyu-makes-medical-school-tuition-free/#643333e6a9d8. Published August 17, 2018.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Code:	ST Informational Report I-18-04
Title:	Report of the Secretary-Treasurer
Sponsor:	Joseph Bergeron, MD, Secretary-Treasurer

Background

Section 8.054(8) of the Massachusetts Medical Society (MMS) Bylaws requires the Secretary-Treasurer, in conjunction with the Committee on Finance and the Vice President of Finance, to oversee an annual audit of the financial accounts of the Society by a certified Public Accountant, and submit an annual report to the Board of Trustees and House of Delegates of the results of the audit of the previous fiscal year-end.

Our independent auditors, PricewaterhouseCoopers, LLP, completed their audit of the consolidated financial statements of the MMS and affiliates as of May 31, 2018, and May 31, 2017. PricewaterhouseCoopers, LLP, rendered its opinion on the Society's consolidated financial statements by stating that such consolidated financial statements present fairly, in all material respects, the financial position of the MMS and affiliates at May 31, 2018, and May 31, 2017, and that the results of their activities and changes in their net assets and cash flows for the years then ended are in conformity with accounting principles generally accepted in the United States.

For the full text of our financial statements, please request a copy in writing from the Secretary-Treasurer of the MMS, 860 Winter Street, Waltham, MA 02451-1411.

MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Code:	C&E Informational Report I-18-05
Title:	Charitable and Educational Fund
Sponsor:	Charitable and Educational Fund Board of Directors Michele P. Pugnaire, MD, Chair

Background

The provisions of the Massachusetts Medical Society (MMS) Charitable and Educational Fund (the Fund), re-affirmed at A-15, require the Board of Directors of the Fund to provide on an annual basis an informational report to the House of Delegates on the Fund's finances.

Current Status

Our independent auditors, PricewaterhouseCoopers, LLP, completed their audit of the financial statements of the Fund as of May 31, 2018, and May 31, 2017.

PricewaterhouseCoopers, LLP, rendered its opinion in the Fund's financial statements by stating that such financial statements present fairly, in all material respects, the financial position of the Fund at May 31, 2018, and May 31, 2017, and that the results of the Fund's operations and its cash flows for the years then ended are in conformity with accounting principles generally accepted in the United States.

For the full text of our financial statements, please request a copy in writing from the Secretary-Treasurer of the MMS, 860 Winter Street, Waltham, MA 02451-1411.

Informational Report I-18-06
Status/Implementation Chart for 2017 Interim Meeting Resolutions/Reports
REFERENCE COMMITTEE A: Public Health

Item #	Title	Code	Action	Referred to	Report Due	(If Directive) Completed
I-17 Item 1	Neurotoxin Exposure in Pregnant Women and Children	CEOH Report I-17 A-1 [I-16 A-106]	Adopted (the CEOH's Recommendation to Not Adopt)	NA		
I-17 Item 2	Family Leave for Early Child Care	CMPW/COL Report A-2 [I-16 A-103]	Adopted	(*MMS Policy Compendium* (1) Maternal and Perinatal Welfare (2) Maternal and Perinatal Welfare Legislation (3)	I-18	Completed
STATUS: **Legislation** The MMS supported legislation to establish family leave for early child care (see below), alongside other stakeholder advocacy groups. **Maternal and Perinatal Welfare/Legislation** The MMS monitored legislation on family leave and supported a state bill to establish paid family leave for early child care in Massachusetts. In July, Governor Baker signed the bill, which established an entitlement to 12 weeks of paid family leave to care for a newborn or sick family member, which will come into effect on January 1, 2021. The leave will be funded by a payroll tax, split by employers and employees. The MMS will continue to follow the implementation and effects of this law on the health of Massachusetts patients.						
I-17 Item 3	Availability of Intramuscular and Subcutaneous Forms of Naloxone for First Responders and Cost of Auto-Injectors	Resolution I-17 A-101	Adopted as Amended	Task Force on Opioid Therapy and Physician Communication	I-18	Completed
STATUS: Improved access to naloxone is a priority for the MMS Task Force on Opioid Therapy and Physician Communication. The MMS has been a strong and vocal advocate with respect to affordable and adequate access to naloxone, and regularly works with public officials, payers, healthcare professionals and other stakeholders on improving cost sharing, product availability and training. Chapter 208 of the Acts of 2018, "An Act for Prevention and Access to Appropriate Care and Treatment of Addiction" (CARE ACT), which MMS strongly supported, was enacted in summer 2018 and includes several provisions addressing prescribing, dispensing, access and affordability.						
I-17 Item 4	Naloxone Training for Massachusetts Medical Students	Resolution I-17 A-102	Adopted as Amended	Task Force on Opioid Therapy and Physician Communication	I-18	Completed

STATUS: Improved access to naloxone is a priority for the MMS Task Force on Opioid Therapy and Physician Communication. In response to the adopted policy MMS worked with the resolution sponsors to produce a public service announcement. In the PSA, MMS member medical students explain how to identify an overdose, and why everyone should consider carrying naloxone. In addition, the opioid-related content on the MMS website has been updated. Included are information and resources about naloxone such as the 2018 Surgeon General's Advisory on Naloxone and Opioid Overdose with information for prescribers, links to trainings for responding to an opioid overdose, resources and information about naloxone rescue kits, and tools for advocacy, outreach and communications initiatives.						
I-17 Item 5a	Medical Aid-in-Dying Survey	OFFICERS Informational Report I-17 06 [I-16 A-102]	Filed	NA		
I-17 Item 5	Engaged Neutrality on Medical Aid-in-Dying	Resolution I-17 A-103	Adopted as Amended	(*MMS Policy Compendium*) (1) (1a-6) MMS Presidential Officers (5)	A-18	Completed
STATUS: MMS President Dr. Henry Dorkin, sent a letter (http://www.massmed.org/MAIDPolicyAMA/) dated March 8, 2018, to Dennis S. Agliano, MD, FACS, Chair, Council on Ethical and Judicial Affairs, at the American Medical Association explaining MMS's change in position and new policy on medical-aid-in-dying.						
I-17 Item 6	Medical Parole for the Incapacitated and Terminally Ill	Resolution I-17 A-104	Adopted as Amended	Legislation	I-18	Completed
STATUS: The MMS supported a state bill to establish medical parole for terminally ill or incapacitated patients in the Commonwealth. That bill was signed into law in April 2018. Incarcerated persons who meet the medical criteria stipulated in the bill may now petition the Massachusetts Department of Corrections for early release, and may be granted medical parole, provided that the Department deems them to no longer pose a safety risk.						
I-17 Item 7	Urine Drug Screens in Prisoners	Resolution I-17 A-105	Referred for Report Back at I-18	Public Health	I-18	
STATUS; Please see CPH Report I-18 A-9 in I-18 Delegates' Handbook.						
I-17 Item 8	Supporting "Good Samaritan" Access to Naloxone by Physicians	Resolution I-17 A-106	Adopted as Amended	The Quality of Medical Practice	A-18	Completed
STATUS: The MMS composed a letter (http://www.massmed.org/naloxone/) that is being sent to all the health plan medical directors and the life insurance association in Massachusetts. The letter discusses the benefits of naloxone for addicted patients and encourages and advocates for these companies to be supportive of and not penalize or discriminate against individuals who choose to purchase naloxone for "Good Samaritan" purposes.						

Informational Report I-18-06
Status/Implementation Chart for 2017 Interim Meeting Resolutions/Reports
REFERENCE COMMITTEE B: Health Care Delivery

Item #	Title	Code	Action	Referred To	Report Due	(If Directive) Completed
I-17 Item 1	Unbundling Postpartum Contraception from the Global Delivery Payment	Resolution I-17 B-201	Adopted as Amended	The Quality of Medical Practice Legislation	I-18	
STATUS: **The Quality of Medical Practice** In Nov. 2017, the Governor passed legislation to mandate coverage of a 12-month supply of prescription contraception after a 3-month trial, emergency contraception, and voluntary female sterilization procedures at no charge to most woman. An effort to ensure that the Trump administration efforts do not minimize these benefits. MMS is working with stakeholders to facilitate adoption of this policy. MMS reached out to the Massachusetts Associations of Health Plans (MAHP) to clarify which plans may already make this benefit available and to continue to advocate for all plans to adopt this protocol. In short, we have learned that all MAHP plans cover LARC insertion immediately post-partum. Further, they shared that the ACA requires coverage of FDA-approved contraceptives and through sub-regulatory guidance defines 18 FDA approved methods, 2 of which are IUDs. This includes clinical services and patient education and counseling **Legislation** MMS is working with fellow stakeholders in Massachusetts, at Planned Parenthood, and at Brigham and Women's Hospital, to develop and enact a legislative solution to this issue. MMS will work with those and other groups, and will monitor the legislature during the upcoming session, with the goal of finding a legislative vehicle through which to achieve this aim. MMS raised this issue last legislative session during some discussions surrounding the ACCESS bill, a bill aimed at assuring patients the right to contraception. Unfortunately, this was deemed outside the scope of the bill, though many stakeholders acknowledged it as an important issue.					
I-17 Item 2	Retraining of Immigrant Physicians	Resolution I-17 B-202	Referred to the BOT for Report Back at I-18	IMG Section Legislation	I-18	
STATUS: Please see IMG/COL Report I-18 B-2 in I-18 Delegates' Handbook.						
I-17 Item 3	Conference on Universal Health Care	Resolution I-17 B-203	Adopted as Amended	Medical Education (In consultation with) MMS Departments of: Advocacy, Government & Community Relations; Health Policy and Public Health; and Practice	I-18	

				Solutions & Economics		
STATUS: Please see CME Informational Report I-18-02 in I-18 Delegates' Handbook, Informational Reports.						
I-17 Item 4	Permitting Massachusetts Physicians to Dispense Prescription Medications from the Office	CSPP Report I-17 B-1	Adopted	Legislation	I-18	
STATUS: MMS staff researched the legal landscape of in-office prescription drug dispensation and confirmed that Massachusetts has among the most stringent laws regarding this practice. Section 9 and 19 of Chapter 94C of the Massachusetts General Laws prohibit the dispensing of prescription medications, with only very narrow exceptions. In office medication dispensing is permitted when distributing medication samples, and when dispensing for immediate treatment. These, and some other exceptions, such as sales of prescription contact lenses, are also detailed in the Massachusetts Board of Registration in Medicine *Prescribing Practices Policy and Guidelines*, available on the Board's website. Therefore, MMS will need to seek legislative change to Chapter 94C to enable in-office sales. The next open filing period for legislation will be in January 2019. MMS will plan to file legislation or support existing legislation to pursue the legalization of dispensing prescription medication out of physician offices in Massachusetts						
I-17 Item 5	Support for Patients and Physicians in Direct Primary Care	CSPP Report I-17 B-2	Adopted as Amended	Legislation	I-18	
STATUS: In March of 2018, MMS sent a letter to US Representative Earl Blumenauer, of Oregon, supporting his bill, H.R. 365, the "Primary Care Enhancement Act of 2017." The bill would help to increase patient access to primary care physicians by eliminating the current legal barriers which prevent people with health savings accounts from contracting for their care with physicians who participate in Direct Primary Care (DPC) practices. Specifically, the bill would correct current tax law's treatment of DPC payments, so that those payments would no longer be considered insurance, and could thereby be made using HSA savings. As HSAs are pre-tax funds, this bill, if passed, would allow patients to use pre-tax money for DPC payments. The MMS has not yet found an appropriate legislative vehicle through which to advocate for physicians not covered under patients' insurance plans to make referrals that allow patients coverage for care from specialists who are within those insurance plans. MMS staff will advocate for the passage of this change during the upcoming legislative session, through filing legislation to that end if appropriate.						
I-17 Item 6	Promoting a Model Medical Staff Code of Conduct and Its Application to Employed Physicians	OMSS Report I-17 B-3	Adopted	Organized Medical Staff Section (1) Legislation (2)	I-18	
STATUS: **Organized Medical Staff Section** Leveraging the Society's many communication channels, e.g., Massmed.org, *Vital Signs* and social media, the MMS will develop a series of articles and resources to educate all physicians about the AMA Medical Staff Code of Conduct. The MMS has already begun a review and update to its Model Medical Staff Bylaws, which it will make available to member physicians via the website. **Legislation**						

Informational Report I-18-06
Status/Implementation Chart for 2017 Interim Meeting Resolutions/Reports
REFERENCE COMMITTEE B: Health Care Delivery

MMS has reviewed the most recent updates to the MMS Model Medical Staff Bylaws to confirm that there was consistent and explicit attempts to assure genuine separation between terms of employment and medical staff privileges. MMS has also reviewed it related legislative filings and will plan to amend a bill on medical staff legal issues to include this important provision.						
I-17 Item 7	Prescription Availability for Weekend Discharges	OMSS Report I-17 B-4	Adopted	The Quality of Medical Practice	I-18	
STATUS: The CQMP asked staff to reach out to the AMA to learn what AMA has accomplished to date. MMS staff checked with the AMA and learned that the following was reported back to the AMA House of Delegate sin the status chart for the AMA 2017 Interim Meeting: *As part of the broader advocacy campaign connected to the Prior Authorization Reform Principles, our AMA is engaged in active discussions with health plans and benefit managers regarding policy changes needed to prevent coverage restrictions and formulary issues from adversely impacting patient care. Our AMA is urging payers to adopt reforms needed to improve patient safety and prevent treatment gaps during care transitions and plan changes.* Further, CQMP encouraged MMS to reach out to Mass. Association of Health Plan (MAHP) to begin to discuss this issue further. The MMS staff has begun conversation with MAHP and will continue to work to ensure patient access to vital medications at all times. On preliminary check in MAHP is open to conversations and has not heard from the community that this staff availability on weekends or holidays is an issue.						
I-17 Item 8	Timeliness in Obtaining Medical Records from Other Providers	OMSS Report I-17 B-5	Adopted	Organized Medical Staff Section (1) The Quality of Medical Practice (2) (in consultation with) MMS Office of the General Counsel	I-18	
STATUS: **Organized Medical Staff Section** In partnership with organizations like the MHA, the MMS will utilize its communications channels, e.g., Massmed.org and *Vital Signs*, to inform physicians about current best practices in the transfer and sharing of Personal Health Information among members of a patient's treatment team. Examples might include a *VS* feature or recorded video CME outlining current requirements and options under HIPAA. **The Quality of Medical Practice** The CQMP discussed these directives and questions were raised as to whether obtaining medical records from other providers was truly an issue, many committee members stating it has not been an issue for them in their experience and practice. However, to address the resolution the committee felt that this should be further explored and if gaps exist, they should be identified and a process developed that addresses the issues of obtaining medical records from other providers. To better identify the issue and determine where gaps exist, research will be conducted through various methods including outreach to the AMA who originated the directive, talking with the MHA and other specialty societies and other provider organizations to get to the root of the problem. The committee will develop procedures and templates that focus on addressing the gaps once they have been identified.						

I-17 Item 9	Physician-Rating Websites	COC Report I-17 B-6 [A-17 B-209]	Adopted as Amended	(*MMS Policy Compendium*)		
I-17 Item 10	Independent Surgi-centers Are Safe and Cost Effective	COL Report I-17 B-7 [I-16 B-207]	Adopted (COL's Recommendation to Not Adopt)	NA		

ADDITIONAL UPDATES

I-16 B Item 7	Third-Party Payers Contracted Fee Schedule Should Be Based on at Least 100 Percent of the Current and Geographically Appropriate Medicare Fee Schedule at Time of Contracting	Resolution I-16 B-204	Referred to BOT for Decision *Update: (Adopted as Amended)*	(Oct. BOT Meeting: Legislation, The Quality of Medical Practice) ********** The Quality of Medical Practice	I-17 I-18	(For implementation)
STATUS: In quarterly conversations, the MMS Physician Practice Resource Center (PPRC) is raising this issue with the third-party payers. Further, when meeting with the health plan medical directors, this topic will also be raised. Lastly, PPRC staff is including this issue in in its Trending report about the importance of providers contracting with health plans and including the most recent economic data and the cost of delivering care at the time of contracting in the geographic area where the physician is practicing.						

Informational Report I-18-06
Status/Implementation Chart for 2017 Interim Meeting Resolutions/Reports
REFERENCE COMMITTEE B: Health Care Delivery

A-17 B Item 12	Reimbursement for Physician Oversight in Incident to Billing	COL/CQMP Report A-17 B-2 [I-16 B-3]	Referred to the BOT for Decision *Update: (Adopted as Amended)*	Board of Trustees (Oct. BOT Meeting: Legislation, The Quality of Medical Practice) ********** The Quality of Medical Practice (1) Legislation (2)	I-17 I-18	(For implementation) Completed

STATUS:

The Quality of Medical Practice

The PPRC advocates for payment of this "incident to" issue on an on-going basis. It actively advocated for this with Tufts two years ago and turned back the proposed elimination of the reimbursement policy. Further, similar efforts were thwarted with MassHealth.

The PPRC monitors this and other payment policy issues on an on-going basis. MMS members are encouraged to notify PPRC about this or any other dramatic shift in payments as well.

Legislation

The Medical Society has advocated in several venues for policies to reimburse physicians for services provided by PAs or NPs who they supervise at 100 percent of the physician's reimbursement rate. MMS testified to this end in MassHealth regulations which were reconsidering many physician payment and billing issues. Ultimately, as MassHealth has never compensated PAs and NPs at 100 percent, this advocacy attempt was not successful.

In addition, MMS will plan to file legislation for the upcoming 2019-2020 legislative session to require payers to reimburse at 100 percent for these supervised services. MMS will also continue to look for non-legislative advocacy opportunities to support this policy, such as meetings with individual health insurers, and relevant professional associations.

A-17 B Item 11	Scope of Practice	Resolution A-17 B-210	Referred to the BOT for Decision *Update (Adopted)*	Board of Trustees (Oct. 2017 BOT Meeting: Legislation) ********** Legislation	I-17 I-18	(For implementation)

STATUS:

MMS staff have continued to monitor legislative proposals related to expansions of the scope of practice of non-physician clinicians. Of particular concern was a comprehensive Senate proposal, contained in a larger bill, to expand the scope of practice of nurses, optometrists, podiatrists, and other clinicians. The MMS successfully advocated to prevent the passage of that legislation, which would have largely expanded scopes of practice, on the basis of maintaining patient safety and promoting physician leadership in team-based care.

While the Medical Society opposed the bill, we are pleased to note that this legislation represented the first time that the concept of "parity" in requirements was addressed. Section 107 of Senate bill 2573 contained the following provision:

> *Section 80K. The board shall promulgate regulations, which shall be subject to approval by the commissioner, to ensure that nurse practitioners, nurse anesthetists and psychiatric nurse mental health clinical specialists under the board of registration in nursing are subject to requirements commensurate to those that physicians are subject to under the board of registration in medicine pursuant to the sixth and seventh paragraphs of section 5 and sections 5A to 5M, inclusive, as they apply to the creation and public dissemination of individual profiles and licensure restrictions, disciplinary actions and reports, claims or reports of malpractice, communication with professional organizations, physical and mental examinations, investigation of complaints and other aspects of professional conduct and discipline…*

MMS was pleased to see reference to this concept of parity in requirements. MMS staff will continue to monitor the legislature for other such proposals, and will advocate as needed to maintain current licensure laws and regulations.

Informational Report I-18-06
Status/Implementation Chart for 2017 Interim Meeting Resolutions/Reports
REFERENCE COMMITTEE C: MMS Administration

Item #	Title	Code	Action	Referred to	Report Due	(If Directive) Completed
I-17 C Item 1	Strengthening the Medical Malpractice Tribunal	CPL Report I-17 C-1	Adopted as Amended	Professional Liability	A-18	Ongoing
STATUS: Please see COPL Informational Report A-18-06 in A-18 Delegates' Handbook at www.massmed.org/recentproceedings.						
I-17 C Item 2	MMS Former Speakers and House of Delegates Membership	Resolution I-17 C-301	Referred to BOT for Report Back	MMS Presidential Officers	I-18	
STATUS: Please see OFFICERS Report I-18 C-2 in I-18 Delegates' Handbook.						
I-17 C Item 3	Bylaws Changes	COB Report I-17 C-2	Adopted	(Annual Meeting of the Society)	(Annual Meeting of the Society)	
I-17 C Item 4	Special Committee Renewals	BOT Report I-17 C-3	Adopted	NA		

Informational Report I-18-07
Status/Implementation Chart for 2018 Annual Meeting Resolutions/Reports
REFERENCE COMMITTEE A: Public Health

Item #	Title	Code	Action	Referred to	Report Due	(If Directive) Completed
A-18 A Item 1	Physician-Involvement in Extreme Risk Protection Orders	Resolution A-18 A-101	Adopted as Amended	Legislation	A-19	
A-18 A Item 2	Opposition to "Concealed Carry Reciprocity"	Resolution A-18 A-102	Adopted	Legislation (1) MA AMA Delegation *(Expedited by MMS Officers for June AMA Meeting)* (2)	I-18	Completed (Item 2)

STATUS:

Legislation

The MMS has shared our position opposing the federal conceal and carry law with our senators who also oppose the legislation. The MMS will actively advocate our position in the lame duck and next Congress when and if the issue resurfaces with our entire Congressional Delegation. The MMS also continues to actively support legislation to allow federal research into the prevention of gun violence.

MA AMA Delegation

The MMS Presidential Officers expedited the resolution to the MA AMA Delegation for inclusion at the AMA 2018 Annual Meeting. On May 5, 2018, the MA AMA Delegation presented the resolution to the New England Delegation for their support and unanimous support was given as written.

The resolution was accepted as business and assigned to Reference Committee B (Resolution 248). The reference committee heard testimony and agreed to amend current policy, H-145.985.

It is the policy of the AMA to:
(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
(d) the imposition of significant licensing fees for firearms dealers;
(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(f) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical

societies to evaluate and support local efforts to enact useful controls. *(4) Oppose "concealed carry reciprocity" federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.* *(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.*						
A-18 A Item 3	Opposition to the Criminalization of Self-Induced Abortion	Resolution A-18 A-103	Adopted as Amended	Legislation (1) MA AMA Delegation (2)	A-19 *(MA AMA SUBMITTED AT I-18)*	(Item 2) Completed
STATUS: At the AMA 2018 Annual Meeting, the AMA Women Physicians' Section submitted Resolution #007, entitled, "Oppose the Criminalization of Self-Induced Abortion." The Reference Committee on Amendments to Constitution and Bylaws reviewed the resolution. Citing strong concerns of the many recent legal restrictions on abortion around the country, increases in women turning to self-induced abortions, and the increases in criminal prosecution of women for self-induced abortion, the resolution asked that our AMA oppose and advocate against the criminalization of self-induced abortion, as criminalization increases medical risks and deters women from seeking medically necessary services. The Reference Committee heard generally supportive testimony on Resolution 007. There was broad agreement that measures aimed at criminalizing self-induced abortion would increase risks to patients and discourage patients from seeking medical treatment. Limited opposing testimony was offered and raised concerns about the potential timing of self-induced abortions. A proposed amendment recommended expanding the resolution to oppose efforts to criminalize abortion, including but not limited to those that are self-induced, noting that our AMA currently does not have any policy in place addressing the legality of abortion. However, subsequent testimony did not support the amendment. The new AMA policy is entitled, "Oppose the Criminalization of Self-Induced Abortion," H-5.980.						
A-18 A Item 4	Limiting the Scope of Involuntary Civil Commitment of Persons for Reasons Related to Substance-Use Disorder	Resolution A-18 A-104	Adopted as Amended	Task Force on Opioid Therapy and Physician Communication (1, 3) Legislation (2, 5) MA AMA Delegation (4, 6)	A-19	
A-18 A Item 5	Section 35 Reform: Ensuring Acceptable Standards for the Treatment of Persons Involuntarily Civilly Committed for Substance-Use Disorders	Resolution A-18 A-105	Adopted as Amended	Legislation	A-19	
A-18 A Item 6	Opioid Crisis May Be Ameliorated by Decriminalization, But Legalization Would Be More Effective at Reducing Deaths	Resolution A-18 A-106	Referred to the BOT for Report Back at A-19	Legislation (in consultation with) Task Force on Opioid Therapy and Physician Communication	A-19	
A-18 A Item 7	Capital Punishment Policy	EGPS Report A-18 A-1	Adopted	(MMS *Policy Compendium*)	NA	

A-18 A Item 8	Addressing the Human Health Impacts of Neonicotinoids	Resolution A-18 A-107	Adopted as Amended	(MMS *Policy Compendium*)	NA	
A-18 A Item 9	Gaming Addiction Now a Mental Health Disorder	Resolution A-18 A-108	Not Adopted	NA	NA	
A-18 A Item 10	Child Abuse in the Fashion Industry	Resolution A-18 A-109	Not Adopted	NA	NA	
A-18 A Item 11	Fetal and Infant Mortality Review in Massachusetts	CMPW Report A-18 A-2	Adopted as Amended	Legislation Maternal and Perinatal Welfare	A-19	
A-18 A Item 12	Ensuring Oral Health as a Component of Accountable Care Organizations	COOH Report A-18 A-3	Adopted as Amended	(MMS *Policy Compendium*) (1) Legislation, The Quality of Medical Practice (Item 2) The Quality of Medical Practice (Item 3)	A-19	
A-18 A Item 13	Food Insecurity Screening	CNPA Report A-18 A-4	Adopted as Amended	(MMS *Policy Compendium*) (Items 1, 2) Nutrition and Physical Activity (Item 3)	A-19	
A-18 A Item 14(a)	Streamlining Human Immunodeficiency Virus Testing of Source Patients following an Occupational Exposure	CPH/COL/MA AMA/OMSS Report A-18 A-5 [A-17 A-103]	(Divided): Item 14(a) Adopted as Amended	MMS Presidential Officers	A-19	
A-18 A Item 14(b)	Streamlining Human Immunodeficiency Virus Testing of Source Patients following an Occupational Exposure	CPH/COL/MA AMA/OMSS Report A-18 A-5 [A-17 A-103]	(Divided): Item 14(b) Referred to the BOT for Report Back at I-18	Legislation (in consultation with) Public Health	I-18	
STATUS: Please see COL Report I-18 A-6 in I-18 Delegates' Handbook.						

Informational Report I-18-07
Status/Implementation Chart for 2018 Annual Meeting Resolutions/Reports
REFERENCE COMMITTEE B: Health Systems

Item #	Title	Code	Action	Referred to	Report Due	(If Directive) Completed
A-18 B Item 1	Massachusetts Should Look toward Ending Its Determination of Need (DON) Laws	Resolution A-18 B-201	Referred to BOT for Report Back at A-19	Legislation	A-19	
A-18 B Item 2	Ensuring Prescription Drug Price Transparency from Retail Pharmacies	Resolution A-18 B-202	Adopted as Amended	Legislation (Item 1) MA AMA Delegation and Legislation (Item 2) MA AMA Delegation (Item 3)	A-19	
A-18 B Item 3	Patient-Reported Outcome Measures: Current State and Proposed MMS Principles	CQMP Report A-18 B-1	Adopted as Amended	(MMS *Policy Compendium*) The Quality of Medical Practice (#13) (and *MMS Policy Compendium*)	A-19	
A-18 B Item 4	Current State of OpenNotes Medical Records	CQMP Report A-18 B-2	Adopted as Amended	(MMS *Policy Compendium*) (Item 1) The Quality of Medical Practice (Item 2) (and MMS *Policy Compendium*)	A-19	
A-18 B Item 5	Impact of the High Capital Cost of Hospital EMRs on the Medical Staff	OMSS Report A-18 B-3	Adopted as Amended	Organized Medical Staff (in consultation with) Informational Technology	A-19	

A-18 B Item 6	Billing and Collections Practice Policy	EGPS Report A-18 B-4	Adopted	(MMS *Policy Compendium*)	NA	
A-18 B Item 7	No-Cost Volunteer License to Practice Medicine	Resolution A-18 B-203	Adopted	Legislation	A-19	
A-18 B Item 8	Provision of Access to Third-Party Payer Medical Directors to Treating Providers to Facilitate Patient Care	Resolution A-18 B-204	Adopted as Amended	The Quality of Medical Practice	A-19	
A-18 B Item 9	One Reimbursement Fee Schedule for All Medicaid ACOs	Resolution A-18 B-205	Referred to BOT for Report Back at A-19	Legislation (in consultation with) The Quality of Medical Practice	A-19	
A-18 B Item 10	Equality in Reimbursement for Patient-Related Care	Resolution A-18 B-206	Adopted	The Quality of Medical Practice	A-19	
A-18 B Item 11	Hospital Disaster Plans and Medical Staffs	OMSS Report A-18 B-5	Adopted	Organized Medical Staff Section (in consultation with) Preparedness	A-19	
A-18 B Item 12	Transforming the Medical Liability Environment	CPL Report A-18 B-6	Adopted	Finance	NA	
A-18 B Item 13	Health Care Is a Basic Human Right	OFFICERS Report A-18 B-7 [A-17 B-202]	Adopted as Amended	MMS Presidential Officers (in consultation with) Ethics, Grievances, and Professional Standards	A-19	
A-18 B Item 14	Maximizing Function and Minimizing Disability	CPH/CME Report A-18 B-8 [A-17 A-111]	Adopted as Amended	(MMS *Policy Compendium*) (Item 1) Medical Education (in consultation with) Environmental and Occupational Health	A-19	

				(Item 2)		
A-18 B Item 15	Recognition of Out-of-State DNR/Physician Orders for Life Sustaining Treatment (POLST) Forms in Massachusetts	CGM Report A-18 B-9 [A-17 B-207]	Adopted as Amended	Geriatric Medicine (Items 1-2) Geriatric Medicine and MA AMA Delegation (Item 3)	A-19	
A-18 B Item 16	Protecting the Patient-Physician Relationship: MassHealth ACO	COSPP Report A-18 B-10	Adopted as Amended	(MMS *Policy Compendium*) (Item 1) Legislation (Items 2-4)	A-19	

Item #	Title	Code	Action	Referred to	Report Due	(If Directive) Completed
A-18 C Item 1	MMS Annual Strategic Plan	CSP Report A-18 C-1	Adopted	MMS Presidential Officers	NA	
A-18 C Item 2	Establishing a Women Physicians Section	CWIM Report A-18 C-2	Adopted	Bylaws (Item 1)	I-18	
STATUS: Please see COB Report I-18 C-4 in I-18 Delegates' Handbook.						
A-18 C Item 3	Sexual Orientation and Gender Identity Demographic Data Collection by the MMS	CLGBTQ Report A-18 C-3	Adopted as Amended	Membership	A-19	
A-18 C Item 4	MMS Leadership Promotion and Governance	OFFICERS Report A-18 C-4 [CWM Report I-16 C-3]	Adopted as Amended	Task Force on Governance	A-19	
(A-18 C Section) 5a	Policy Sunset Process (Section: Reaffirm for 7 Years)	OFFICERS Report A-18 C-5 (SECTION A)	Adopted	(MMS *Policy Compendium*)	A-19	
A-18 C (Section) 5b	Policy Sunset Process (Section: Amend and Reaffirm for 7 Years)	OFFICERS Report A-18 C-5 (SECTION B)	Adopted	(MMS *Policy Compendium*)	NA	
A-18 C (Section) 5c	Policy Sunset Process (Second: Reaffirm for 1 Year)	OFFICERS Report A-18 C-5 (SECTION C)	Adopted *(reaffirmed for 1 year for further review whether to reaffirm, sunset, or amend)*	**ETHICS: Genetic Information and Patient Privacy Item 1c)** Ethics, Grievances, and Professional Standards (Item 10 in consultation with Medical Education)	A-19	
				HEALTH SYSTEM REFORM (Item 2c) The Quality of Medical Practice (Items 11, 13 in consultation with Legislation & item 12 in consultation with Professional Liability)	A-19	

				HOSPITALS: Mergers of Conversions (Item 3c) The Quality of Medical Practice (Item B1 in consultation with Legislation)	A-19	
				MINORITIES: **Race and Ethnicity Data (Item 4c)** Public Health and Diversity in Medicine	A-19	
				PROFESSIONAL LIABILITY: **Physician Expert Witness (Item 5c)** Professional Liability	A-19	
				PUBLIC HEALTH: **Human Medicine, Veterinary Medicine, and Environmental Sciences (Item 6c)** Public Health	A-19	
				QUALITY OF CARE: **Measurement/Quality Improvement (Item 7c and 8c)** The Quality of Medical Practice	A-19	
A-18 C Item 6	Prescription Marketing Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)	CPH Report A-18 C-6 [A-17 C-2]	Adopted (Sunset)	(MMS *Sunset Compendium*)	NA	
A-18 C Item 7	Ethics and Managed Care Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)	CEGPS/CQMP Report A-18 C-7 [A-17 C-2]	Refer to E,G, and PS	Ethics, Grievances, and Professional Standards	A-19	

A-18 C Item 8	Principles on Medical Professional Review of Physicians (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)	CQMP/CEGPS Report A-18 C-8 [A-17 C-2]	Adopted	(MMS *Policy Compendium*)	NA	
A-18 C Item 9	Physician Call Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)	CQMP Report A-18 C-9 [A-17 C-2]	Adopted as Amended	(MMS *Policy Compendium*)	NA	
A-18 C Item 10	Third-Party Insurers Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)	CQMP Report A-18 C-10 [A-17 C-2]	Adopted as Amended	(MMS *Policy Compendium*)	NA	
A-18 C Item 11	Patient Safety Policy (Policy Sunset Process: Reaffirmed One Year at A-17 Pending Review)	CQMP Report A-18 C-11 [A-17 C-3]	Adopted	(MMS *Policy Compendium*)	NA	
A-18 C Item 12	Delegates-at-Large	BOT Report A-18 C-12	Adopted	NA		
ADOPTED FIRST SESSION, SPEAKERS' CONSENT CALENDAR						
A-18 C Item 13	Membership Dues for Calendar Year 2019	COF Report A-18 C-13	(Adopted)	NA	NA	