HOUSE COMMITTEE ON BYLAWS

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PRINTED COPIES OF LATE RESOLUTIONS WILL BE DISTRIBUTED ON FRIDAY, APRIL 21 ALONG WITH THE REPORT OF THE COMMITTEE ON RULES, CREDENTIALS AND ORDER OF BUSINESS.

MATERIALS WILL BE FOUND IN THE BACK OF THE GRAND BALLROOM.
Whereas, the number of employed physicians is rising significantly such that there are, or soon
will be, more physicians employed than in independent practice; and

Whereas, Article XII-A of the MSSNY Bylaws establishes an Organized Medical Staff Section
(OMSS) with one delegate to the MSSNY House of Delegates; and

Whereas, Article XII-B of the MSSNY Bylaws establishes the Young Physicians Section (YPS)
with similar representation in the House of Delegates; and

Whereas, the focus of neither YPS nor OMSS is specific to the needs of Employed Physicians;
therefore, be it

RESOLVED, that Article III of the MSSNY Bylaws be amended to read:

SECTION 1. COMPOSITION
The House of Delegates shall be composed of: (a) duly designated delegates from the
component county medical societies; (b) officers of the Medical Society of the State of New
York, councilors, and trustees; (c) a duly designated delegate from each district branch; (d) a
duly designated delegate from each recognized specialty society; (e) duly designated delegates
from the medical student section; (f) the Commissioner of Health of the State of New York, or a
deputy designated by the Commissioner, provided that any representative shall be a member of
the State Society; (g) past-presidents of the State Society and any past president of the
American Medical Association, provided that individual is a member of the Medical Society of
the State of New York who shall be members for life; (h) any past executive vice-president of
the State Society, who shall be a member for life, provided that individual is a member of the
Medical Society of the State of New York, resides in the State of New York and is not otherwise
a member of the House of Delegates for life in accordance with this section; (i) any past deputy
executive vice-president of the State Society who has served a minimum of three years as
deputy executive vice-president, who shall be a member for life, provided that the individual is a
member of the State Society, resides in the State of New York, is not otherwise a member of the
House of Delegates for life in accordance with this section, and is elected as a member for life
by a majority of the members of the House of Delegates present and voting; (j) a representative
from each of the medical schools in New York State, provided said representative is a member
of the Medical Society of the State of New York; (k) delegates representing the resident and
fellow section; (l) a delegate representing the organized medical staff section; (m) delegates
representing the young physicians section; and (n) elected officers, trustees, and speakers of
the American Medical Association, provided those individuals are members of the Medical
Society of the State of New York and (o) a delegate representing the employed physicians
section; and be it further

RESOLVED, that Article IV. COUNCIL be amended as follows:

SECTION 1. COMPOSITION
Four councilors shall be elected annually by the House of Delegates, each for a term of three years. One councilor representing the young physicians section shall be elected every third year by the House of Delegates for a term of three years. Two councilors, one councilor representing the medical student section, and one councilor representing the resident and fellow section, and one councilor representing the employed physicians section to the Medical Society of the State of New York, shall be elected every year by the House of Delegates, each for a term of one year. Article IV, Section 1, paragraph 4 is not applicable to the term of office of a resident or student councilor or the councilor representing the employed physicians section. In the event of a vacancy, a councilor shall be elected by the Council to serve until the next meeting of the House of Delegates, at which time the House of Delegates shall elect a councilor to fill the unexpired term.

No person shall serve, consecutively, more than two terms as councilor. An unexpired term shall not be construed as a term of office.

The councilors shall assume office on election and shall hold office until their successors are duly elected and qualified.

Councilors, other than the councilor representing the medical student section, the councilor representing the resident and fellow section, and the councilor representing the young physicians section, and the councilor representing the employed physicians section shall be assigned to specific county societies as liaison for the Council in accordance with the provisions of Article V, Section 2. Councilors shall be required to disseminate information of Council activity as well as returning information to the Council, and shall report regularly to the Council on their activity. The councilor representing the young physicians section must be a young physician member of the Medical Society of the State of New York and must have completed residency training and be under the age of 40, or regardless of age, have completed residency training within the past eight years, at the beginning of his/her term as councilor. The councilor representing the medical student section must be a student member of the Medical Society of the State of New York; the councilor representing the resident and fellow section must be a resident member of the Medical Society of the State of New York. The councilor representing the employed physicians section must be a member of the Medical Society of the State of New York and employed as a salaried employee of a New York hospital or health care network that serves New York State; and be it further

RESOLVED that Article XII of the MSSNY Bylaws be amended as follows:

ARTICLE XII-C Employed Physicians Section

An Employed Physicians Section shall be established, the focus of which shall be specific needs of New York physicians who are salaried employees of a hospital, hospital-based network or system, or other healthcare entity which employs physicians. The Employed Physicians Section shall focus on issues of interest specific to salaried physicians, it shall establish internal governance and operating procedures which shall not be in conflict with MSSNY Bylaws. Members of the Employed Physicians Section shall be paid members of MSSNY and their respective county medical society.
RECOMMENDATION:
Madam Speaker, Your Reference Committee recommends that the policies contained in 2017 Governmental Affairs and Legal Matters (A) Sunset Report be acted upon in the manner indicated and that the remainder of this report be filed:

REAFFIRM 80.996 Bifurcation of Trial:
MSSNY will seek legislation to require bifurcation of trial in all medical liability cases. (HOD 2007-53)

RECOMMENDATION: Re-Affirm. The policy is still relevant

80.997 Use of Expert Testimony:
MSSNY continues to advocate for meaningful reform regarding the use of expert testimony, including but not limited to: (1) requiring pre-trial disclosure of the identity of experts; (2) requiring the deposing of experts; (3) requirements that experts have a similar specialty, clinical background, and be in active practice similar to that of the physician whose care is the subject of the action; or (4) through the establishment of programs where expert testimony can be pre-approved by appropriate medical experts. (HOD 2007-52)

RECOMMENDATION: Re-Affirm. The policy is still relevant

130.967 Reform of the Civil Litigation and Medical Liability Insurance Systems in New York State:
MSSNY approved the comprehensive plan to reform the Civil Litigation and Medical Liability Insurance Systems in New York developed by:
   American College of Obstetricians and Gynecologists - District II
   Greater New York Hospital Association
   Healthcare Association of New York State
   Medical Society of the State of New York
   New York Chapter, American College of Physicians
   New York Chapter of the American College of Surgeons

The major components of the plan are as follows
1. Medical Malpractice Civil Litigation Process Reform
   Systemic Remedies
   Immediate Remedies
2. Financial Relief
3. Quality and Outcome Improvement Measures
(More detailed information about the plan is available from MSSNY’s Division of Governmental Affairs.) (Council 9/20/07)

RECOMMENDATION: Re-Affirm. The policy is still relevant.
65.899 Phlebotomy Services by Physician Offices:
MSSNY to oppose penalties on physicians for referring patients for out-of-network services and work with health insurance plans to appropriately reimburse the expense for phlebotomy services at physician offices. (HOD 2007-73)

RECOMMENDATION: Retain, the policy is still relevant

165.904 Reform of Managed Care Denial Process:
MSSNY will:
(1) support legislation or regulation requiring health plans to submit quarterly detailed schedules of reimbursement denials, including the number of denials, the amount, and the reasons for denials to deter abusive practices and improve quality of care;
(2) continue sharing with all relevant state agencies the most frequent causes of health plan denials reported to MSSNY, so that the Superintendent of Insurance and Commissioner of Health may investigate such denials; and
(3) urge the Superintendent of Insurance to investigate patterns of inappropriate denials by health plans as part of their routine market conduct audits. (HOD 2007-68)

RECOMMENDATION: Re-Affirm. The policy is still relevant

165.905 Reimbursement for Pre-Authorized Services Subsequently Denied by MCOs:
MSSNY will take all appropriate steps to assure that physicians have the ability to seek payment from patients where a health plan subsequently denies a pre-authorized service and seek to assure that the insurer notify the patient regarding their financial responsibility. (HOD 2007-67)

RECOMMENDATION: Re-Affirm. The policy is still relevant

165.906 Hard-Coded Personal Computer Dates as Proof of Timely Filing of Paper Claims:
Legislation, regulation, or other appropriate means will be sought by MSSNY to require all insurers, including workers compensation carriers, to accept hard-coded-system generated data as proof that a paper claim was timely filed, provided the physician attests that the claim was mailed on or about the day the claim was generated. (HOD 2007-65)

RECOMMENDATION: Re-Affirm. The policy is still relevant

165.909 Psychiatric Medication Formulary Exclusion:
MSSNY should: (1) promote passage of legislation that would allow patients who, based upon the judgment of the treating physician, demonstrate stability on current medication regimens not be required to be subjected to therapeutic equivalent changes based on formulary preferences; and (2) work with the Insurance Department and the Health Department to enable a patient or physician to request an exemption from a health plan when the required drug is placed on a high-cost tier. (HOD 2007-56)

RECOMMENDATION: Re-Affirm. The policy is still relevant

175.984 Reconsideration of the Current Medicaid Process:
MSSNY will contact the newly-elected New York State Governor to: (1) reconsider the hassles associated with the current process which are impediments to physician participation; and (2) work with MSSNY in an effort to alleviate these impediments. (Council 1/25/07)

RECOMMENDATION: Re-Affirm. The policy is still relevant
250.995 **OPMC and Medicaid:** MSSNY should encourage the Office of Medicaid Services to discontinue its policy of excluding physicians from its panel solely because they are on probation with the Office of Professional Medical Conduct. (HOD 2007-93)

**RECOMMENDATION:** Re-Affirm. The policy is still relevant

250.996 **Changes to OPMC Procedures:** If the complainant is an insurer, an employee or agent of any insurer, or an attorney, MSSNY should advocate for legislation that will require the disclosure of the name of the person or entity that has filed a complaint against a physician with the Office of Professional Medical Conduct. (HOD 2007-92)

**RECOMMENDATION:** Re-Affirm. The policy is still relevant

265.913 **Managed Care and Medicare “Carve-Out” Services:** In those instances where an insurance company has carved out specific services, and has contracted with an outside party to arrange and pay for these services, and then denies reimbursement on the basis that such payment is no longer their responsibility, MSSNY to (1) advocate for a physician’s ability to seek payment directly from the patient without being considered a violation of the physician’s participation agreement; and (2) seek legislation, regulation or other appropriate means to assure that participating physicians and patients are given advance written notification by payors that the plan has carved out the provision of and payment for specific services such as radiology or diagnostic studies to a specific third party. (HOD 2007-66)

**RECOMMENDATION:** Re-Affirm. The policy is still relevant

265.914 **Electronic Payment or Funds Transfer Systems:** MSSNY will: (1) urge insurance companies initiating electronic payment or funds transfer systems to allow physicians with fewer than 10 Full-Time Equivalent (FTE) Employees to claim an exemption to mandatory electronic payment or funds transfer system; (2) seek to assure that physician practices of all sizes have the option to receive payments electronically; and (3) work with appropriate regulatory agencies to assure that health insurers may not withdraw funds from a physician’s account, except with the express written authorization of the physician. (HOD 2007-63)

**RECOMMENDATION:** Re-Affirm. The policy is still relevant

265.918 **Payment for Urgent and Emergent Health Care Services:** That MSSNY seek public policy, regulation or legislation that would require health care payers in New York to pay for all reasonable urgent and emergent medical services for their covered patients, that the definition of reasonable urgent medical services should carry the prudent lay-person standard similar to what is already in effect for emergent medical services, and that health care payers reimburse out of network physicians for care provided on urgent or emergency basis at a level which the physician believes fairly reflects the costs of providing a service and the value of their professional judgment. (Council 1/26/06)

**RECOMMENDATION:** Re-Affirm. The policy is still relevant
AMEND
265.912 Reimbursement for Participation:
MSSNY adopts the American Medical Association’s Principles for Pay-for-Performance and Guidelines for Pay-for-Performance, H-450.947:

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS
Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician’s sound clinical judgment and should not adversely affect PFP program rewards.

2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients’ health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS
Safe, effective, and affordable health care for all Americans is the AMA’s goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA’s Principles for Pay-for-Performance Programs and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care
- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality of care measures must be the primary measures used in any program.
1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best-available risk-adjustment for patient demographics, severity of illness, and co-morbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship
- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.
1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-adherence and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation
- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
1. Programs should provide physicians with tools to facilitate participation.
2. Programs should be designed to minimize financial and technological barriers to physician participation.
   - Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
   - Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
   - Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
   - Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting
- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
1. Programs should use accurate administrative data and data abstracted from medical records.
2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting. 1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives. 2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.
- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards
- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician’s control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

(2) Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA’s Principles and Guidelines for Pay-for-Performance. (HOD 2007-94)

RECOMMENDATION: Retain. Modify to amend the component of the lengthy policy relating to Patient/Physician Relationship to incorporate 2011 modification to AMA policy that changed the term non-compliance to non-adherence. The policy has been re-affirmed numerous times by the AMA since then, including most recently at the 2016 AMA Annual House of Delegates.
SUNSET

85.972 Broad-based Education Campaign for New Yorkers on the Medical Liability Crisis:
Because of the medical liability crisis which exists in New York State and which is worsening, MSSNY shall undertake and be prepared to expand a broad-based education campaign utilizing every New York State physician, the public, the media, and government leaders. The campaign’s objective would be to fully inform all New Yorkers of the fact that unless fundamental reform of the liability system is enacted a health care service delivery crisis will be unavoidable; and, as a result, loss of patient access to necessary care will be extensive, immediate and devastating. (HOD 2007-96)

RECOMMENDATION: Sunset. The requested action has been taken. MSSNY executed a million dollar medical liability public reform campaign in 2007-08 following adoption of this resolution. It should be noted that the goals of such public education campaign to achieve comprehensive medical liability reform remain among MSSNY’s top legislative priorities and are encompassed in many existing MSSNY policies. Moreover, educating the public regarding the impact of high liability costs remains an ongoing key MSSNY activity.

250.997 Changes to OPMC Procedures:
MSSNY will seek legislation and/or regulation which create a statute of limitations on all investigations and hearings of the OPMC. Such legislation will provide that any accused physician receive within a reasonable period of time, in advance of any interview, a copy of all documentary evidence (including expert witness reports) which can be admissible at any hearing of the OPMC and that the physician be informed of his/her right to bring counsel to an interview along with receiving a transcript of the interview.

MSSNY support any changes designed to reform the activities of the OPMC which protect the public against incompetent and impaired physicians while protecting due process rights of such physicians. (HOD 2003-51; Reaffirmed HOD 2004-56, HOD 2006-77 & HOD 2007-92)

RECOMMENDATION: Sunset. The requested policy was largely achieved as part of a comprehensive physician disciplinary law enacted in 2008.

265.920 Payments for Urgent and Emergent Health Care Services:
MSSNY seek public policy, regulation or legislation that would require health care payers in New York to pay for all reasonable urgent and emergent medical services for their covered patients; that the definition of reasonable urgent medical services should carry Prudential layperson standards similar to what already is in effect for emergent medical services; and that health care payers reimburse out of network physicians for care provided on urgent or emergency basis at a level which the physician believes fairly reflects the costs of providing a service and the value of their professional judgment. (HOD 2005-69; Council 1/26/06)

RECOMMENDATION: Sunset, the policy is redundant of MSSNY Policy 265.918
Whereas, home care services are a critical link in the continuum of healthcare delivery, reducing
the cost of healthcare overall by reducing patient risk for hospitalization, re-hospitalization and
nursing home care; and

Whereas, the need to assure appropriate home care services for patients is even greater for a
patient who has been recently discharged from a hospital, including helping to assure discharge
instructions are followed and reducing the risk of infection; and

Whereas, Medicare eligibility for coverage for home care services requires physician
certification and documentation, including a “Face to Face” (F2F) requirement which is
burdensome to the physician, and as a result, is often is not completed; and

Whereas, the US Department of Health and Human Services Office of Inspector General
reported in 2014 that there were nearly $2 billion in payments for home care services that
should have not been made due to lack of compliance with the F2F requirement; and

Whereas, this has prompted HHS and CMS to undertake extensive audit and review to confirm
the documentation of F2F certification of eligibility for home care by a physician; and

Whereas, home care agencies are faced with significant financial challenges in providing care
as a result of the significant number of claims which are not reimbursed due to lack of a F2F
certification; and

Whereas, these financial pressures can in some instances cause home care agencies to avoid
providing care to some patients where a F2F certification is not provided; and

Whereas, these financial pressures will cause in some instances home care agencies to make
repeated contact to physicians to complete these forms to assure payment for care; and

Whereas, physician time is already overburdened with needless administrative tasks that
interfere with patient care delivery; and

Whereas, the new Trump Administration has publicly expressed a desire to reduce burdensome
regulations; therefore, be it

RESOLVED, that the Medical Society of the State advocate to its Congressional delegation for
repeal or substantial modification of the documentation requirement of a “Face to Face” visit by
a physician as a precondition for Medicare home health coverage; and be it further
RESOLVED, that the Medical Society of the State of New York urge the American Medical Association to make it a priority to achieve repeal or substantial modification of the documentation requirement of a "Face to Face" visit by a physician as a precondition for Medicare home health coverage; and be it further RESOLVED, that the MSSNY delegation present this resolution to the AMA House of Delegates for their consideration at the AMA HOD 2017.
Whereas, the McCarran-Ferguson Act of 1945 guides that the business of insurance be regulated by individual states and that it is in the public’s best interest that states regulate this industry; and

Whereas, the Financial Modernization Act of 1999 (Gramm-Leach-Bliley) reaffirms that states should regulate the business of insurance; and

Whereas, individual states are more directly aligned to address and protect the consumers with stringent licensing requirements, product regulations, financial regulations, and marketing regulations; and

Whereas, individual states provide essential consumer protection with the support of the National Association of Insurance Commissioners (NAIC); and

Whereas, individual states have firmly established services geared to interact with the consumer, including toll-free hotlines, websites, special consumer service units, etc.; and

Whereas, individual states are more sensitive to, and can more easily respond to local consumer needs; and

Whereas, individual state governance of health insurance sales provides significant state revenues and jobs; and

Whereas, disruption of state regulations of health insurance sales can negatively affect doctor-patient relationships, promote medical tourism and disrupt the robust local provider market place infrastructure; and

Whereas, distance and breadth of interstate regulations, by far removed regulators, prevents quick and timely legal remedies available at the state level for consumer protection via the voting preferences of policy holders; therefore, be it

RESOLVED, That in order to protect consumers, providers, and the market for insurance and health care jobs, that the Medical Society of the State of New York (MSSNY) oppose initiatives that would permit the sale of health insurance products that escapes state regulations, and be it further

RESOLVED, That MSSNY introduce a similar resolution at the annual AMA HOD.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017- 52

Introduced by: Ninth District Branch

Subject: Improving EHR Technology to Enhance and Track Clinical Outcomes

Referred To: Reference Committee on Governmental Affairs - A

Whereas, current electronic health record technology has focused primarily on managing payments and dollar cost and not on documenting clinical management, tracking care, and improving clinical outcomes; and

Whereas, trying to extrapolate quality through the process of Meaningful Use has been time-consuming, obstructive, and has yielded little positive quality improvement; and

Whereas, it is clear that simply managing cost and/or expense not only has not yielded clinical improvement, but at times has led to negative impacts on clinical outcomes; and

Whereas, the current and past iterations are known to be significantly obstructive to the flow of care in the ambulatory-care setting, through time-consuming data entry, poor ability to retrieve information in a clinically-meaningful way, and poorly constructed for physician and staff interaction; and

Whereas, the interchange of clinical information between physician and staff, between physicians and consultants, and between physicians and other providers of healthcare due to the lack of standardization of information, and the attempt to use "healthcare information exchange" has been expensive, obstructive, and not clinically useful; therefore, be it

RESOLVED, that MSSNY seek through legislation and/or regulation to require EHR vendors to simplify and standardize electronic health record systems so that they are clinically oriented through episodes of care; and be it further

RESOLVED, that MSSNY seek through legislation &/or regulation to require the EHR vendors to:

a) Achieve standardization of information;

b) Produce products that are clinically oriented for managing care and improving outcomes, through use of episodes of care.

c) Develop and institute outcomes statements for episodes of care

d) Develop user friendly information tracking and retrieval

e) Develop real time comparative management and comparative outcomes analysis tools;

and be it further

RESOLVED, that MSSNY bring a similar resolution to the AMA.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017-53

Introduced by: Parag H. Mehta, MD, as an Individual Delegate, Medical Society of the County of Kings

Subject: EHR Data Access and Data Migration

Referred To: Reference Committee on Governmental Affairs - A

Whereas, electronic health record (EHR) systems are part of the fabric of medical practice in the 21st century, but many of today's systems are far from perfect; and

Whereas, physicians are changing from one EHR to another, and it is challenging; and

Whereas, data migration from one EHR to another is extremely important to take care of the patient, patient safety and quality of care; and

Whereas, upgrades from one version to another may alter the printed view if the fields do not align and billing records and all components must be assured of their integrity; and

Whereas, several EHR are not so user friendly in delivering the data, it increases the burden and hinders quality of care; therefore, be it

RESOLVED, that MSSNY and AMA pursue regulations which would require EHR vendors to provide data in a timely and meaningful way and at reasonable cost to the next EHR vendor when requested to do so by the users; and; be it further

RESOLVED, MSSNY and the AMA must make it a requirement for vendors to provide access to legacy charts on a server for the legal statutory requirement of the specialty and the State for the longest required time and additionally they must certify and attest to its accuracy and completeness; and be it further

RESOLVED, MSSNY and AMA must make it a requirement for certification that all upgrades and updates to an electronic health record provide the records in the format of the previous version; and be it further

RESOLVED, MSSNY and AMA must NOT hold vendors harmless if litigation results from imperfections or errors caused by their product, i.e. server failures etc.
Whereas, Physicians have become more and more burdened with increasing federal and state
unfunded regulation and mandates over the past decade; and

Whereas, Electronic Health Records implementation and Meaningful Use requirements have failed
to facilitate improved care quality and/or clinical outcome; and

Whereas, Quality measure reporting including Physician Quality Reporting System (PQRS) has not
been associated with relevant outcome measurement or improved quality; and

Whereas, Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) rid the flawed
Medicare Sustained Growth Rate formula, it incorporated many detrimental regulatory and punitive
elements on physician practices; and

Whereas, alternative payment models including Accountable Care Organization (ACOs), Health
Home, and chronic disease management model have not consistently demonstrated program
savings; and

Whereas, these mandates, most of it unfunded, make it extremely difficult for a physician to start
his/her own practice in today’s environment; and

Whereas, the increased administrative burden imposes significant physical, mental, and financial
stress on many physician practices; and

Whereas, many of the requirements reduce patient-physician direct contact time and interfere with
the physician-patient relationship; and

Whereas, such administrative burden reduces patient access to available physician care in various
care settings and models; therefore be it

RESOLVED, That MSSNY seek repeal, through legislation and/or regulation, state and/or federal
mandates on Advanced Alternative Payment Model (APM), Merit-based Incentive Payment Systems
(MIPS), and Electronic Health Record (EHR) or their derivatives which require physician
participation; and be it further

RESOLVED, That the MSSNY Delegation to the American Medical Association (AMA) introduce
a similar resolution at the next meeting of the AMA House of Delegates for federal actions.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 55

Introduced by: Natalie Adler, MD
Gregory Pinto, MD
Third and Fourth Districts

Subject: Truth in Advertising with Regard to Board Certification

Referred To: Reference Committee on Governmental Affairs - A

Whereas, Physicians often include in their advertisements that they are "board-certified" and
Whereas, The board that is certifying said physician may have nothing to do with the service(s)
that the physician is advertising (e.g., a board-certified psychiatrist may be advertising his
freestanding colonoscopy clinic); and
Whereas, Patients deserve to know the nature of a physician’s board certification if said
certification is part of the physician’s advertisements; therefore be it

RESOLVED, That MSSNY seek legislation or regulation to require that any physicians’
advertisements that include claims of "board certification" must specify the certifying boards.
Whereas, Non-physician healthcare practitioners are increasingly earning doctorate degrees; and
Whereas, There is still a substantial difference between the clinical training obtained by non-physician holders of doctorate degrees and that obtained by M.D.s and D.O.s; and
Whereas, Patients deserve to know the nature of the degree of the practitioner being advertised as a "doctor" therefore be it
RESOLVED, That MSSNY seek legislation or regulation to require that any advertisements that include descriptions of practitioners as doctors be required to describe the practitioners’ actual degrees; and be it further
RESOLVED, That the New York Delegation to the AMA bring a resolution to the Annual AMA meeting which seeks to provide model legislation or regulation which would require advertising to include accurate descriptions of the educational degree held by a practitioner.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 i 57

Introduced by: New York County Medical Society
New York State Society of Plastic Surgeons
Suffolk County Medical Society

Subject: Percentage-Based Billing Services Arrangements

Referred To: Reference Committee on Governmental Affairs - A

Whereas, Section 18 NYCRR 360-7.5 (c) of the regulations of the New York State Department of Health's Office of Medicaid Management (NYSDOH i OMM) states that a physician is permitted to employ a business agent such as a billing service or an accounting firm, and that these business agents are permitted to prepare and send bills and receive Medicaid payments made out in the name of the physician; and

Whereas, The regulations forbid these business agents to charge Medicaid providers a percentage of the amount claimed or collected, because such a percentage-based payment arrangement will violate Section 18 NYCRR 360-7.5 (c), and will also violate the New York State Education Law and the State Education Department's regulations on unlawful fee-splitting; and

Whereas, Under current law, a physician's payment arrangement with a business agent such as a billing service is permissible only if compensation paid to the agent is (1) reasonably related to the cost of the services; (2) unrelated, directly or indirectly, to the dollar amounts billed and collected; and (3) not dependent on actual collection of payment; and

Whereas, The Medicaid program has been informed of several violations of the ban on percentage-based payment arrangements with business agents; and

Whereas, In Winter, 2017, the Fraud Control Unit of the New York State Attorney General began conducting audits of physicians' payment arrangements with business agents, and actively seeking refunds of monies paid under arrangements that are percentage-based; and

Whereas, The Attorney General's Fraud Control Unit has recently sent refund demand letters concerning this issue to several New York State physicians; and

Whereas, Despite this recent focus on the issue, it is perceived by organized medicine that since the original regulations date from the mid-1990s and the New York State Department of Health's Office of Medicaid Management (NYSDOH i OMM) has released no reminder since 2001, the New York physician community has not been properly informed concerning the regulations' potentially serious financial impact (e.g., that refund demands might be involved) ï in fact, many physicians are not aware of the regulations at all; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) work for repeal of the New York State law barring percentage-based payment arrangements between physicians and their billing agents; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) seek legislation to repeal that portion of the law which allows for audits and refund demands, replacing it with a requirement that before a refund demand is issued to a physician, an initial educational
contact must be made with him or her, warning that percentage-based billing arrangement is prohibited and that the physician must make immediate and proper changes to his or her billing-service payment arrangements or be subject to the legal consequences; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) petition the Fraud Control Unit of the New York State Attorney General for 1) a moratorium on refund demands on Medicaid providers who have percentage-based payment arrangements with their contracted billing services, and for 2) establishment of a “date certain” after which further violations of the regulations on business-agent payment arrangements will be subject to full audits and refund demands; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) urge the Fraud Control Unit of the New York State Attorney General to issue a one-time clemency to physicians who have already been subjected to audits and refund demands related to prohibited percentage-based payment arrangements with their business agents, if those physicians will attest that they did not know and could not reasonably be expected to know that such a prohibition existed; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) launch an intensified campaign to alert the New York State physician community that their billing agents are prohibited from charging Medicaid providers a percentage of the amount claimed or collected, and include information on what payment arrangements are satisfactory.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 58

Introduced by: The Suffolk County Medical Society
Subject: Collection of Deductible and Co-Insurance

Referred To: Reference Committee on Governmental Affairs - A

Whereas; detailed in a November 9, 2016 letter from the Department of Financial Services to all New York State physicians, physicians who elect not to bill patients for deductible and co-insurance amounts, can be considered guilty of committing insurance fraud; and

Whereas; a physician who has been accused of engaging in fraudulent practices (insurance fraud) may be subject to severe hardship and professional misconduct penalties even if the physician is innocent, including but not limited to extremely high defense costs, removal from Medicare and Medicaid programs, severe fines, revocation of his/her medical license; and

Whereas; over the years many insurance plans have increased their deductible and co-insurance amounts which, even for individuals and families of modest incomes, can prove to be a financial burden such that access to care is limited, and most patients don’t understand that such amounts are expected to be paid by the patient; and

Whereas; most public health plans do not allow collection of deductibles until after the plan has been billed and an Explanation of Benefits has been issued to the physician; and

Whereas; many patients may not pay their deductible/co-insurance responsibilities at all, or if they do, not for weeks/months after the physician visit, which often necessitates collection notices to be sent; and

Whereas, if deductibles are not paid at the time of the visit, the odds of nonpayment of deductibles is greatly increased even for patients who can afford to pay such deductibles; and

Whereas; because of the rapidly increased deductible and co-insurance amounts, patients may delay or even not follow through with medically necessary care because of their inability to pay these higher amounts or because other family members may have incurred large out-of-pocket expenses; and

Whereas; depending on the patient population needs and financial abilities, physicians may more often determine that they have to waive billing for deductible and/or co-insurance amounts so that patients don’t delay, or not follow through with, the provision of medically necessary services; and

Whereas; waving of deductibles and co-insurance amounts in these instances could possibly be interpreted as a "routine" or "frequent" waiver, thereby raising issues of fraud or abusive billing; therefore, be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) seek regulation or legislation that permits physicians to collect deductibles and copayments up front from patients at the time of services who have any public or private insurance plan; and be it further
RESOLVED, That MSSNY seek regulation or legislation that requires all public and private insurance plans to develop a system where a physician’s office can quickly, efficiently and accurately determine a patient’s deductible and copayments at the time of service; and be it further

RESOLVED, That MSSNY seek regulation or legislation that requires all public and private health insurance plans to notify patients that their deductibles and copayments are a result of the health insurance plan policies and ARE required at the time of visit AS PER INSURANCE PLAN CONTRACTS; and be it further

RESOLVED, That MSSNY seek regulation or legislation that if a physician in his or her best judgment, believes that high deductibles and copayments are a significant factor in a patient’s decision to follow up or not for needed assessment and/or care, then the decision to waive or reduce such patient payments will not be considered fraudulent or abusive billing, even if there is a pattern of such decisions based on patients’ needs.
Whereas; over the years many insurance plans have consistently increased patients' deductibles and coinsurance amounts which often places an undue financial burden on the patient and/or family; and

Whereas; the average deductible for people with employer provided health coverage rose from $303 to $1,077 between 2006 and 2016; and

Whereas; between 2004 and 2014, average payments for deductibles and coinsurance rose considerably faster than the overall cost for covered benefits, and

Whereas; during the same time period patient cost-sharing rose substantially faster than payments for care by health plans, and

Whereas; overall patient cost-sharing rose by 77% from an average of $422 to $747 in 2014; and

Whereas; because of these rapidly increasing deductibles and coinsurances, many patients delay or forego medically necessary care because of their inability to pay, and

Whereas; many public and private insurance plans do not allow a physician to collect the deductible at the time of service which therefore increases billing costs and too often leaves such deductibles unpaid, therefore be it

RESOLVED, That due to the dramatically increasing patient cost-sharing responsibilities, often resulting in patients decisions to delay or forego medically necessary services, that the Medical Society of the State of New York issue an official policy statement that any deductibles in excess of $500 represents an unacceptable patient burden and barrier to achieving health care for the majority of New York citizens; and be it further

RESOLVED, That a similar resolution be introduced at the June AMA House of Delegates, calling for the AMA to issue a similar policy statement on a national level.
Whereas, the "All Payer Database" cannot be representative of all insurance payers due to the omission of Employee Retirement Income Security Act (ERISA) plan data; and

Whereas, an "All Payer Database" is not representative of the true cost to provide care in this state; and

Whereas, generous hospital facility fees insulate large institutions financially and enable them to employ physicians who are reimbursed at an artificial rate based upon "production" sometimes employing RVU collections to justify a given salary and bonus; and

Whereas, an increasing number of physicians are in fact employees of large medical centers and have no knowledge of fees charged or collected on their behalf; and

Whereas, many private hospitals are unable to provide specialized emergency care in-house because covering private physicians cannot afford to provide that care, leading to patient transfers to other hospitals via ambulance at increased costs to the health care system; therefore, be it

RESOLVED, that the Medical Society of the State of New York advocate to ensure that the payment data collected in an All Payer Database (APD) NOT form the basis for a reimbursement standard to health care providers, because the APD does not include payment data from ERISA plans, which results in an artificial narrowing of the range of fee data collected by the APD.
Whereas, individual health insurance policies in New York have traditionally included out of network benefits with Usual Customary and Reasonable (UCR) payment methodology; and

Whereas, out-of-network insurance coverage for the individual market is scarcely available in New York State, and completely unavailable in Hudson Valley, New York City, and Long Island; and

Whereas, the out-of-network transparency laws of 2015 empower the Department of Financial Services to mandate availability of out-of-network insurance policies including ones with UCR payment methodology for small groups but not in the individual market; and

Whereas, none of the NY State Exchange (The New York State of Health) individual health plans contains out-of-network benefits; and

Whereas, network adequacy, while poorly defined, remains a significant barrier for patients seeking necessary care in a timely and safe manner; and

Whereas, MSSNY has consistently advocated for the availability of out-of-network insurance policies to patients, consumers and employers; and

Whereas, there is no requirement at the federal level for out-of-network benefits for self-funded plans; therefore, be it

RESOLVED, That MSSNY seek, through legislation and/or regulation, the availability of out-of-network benefits including plans utilizing usual, customary and reasonable (UCR) payment methodology for out-of-network benefits in all tiers, including the individual market and New York State of Health; and be it further

RESOLVED, That the MSSNY Delegation to the American Medical Association (AMA) introduce a similar resolution at the next meeting of the AMA House of Delegates for similar requirement in federally sponsored plans, federal exchange, and/or self-funded plans.
Whereas, Our present national healthcare system is in turmoil, and

Whereas, Millions of our patients will have no insurance or be underinsured due to the high cost of insurance and high deductibles; and

Whereas, As physicians are directly responsible for delivering the best healthcare possible; and

Whereas, The present healthcare system is destroying our ability to practice medicine due to insurance company policies of harassing physicians with exclusivity panels, payment denials and complicated paperwork; and

Whereas, The CEOs and shareholders of these for-profit insurance companies are making obscene profits at our expense and the expense of our patients; and

Whereas, Many MSSNY members, including specialty societies such as The New York Academy of Family Medicine, are advocating for a single payer universal healthcare system; and

Whereas, Medical students and residents in vast numbers want a single payer, universal healthcare system and they deserve to have a voice as they are the future of medicine; and

Whereas, The New York Nurses Association supports the single payer healthcare; and

Whereas, The New York State Assembly has passed legislation for a single payer system; and

Whereas, Physicians must play a vital role in any healthcare delivery system and be included in all decisions pertaining to healthcare delivery; and

Whereas, New York State must take a vanguard role in establishing a healthcare delivery system which could be a model for the rest of our nation; therefore, be it

RESOLVED, That MSSNY support a healthcare delivery system based on a universal, single payer healthcare system; and be it further

RESOLVED, That physicians must have direct input and ongoing involvement on all aspects of a single payer system; and be it further

RESOLVED, That MSSNY lobby the New York State Legislature position in support of a single payer healthcare system.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017 - 63

Introduced By: Medical Society of the County of Kings

Subject: MSSNY Support Single Payer Health Insurance

Referred To: Reference Committee on Governmental Affairs - A

Whereas, Americans have lower life expectancy and higher infant mortality than populations in the rest of the developed world; and

Whereas, America spends more per capita on health care than any other country in the world; and

Whereas, the current multi payer system of healthcare financing in the United States is burdensome, inefficient and regressive; and

Whereas, patients, providers and taxpayers are frustrated with our current healthcare financing system; and

Whereas, the majority of New York State physicians and patients favor a single payer over a multi payer system; therefore, be it

RESOLVED, that MSSNY support a New York State single payer health insurance bill; and be it further

RESOLVED, that MSSNY introduce a resolution at the AMA to support federal single payer health care legislation.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017 - 64

Introduced By: Medical Society of the County of Kings
Subject: MSSNY Support Universal Health Insurance
Referred To: Reference Committee on Governmental Affairs - A

Whereas, a 2013 National Research Council/Institute of Medicine study of seventeen high-income countries concluded that Americans have "shorter lives" and "poorer health"; and

Whereas, life expectancy in New York State and the United States of America is significantly lower than other Organization for Economic Cooperation and Development (OECD) countries despite higher per capita healthcare spending; and

Whereas, despite implementation of the Affordable Care Act of 2010 (ACA) almost 30 million Americans remain uninsured and even more remain underinsured; and

Whereas, 62% of bankruptcies in America result from health care expenses (75% had health insurance at the onset of their bankrupt and illness); and

Whereas, most developed countries, including those studied in the National Institutes of Health (NIH) and OECD studies mentioned above, have universal health insurance; and

Whereas, 75% of New York State physicians surveyed in 2015 believe universal coverage should be a goal; therefore, be it

RESOLVED, that the Medical Society of the State of New York (MSSNY) advocate for and support or lobby for legislation in New York State leading to universal health insurance for all New Yorkers; and be it further

RESOLVED, that MSSNY introduce or support a resolution at the AMA for universal health insurance for all Americans.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017i  Late E

Introduced by:  New York County Medical Society

Subject:  Changing MSSNY Goals on Medical Liability

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IF HOUSE COMMITTEE ON RULES, CREDENTIALS AND ORDER OF BUSINESS
RECOMMENDS ACCEPTANCE FOR BUSINESS, THIS WILL BECOME

Resolution 2017 - 65

Referred to:  Reference Committee on Governmental Affairs - A

1 Whereas, The Medical Society of the State of New York has struggled unsuccessfully for years
to achieve significant tort reform, including a cap on pain and suffering; and
2 Whereas, The political makei up of the State of New York’s legislature has precluded any
significant success in achieving organized medicine’s legislative goals on tort reform; and
3 Whereas, Lack of results in tort reform may discourage doctors’ participation in legislative
activities from Physician Advocacy Day to MSSNYPAC membership; and
4 Whereas, Tort reform is not even the principal issue for all specialties, and the need to devote
attention to it in the legislative agenda means that less attention and political capital can be
spent on other more universal items of interest which may have a better chance of success; and
5 Whereas, It is demoralizing to the membership to see effort expended on achieving significant
tort reform without gaining results, thus eventually discouraging doctors’ participation in
legislative activities from Physician Advocacy Day to MSSNYPAC membership; and
6 Whereas, Tort reform is not even the principal issue for all specialties, and the need to devote
attention to a perennial losing cause in the legislative agenda means that less attention and
political capital can be spent on other more universal items of interest which may have a better
chance of success; and
7 Whereas, The fight for tort reform works against the idea of lowering medical liability premiums,
because if medical liability rates go down, there is less urgency in promoting tort reform, so the
two ends work at cross purposes; and
8 Whereas, The significant surplus that MLMIC has been able to build, based on premiums paid
by physicians beyond the reserves needed, indicates that premium rates have been higher than
necessary for many years; therefore, be it
9 RESOLVED, That the Medical Society of the State of New York deï emphasize tort reform from
its legislative agenda and instead focus its efforts on working with the New York State
Department of Financial Services to lower medical liability premiums in the future.
RECOMMENDATION:
Madam Speaker, Your Reference Committee recommends that the policies contained in 2017 Governmental Affairs and Legal Matters (B) Sunset Report be acted upon in the manner indicated and that the remainder of this report be filed:

REAFFIRM
110.994 Health Care Reform Based Upon Evidence Not Ideology:
In recognition that the current health care delivery system model has proven ineffective at the goals of cost containment, improved access, and improved outcomes, MSSNY should actively engage in pursuit of a new health care delivery system model that is primarily based upon evidence which supports these stated objectives, and not reforms based just upon political or economic ideology. (HOD 2007-103)

RECOMMENDATION: Re-Affirm. The policy is still relevant.

110.996 Oral Maxillofacial Surgery Scope of Practice:
MSSNY should oppose any and all legislation to expand the dental scope of practice to allow non-physicians to perform plastic facial rejuvenation and reconstructive surgery of the oral and maxillofacial area that is not directly related to restoring and maintaining dental health. (HOD 2007-98)

RECOMMENDATION: Re-Affirm. The policy is still relevant.

130.968 The Role of Physicians in Health Care Reform in New York State:
MSSNY should seek practicing member physician involvement in health care policy and reform in the state, offering policies formulated by its Task Force on Health Care Reform, by vigorously petitioning, lobbying and conferencing with the Governor’s office and the Department of Health to be included as a key partner in any state-mandated health care reform program. (HOD 2007-106)

RECOMMENDATION: Re-Affirm. The policy is still relevant.

130.969 Universal Health Care:
MSSNY opposes funding universal health insurance through decreased reimbursement, or any tax on physicians. (HOD 2007-105)

RECOMMENDATION: Re-Affirm. The policy is still relevant.

160.979 Physician Registration Fee:
MSSNY will oppose any future increase to the biennial physician registration fee. (HOD 2007-107)

RECOMMENDATION: Re-Affirm. The policy is still relevant.
165.898 **Health Care Reinvestment Fund:**
MSSNY will support legislation to (1) create a health care reinvestment fund to assure that a portion of health insurer profits are returned to physicians and hospitals within the service area served by each insurer; and (2) limit an insurer’s medical loss ratio. (HOD 2007-110)

**RECOMMENDATION: Re-Affirm.** The policy is still relevant.

205.992 **Health Services Upon Release for Prisoners with Mental Illnesses:**
MSSNY will advocate to ensure that the New York State Division of Parole afford prisoners with serious mental illnesses effective discharge planning services to ensure that continuity of care will be provided. (HOD 2007-111)

**RECOMMENDATION: Re-Affirm.** The policy is still relevant.

217.997 **Quality of Care - Nursing Homes:**
MSSNY will support the mandatory reporting of falls with serious injuries in all nursing homes in New York State to the New York State Department of Health in order to establish a data base to indicate where it is necessary to improve quality of care and reduce falls and injuries and to seek legislation or regulation in New York State to implement this policy that includes a provision that the data remain confidential and not subject to disclosure. (HOD 2007-260)

**RECOMMENDATION: Re-Affirm.** The policy is still relevant.

260.928 **Medical Certification of Drivers Covered by Article 19-A:**
MSSNY will work with the New York State Department of Motor Vehicles to:
(1) produce standard, accessible guidelines that support a medically sound and administratively efficient process for medical certification of drivers covered by Article 19-A;
(2) increase the confidentiality of driver medical records by limiting their access to appropriate personnel; and
(3) provide physician oversight for the medical certification program, including careful revision of required forms and methods for submission of required medical information. (Council 6/25/07)

**RECOMMENDATION: Re-Affirm.** The policy is still relevant.

260.931 **Insurance for People Released from Prison:**
MSSNY will advocate that the New York State Division of Parole assures that parolees are enrolled in public or private insurance programs for which they are eligible at the time they are released. (HOD 2007-111)

**RECOMMENDATION: Re-Affirm.** The policy is still relevant.

260.933 **Manufacturer Labeling of Medical Supplies:**
MSSNY will seek the passage of state regulation and/or legislation that mandates that all manufacturers of sterile medical equipment sold in the state of New York have an easily readable, clearly stamped expiration date on the package. (HOD 2007-100)

**RECOMMENDATION: Re-Affirm.** The policy is still relevant.
270.980  **Physician Prescribing Information:**
MSSNY will:
(1)  endorse the American Medical Association Prescribing Data Restriction Program (PDRP) and work with the AMA to disseminate information to physicians regarding their ability to "opt out" of AMA programs which permit the sharing of physician prescribing information;
(2)  oppose legislative efforts to enable physicians to sell patient prescribing data provided, however, that this prohibition shall not preclude physician participation in programs created by recognized physician organizations, data mining companies and pharmaceutical manufacturers which are directed to: (a) the establishment of aggregated data bases including databases created for use in identifying and monitoring drug utilization trends; (b) to enable physicians to become more fully informed relative to their comparative prescribing patterns; and (c) to enhance the quality of their practices including their performance in "pay for performance" programs; and
(3)  work to assure the continued use of physician prescribing data where all patient data have been de-identified prior to the collection and aggregation of this information.  (Council 3/5/07)

**RECOMMENDATION:** Re-Affirm. The policy is still relevant.

**SUNSET**
110.995  **Appropriate Disclosure by Nurse Practitioners of Collaborating and Coverage Agreement & Scope of Practice:**
MSSNY should advocate for:
(1)  the enforcement of Nursing Education Law 139 stipulating that the collaborating physician(s) be prominently posted;
(2)  extension of this ordinance to include the posting of collaborating physician(s) in all advertising, stationery, business cards, etc.;
(3)  the inclusion of not only the collaborating physician(s) but also all coverage agreements including off hours and emergency in patient areas;
(4)  Medical Society of the State of New York advocate for the principle that, regardless of any previous specialty training or expertise on the part of the extender(s), the scope of their practice be limited to and be congruent with that of their current collaborating physician(s); and
(5)  assurances that any off hours and emergent covering arrangements be consistent with the extender(s) current scope of practice and expertise so as to ensure no gaps in care are incurred by the patient.  (HOD 2007-99)

**RECOMMENDATION:** Sunset. This policy is superseded by the enactment of the Nurse Practitioner Modernization Act which eliminates the need for a written practice agreement between a physician and a NP and which allows an NP to enter into a collaborative relationship with a physician or a hospital.

260.932  **MSSNY as a Patient Safety Organization:**
MSSNY will explore the possibility of becoming a Patient Safety Organization (PSO) as defined in House of Representatives HR.3205 and Senate bill S544; and, if it determined that it is fiscally and practically prudent to become a PSO, then MSSNY will give each county medical society the option of participating with MSSNY as a local partner safety organization with administrative support from MSSNY.  (HOD 2007-109)

**RECOMMENDATION:** Sunset. This policy was never implemented, although there are 46 PSOs serving in New York State listed on the database maintained by the Agency for Healthcare Research and Quality.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 100

Introduced by: Fifth and Sixth District Branches

Subject: Nursing Home Inspections Should Include Physicians

Referred to: Reference Committee on Governmental Affairs - B

Whereas, The State health Department regularly inspects nursing homes; and
Whereas, The inspection includes reviews of medications and diagnoses and medical treatments; and
Whereas, Inspectors frequently will challenge the use of certain medications, questioning doses and appropriateness; and
Whereas, The inspection team often consists of RNs, administrators, dieticians, therapists and social workers; and
Whereas, There is no physician on the health department inspection teams to review any of the recommendations of the team; therefore, be it

RESOLVED, That the Department of Health of the State of New York (NYSDOH) be required to assign at least one physician as a member of every health department nursing home inspection team; and be it further

RESOLVED, That physicians involved in Nursing Home inspections be involved in any appeals; and be it further

RESOLVED, That the NYSDOH physicians be made available to review and answer questions and appeals from physicians working with patients in the home being reviewed.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017-101

Introduced by: MSSNY Committee for Physician Health Advisory Committee
Subject: Promote Legislation to Ensure Confidentiality of Peer Support
Referred to: Reference Committee on Governmental Affairs - B

Whereas, stress is common among physicians; and
Whereas, the manifestations of stress can adversely impact a physician’s overall health as well as professional effectiveness; and
Whereas, physician stress can be effectively ameliorated by peer support; and
Whereas, without the assurance of confidentiality, many physicians may avoid seeking help for stress; and
Whereas, currently there are no existing peer support programs which definitively protect the confidentiality of physicians; therefore, be it

RESOLVED, that the Medical Society of the State of New York adopt a position affirming the confidentiality of peer support; and be it further

RESOLVED, that the Medical Society of the State of New York promote legislation to assure the confidentiality of peer support.

Reference

New York State Senate Bill # 02251 which provides for the confidentiality of all matters relating to the conducting of peer support programs for physicians, dentists, physician assistants and nurse practitioners is viewable at

http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=S02251&term=2017&Summary=Y&Text=Y
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 102

Introduced by: The Suffolk County Medical Society

Subject: Copying and/or Scanning Costs

Referred to: Reference Committee on Governmental Affairs - B

Whereas, The Omnibus Rule "allows for the identification of labor costs for copying protected health information whether in paper or electronic form, which can include a reasonable cost-based fee for time spent creating and copying the file;" and

Whereas, in New York State the charges allowed for copying records are as follows:

pages 1+: $0.75 per page (Statute Sections 17 & 18 of Public Health Law (PHL)); and

Whereas, Public Health Law Statute Sections 17 & 18, passed in 1991, has been unchanged, with enormous advancements in technology and its implementation into medical record upkeep; and

Whereas, in neighboring New Jersey the charges are pages 1-100: $1 per page, 100+: $0.25 per page and a Search Fee of $10.00; and

Whereas, over 30 states have Search Fees which may be as high as $82.87 (Texas); and

Whereas, many physician practices with EMRs still have to scan their records into their system before forwarding them to the requesting party; and

Whereas, more and more parties are requesting records in digital format and expect to avoid the copying fee; and

Whereas, physician practices in New York State have some of the highest costs in the nation i.e., labor, taxes, etc.; therefore, be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) support legislation to amend Statute Sections 17 & 18 of Public Health Law (PHL) to include scanning and electronic transmission, with charges for copying costs, be it further

RESOLVED, That Public Health Law, Statutes Sections 17 & 18 include: copying, scanning, and transmission costs to be set to $1.00 per page, allow a Search Fee of $20.00, and permit a reasonable postage charge to parties requesting medical records.
Whereas; Pharmacy Benefit Managers (PBM) have become increasingly intrusive and arbitrary in denying patients access to medically necessary medications; and

Whereas; PBM have developed rigid, arbitrary “guidelines” for coverage of medically necessary medications; and

Whereas; PBM have developed complicated, detailed, time-consuming processes for seeking approval for coverage of such medically necessary medications; and

Whereas; New York State has recently passed legislation and developed regulations to reign in such abusive practices by PBM; and

Whereas; in reviewing information used to determine medical necessity of medications, PBM routinely ask for detailed forms completion and/or letters demonstrating medical history, medication history and response including positive or negative response to medications, side effects and other patient specific information which demonstrates that medical necessity criteria are met; and

Whereas; PBM have recently developed a new intrusive strategy that includes demanding copies of progress notes from a patient’s medical, mental health, or substance use disorder treatment record; and

Whereas; such personal health information included in progress notes in mental health or substance use disorder treatment records rarely adds new information to be used in determining medical necessity, particularly after detailed questions have been answered, forms completed or summary letter have been provided by the treating physician; and

Whereas; such “required” copies of progress notes often contain much more personal information than is needed to determine medical necessity regarding a requested medication, and can be seen as a HIPAA violation; therefore, be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) seek regulation or legislation that requires Pharmacy Benefit Managers accept a completed form or letter that demonstrates a patient meets medical necessity criteria for medications prescribed in lieu of copies of progress notes from a patient’s medical record.
Whereas, legislation has been introduced in the New York State Assembly which would require the New York State Health Commissioner to adopt universal health care professional application forms; and

Whereas, such universal application forms would be the only forms permitted for use in credentialing and re-credentialing health care professionals by health care plans, hospitals and other health care facilities; and

Whereas, the disclosure of unnecessary personal health information (PHI) may be an invasion of physician privacy and may provide a disincentive for physicians to seek necessary health care; and

Whereas, some physicians will seek health care only if treatment is private and records remain confidential; therefore, be it

RESOLVED, that the Medical Society of the State of New York adopt a policy which restricts the disclosure of personal health information in the absence of impairment; and be it further

RESOLVED, that MSSNY initiate contact with the Health Commissioner to guide the development of future universal credentialing application forms with regard to personal health disclosures for physicians.

References
New York State Assembly Bill #A02389 which relates to certain application and referral forms for health care plans is viewable at

http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A02389&term=2017&Summary=Y&Text=Y
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017 - 105

Introduced By: Nassau County Medical Society

Subject: Expanded Clinical Roles for Medical Assistants in New York State

Referred to: Reference Committee on Governmental Affairs - B

Whereas, unlike many states, New Jersey maintains highly specific rules defining the circumstances under which Medical Assistants (MAs) can work independently; and

Whereas, while New Jersey maintains one of the strictest MA licensing definitions in the country, medical assistants in New Jersey generally enjoy a wide scope of practice whereby clinical duties include:

- Administering medications and injections
- Assisting with minor surgical procedures
- Positioning patients for diagnostic testing
- Applying casts and bandages; and

Whereas, In New York State, tasks that can be performed by medical assistants include the following:

- secretarial work such as assembling charts or assisting with billing
- measuring vital signs
- performing ECGs
- taking laboratory specimens including blood work, assisting an authorized practitioner, under the direct and personal supervision of said practitioner, to carry out a specific task, as a "second set of hands" (e.g. authorized practitioner, after positioning a limb, asks the medical assistant to maintain the limb in the position while a bandage is applied or sutures removed. Medical assistant could not independently position the patient.); and

Whereas, Tasks that cannot be performed by medical assistants in New York State include:

- triage
- administering medications through any route
- administering contrast dyes or injections of any kind
- placing or removing sutures
- taking x-rays or independently positioning patients for x-rays
- applying casts
- first assisting in surgical procedures; and

Whereas, regulations governing MA’s in New York State are much more restrictive and defer judgment to supervising physicians, diminishing the MA’s usefulness to physicians in their offices in spite of their training and qualifications; therefore, be it

RESOLVED, that the MSSNY work with New York State approved Medical Assistant teaching programs to develop suitable rules defining and expanding independent clinical work guidelines that can be incorporated into current New York State regulations.

Sources: http://www.medicalassistantcertification.org/states/new-jersey/
Whereas, most physicians accept Medicare reimbursement; and

Whereas, payment by Medicare represents only 80% of the allowed fee; and

Whereas, providers bill the 20% to the patient or to the secondary insurance purchased by the patient; and

Whereas, Medicaid no longer provides the residual 20% fee; and

Whereas, patient care will be compromised by reducing the number of physicians who will accept a fee that is only 80% of Medicare’s approved amount; therefore, be it

RESOLVED, that the Medical Society of the State of New York pursue regulatory and/or legislative action seeking to have Medicaid resume payment of this shortfall as has been done in the past.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017 - 107

Introduced By: Fourth District Branch

Subject: Medical Liability Coverage through the Federal Tort Claims Act

Referred to: Reference Committee on Governmental Affairs - B

Whereas, malpractice insurance coverage is a major expense for physicians throughout the United States, but particularly in New York State; and

Whereas, the Centers for Medicare and Medicaid Services (CMS) and other federal and state agencies are increasingly mandating specific measures that control the way physicians are able to practice medicine; and

Whereas, the cost of providing quality health care is under tremendous scrutiny by all levels of government; and

Whereas, physicians following government quality and cost cutting measures should not incur personal malpractice liability for unexpected outcomes; and

Whereas, malpractice insurance for federally employed physicians is provided under the malpractice insurance umbrella of the Federal Tort Claims Act; and

Whereas, malpractice claims adjudicated through the Federal Tort Claims Act are proportionately substantially fewer and lead to substantially lower payouts per claim than claims covered by other malpractice insurance companies (especially in New York State); and

Whereas, MSSNY adopted policy on this issue at the 2009 HOD but many more mandates have been put into effect since that time, changing the landscape substantially which justifies revisiting; therefore be it

RESOLVED, that MSSNY once again seek legislation that would lead to malpractice insurance coverage through the Federal Tort Claims Act for all physicians who participate in Medicare and/or Medicaid Insurance plans; and be it further

RESOLVED, that MSSNY introduce a similar resolution to the AMA at its annual Meeting in June, 2017.

120.959 Revision of the Federal Tort Claims Act:
MSSNY will endorse the proposal that all patients whose care is funded in all or in part by federal funds, and/or whose care is delivered in facilities funded in all or in part by federal funds, such as those patients covered by Medicare, Medicaid, Railroad retirement benefits, SCHIP, insurance purchased with pre-tax dollars, treated in not-for-profit facilities, etc., be brought under the jurisdiction of the Federal Tort Claims Act. Also, the MSSNY delegation to the American Medical Association is requested to take this issue to the 2009 AMA House of Delegates for action on the federal level. (HOD 2009-75)
Whereas, Physicians are constantly being harassed and bombarded with insurer requests for medical records (i.e. audits and reviews); and

Whereas, the Medical Society of the State of New York was instrumental in getting Insurance Law Section 3224-b revised to limit recovery activity to 24 months in 2006; and

Whereas, we believe it is now time for MSSNY to re-visit that piece of legislation; therefore, be it

RESOLVED, That the Medical Society of the State of New York seek legislation to amend insurance law to limit recovery activity to 12 months.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Introduced By: Monroe County Medical Society
Eighth District Branch of MSSNY

SUBJECT: Study and Promotion of Telemedicine Payment Parity

Referred to: Reference Committee on Governmental Affairs - B

____________________________________________________________________________

Whereas, New York State signed into law, effective 2016, legislation prohibiting commercial
insurers from excluding coverage for services provided via telemedicine if otherwise covered
under the plan’s benefits; and

Whereas, we believe Health Plan telemedicine reimbursement policies vary throughout the
state; and

Whereas, a study by Excellus of 2,000 Upstate New Yorkers demonstrated that 20-31% plan to
use telemedicine in the future; and

Whereas, the same study demonstrated 80% of those who have used telemedicine rated their
experience as “very good” or “excellent” and

Whereas, the same study demonstrated respondents prefer telemedicine visits with their own
doctor to the use of urgent care centers or telemedicine visits with other providers; therefore, be
it

RESOLVED, That the Medical Society of the State of New York conduct a survey of member
physicians across New York State to determine generally that in their experience, services
provided via telemedicine are reimbursed at the same payment versus the same services
provided in-person, and, be it further

RESOLVED, That the Medical Society of the State of New York work with individual legislators
throughout the state to reintroduce legislation that would require parity of payment for services
provided in-person versus via telemedicine.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017-110

Introduced by: New York County Medical Society

Subject: Insurers Withhold Key Financial Information from Out-of-Network Physicians

Referred to: Reference Committee on Governmental Affairs - B

Whereas, health insurers frequently put non-participating out-of-network (OON) physicians at a significant disadvantage and subject them to great financial uncertainty by withholding information, particularly by refusing to send the OON physician the Claim Remittance or Explanation of Benefits, which has important data the OON physician needs; and

Whereas, lacking the Remittance, if the OON physician is taking assignment or is taking advantage of a point-of-service option in the patient’s plan, he or she has no way of knowing:

a) whether a deductible is applicable and how much to charge,
b) how much the approved amount is,
c) how much the reimbursement is, and
d) how much the physician can charge as coinsurance; and

Whereas, if the OON physician is simply charging his/her full private fee, he or she has no way of knowing the amount of the reimbursement, so that the doctor cannot even guess how much of the fee the patient will have the resources to pay (information that is important as it might help the physician gauge the probable “collectability” of each individual bill and thus the probable “collectability” of total accounts receivable, a key measure of the practice’s overall financial health); and

Whereas, since, lacking the remittance, the OON physician has no way of knowing the “collectability” or ultimate value of each OON bill, the term “co-insurance” as used by insurers is a misnomer and could be misleading; and

Whereas, the term “co-insurance” makes it sound as if the patient who owes “co-insurance” were a type of “insuring entity” analogous to an insurance company that is required by the State to show reserves to cover its liabilities, when the patient is not legally an “insuring entity” as patients are not required to show reserves to cover their liabilities, meaning the physician has no way of knowing whether a patient has the needed resources to pay any part of the bill; and

Whereas, instead of “co-insurance,” insurers should use a neutral term such as “patient’s liability” or “patient’s responsibility,” therefore, be it

RESOLVED, that the Medical Society of the State of New York should seek legislation or regulation requiring important information contained in a Claim Remittance or Explanation of Medical Benefits be sent to all treating physicians; and be it further

RESOLVED, that the Medical Society of the State of New York should seek legislation or regulation prohibiting insurers from using the term “co-insurance” to refer to the obligation of individual policy holders.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 111

Introduced by: Ninth District Branch

Subject: Any Willing Provider with Universal Credentialing

Referred to: Reference Committee on Governmental Affairs - B

Whereas, many insurance companies' physician provider networks have continued to shrink; and

Whereas, many regional insurers including United Healthcare and Emblem Health had actively sought to remove physicians from their panel recently via non-renewal; and

Whereas, patients are increasingly finding it difficult to gain reliable and stable access to in-network health care providers; and

Whereas, some out-of-network physicians are willing to provide elective medical professional services to patients with no out-of-network benefits, when in-network fees are paid by insurers for their services; and

Whereas, network adequacy remains a significant barrier for patients seeking necessary care in a timely and safe manner; and

Whereas, some insurers have voiced concerns of lack of internal policies and ability to credential out-of-network physicians to allow "any willing provider" provision; and

Whereas, nationwide credentialing standards have been established and maintained by National Committee for Quality Assurance (NCQA) or other equivalent credentialing entities recognized by many insurers; therefore be it

RESOLVED, That MSSNY seek, through legislation and/or regulation, mandates for insurer acceptance of any willing provider provision for its members/insured as long as nationally recognized credentialing criteria is met by the provider; and be it further

RESOLVED, That MSSNY, affirms Policy 130.941; and be it further

RESOLVED, That MSSNY seek, through legislation and/or regulation, requirements for insurer to accept and reimburse, at in-network level, out-of-network providers willing to provide elective services to patients with no out-of-network benefits as long as the provider meets nationally recognized credentialing criteria; and, be it further

RESOLVED, That the MSSNY Delegation to the American Medical Association (AMA) introduce a similar resolution at the next meeting of the AMA House of Delegates for similar requirement in federally sponsored plans, federal exchange, and/or self-funded plans with no out-of-network benefits.

MSSNY Policy 130.941: Expand “Any Willing Provider” Legislation
MSSNY will continue to advocate for legislation that requires health insurers to include, within the network of any product offered by the insurer, any physician who is able to meet the terms of participation in that network. (HOD 2013-61; Reaffirmed HOD 2014-57)
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - LATE G

Introduced by: Abhimanyu Amarnani, Kings County
Frank Dowling, MD, MSSNY Assistant Treasurer

Subject: Providing Income Tax Credits to Health Care Professionals for Clinical Preceptorships

IF HOUSE COMMITTEE ON RULES, CREDENTIALS AND ORDER OF BUSINESS RECOMMENDS ACCEPTANCE FOR BUSINESS, THIS WILL BECOME

Resolution 2017 – 112

Referred to: Reference Committee on Governmental Affairs B

Whereas, Senator Murphy recently introduced S.4611, which would establish a clinical preceptorship personal income tax credit for health care professionals who provide community-based instruction to students; and

Whereas, MSSNY does not currently have a position related to a tax credit incentive to encourage clinicians around NYS to participate in clinical preceptorships, and

Whereas, Preceptorships provide students a bridge between classroom education and clinical hands-on training in a variety of medical fields, and

Whereas, Although there are many possible qualified preceptors in the state, both private and public medical student training institutions are struggling to secure and maintain clinical preceptorship placements, and

Whereas, A recent Pace University study showed through a survey of thirty-three institutions found that 75% of them were having difficulty securing and maintaining clinical placements, and 93% of institutions cited "lack of interest by practitioners" as the primary challenge in securing placements, and

Whereas, The time requirement of preceptors is substantial, and some have begun charging institutions anywhere from $250 to $999 per rotation for their services, and

Whereas, Many New York institutions are unable to afford the cost of acquiring preceptors and/or are unable to compete with offshore medical school programs, and

Whereas, The issue of clinical preceptorships is an area where we can build alliances across all our specialties, across age groups and with other healthcare professions, and

Whereas, The an assembly directly addressing this resolution was introduced on March 21st, 2017 (A6820) after the MSSNY HOD deadline for timely submission, and

Whereas, The specifics of 1) exactly how much the tax credit could be, 2) how many maximum hours, and 3) what physicians could qualify for a tax credit as clinical preceptors for medical students, can be decided by our MSSNY Medical Education Committee; therefore, be it
Resolved, That our MSSNY support the development of a New York state-wide clinical preceptorship tax credit, whereby health care professionals can report on their tax returns the time that they precept for New York state training institution students, and be further

Resolved, That our MSSNY refer any legislation specific commentary of this resolution to our MSSNY Medical Education Committee, and be it further

Resolved, That our MSSNY delegation bring forward any finalized proposal related to preceptorship tax credits to the AMA to seek similar relief in the form of a federal tax credit.
RECOMMENDATION:
Madam Speaker, Your Reference Committee recommends that the policies contained in 2017 Public Health and Education Sunset Report be acted upon in the manner indicated and that the remainder of this report be filed:

REAFFIRM

10.987 Reflective Tape for Clothing:
MSSNY encourages the use of reflective clothing for the protection of pedestrians, joggers, and bicyclists during times of poor visibility, inasmuch as the use of reflective tape prevents accidents through increased visibility. (Council 6/13/91; Reaffirmed HOD 2007-153)

RECOMMENDATION: REAFFIRM. Policy is still relevant and should be maintained.

320.992 Reduction of Trans Fats in Food Preparation in Restaurants on a Statewide Basis:
MSSNY will support and encourage the reduction of trans fats in food preparation in restaurants on a statewide basis. (Council 1/25/07)

RECOMMENDATION: REAFFIRM. This policy is still relevant and should be reaffirmed.

50.992 Continuing Medical Education Application Forms:
MSSNY approved revised Continuing Medical Education application forms to be consistent with new standards and accreditation criteria mandated by the Accreditation Council for Continuing Medical Education (ACCME). (Forms are available from MSSNY’s Office of Continuing Medical Education.) (Council 12/13/07)

RECOMMENDATION: REAFFIRM. MSSNY still uses the CME application in question. Although the Subcommittee on Educational Programs has begun to consider making revisions to the form, those discussions are still preliminary. Once revisions have been identified and approved by the full CME Committee, those changes may be submitted to MSSNY Council.

50.993 Continuing Medical Education Mission Statement:
MSSNY adopted the following revised Mission Statement:

CME Purpose and Goal:
The Office of Continuing Education of the Medical Society of The State of New York (MSSNY) is committed to support a statewide system of effective continuing medical education which provides offers all physicians with broad learning opportunities to increase their skills.

The goal of this system is to upgrade medical care throughout the state by maintaining, augmenting, and updating physicians' knowledge, skills and attitudes in order to facilitate delivery of optimal medical care to their patients. This is done by providing educational programming and accreditation of providers of Continuing Medical Education (CME) throughout the state.
Content Areas:
The Continuing Medical Education Program of MSSNY strives to provide educational activities relevant to the practice of all recognized medical disciplines and include forums for public health, socio-economic, ethical and legal issues related to the provision of quality healthcare.

To implement this most effectively, MSSNY, in addition to the educational offerings it provides and sponsors directly, shall also interact and cooperate as an accredited joint sponsor with non-accredited providers of continuing medical education. In this way, MSSNY is able to promote public health goals and an awareness of the public health resources available to physicians and their patients throughout New York State.

Target Audience:
Target audiences include physicians residing or practicing in New York State, with programs offered to physicians practicing in other states. MSSNY plays an important role in sharing education with other healthcare professionals.

Type of Activities:
MSSNY's continuing medical education offerings will promote high quality educational programs delivered in a cost effective and accessible manner. This will be accomplished by using innovative and conventional formats including:

- Didactic presentations, seminars, symposia, workshops, grand rounds
- Enduring material in a print, audio, video or internet format
- Interactive, live audio and video conferencing and web casting activities that encourage physician self-assessment and self-learning

Expected Outcomes of the Program:
Improvements to MSSNY's CME Program shall be made by evaluation of CME activities and self-assessment of the overall program. Measurable outcomes of our CME efforts include:

- Assessment of the achievement of MSSNY's overall CME Mission
- Participant satisfaction
- Measure practice performance through follow up surveys and evaluation
- Acknowledgement of our achievements by others. (Council 1/25/07)

RECOMMENDATION: REAFFIRM. Although the 2014 ACCME simplification of accreditation criteria eliminated the requirement that ACCME-accredited providers' mission statement contain CME purpose, content areas, target audience, type of activities, expected results, removing those components was not required. The MSSNY CME Committee chose to keep those sections in MSSNY's mission statement. The existing mission statement is still relevant and continues to guide MSSNY's CME program.

50.996 CME Mission Statement:
MSSNY, in order to provide the physicians of the State with the means to enhance their competence to deliver high quality medical care, affirms its obligation to support a statewide system of effective continuing medical education. The goal of this system is to upgrade medical care throughout the State by maintaining, augmenting and updating physicians' medical knowledge, skills and attitudes in order to facilitate their delivery of medical care to their patients. This CME system shall include educational activities relevant to the practice of all recognized medical disciplines. To implement this most effectively, MSSNY, in addition to the educational offerings it provides and sponsors directly, shall also interact and cooperate with other creditable sponsors and providers of continuing medical education. It shall be the policy of MSSNY that its continuing medical education offerings be reasonably accessible at reasonable cost to all physicians. MSSNY shall utilize all conventional formats and modes to provide and deliver continuing medical education. (Council 9/20/84; Reaffirmed Council 12/19/91; Revised Council 1/25/07..See Policy 50.993)

RECOMMENDATION: REAFFIRM. Policy is still relevant.
REAFFIRM WITH AMENDMENTS

10.989 Bicycle Helmets:
MSSNY supports legislation requiring the use of approved helmets by all bicyclists on New York State roadways, regardless of age, and has urged the Commissioner of the Department of Motor Vehicles to establish standards for bicycle helmets. (Council 1/26/89; HOD 1992-16 & HOD 2007-154)

RECOMMENDATION: REAFFIRM WITH MODIFICATION. This policy is still relevant and the modification enables MSSNY to support this concept through the legislative and/or regulatory process and recognizes that it is not the Commissioner of Motor Vehicles that sets national standards for bicycle helmets.

65.994 Dextromethorphan Abuse in Adolescents:
MSSNY supports regulation and/or legislation which would mandate policy that dextromethorphan-containing products be placed behind pharmacy counters to prevent abuse in adolescents. (HOD 2007-150)

RECOMMENDATION: REAFFIRM WITH MODIFICATION. Since 2013, New York prohibits pharmacies and stores from selling Dextromethorphan, found in over-the-counter cold medications, to minors unless they have a prescription. Under the law, all retail establishments selling DXM will be required to request proof of age unless the customer appears to be more than 25 years of age. Any retailer violating the new prohibition will be subject to a fine of $250 for each violation. A number of counties in the state including Nassau and Suffolk have already enacted a restriction on the retail sale of DXM to individuals age 18 years and younger. The modification was presented to update the policy to support law.

75.984 Medical Use of Marijuana/Synthetic Cannabinoids:
MSSNY will encourage additional research on the use of cannabinoid products in the treatment of illness and the relief of human suffering without penalty, and acknowledge the AMA Report, Medical Marijuana (A-01), as updated February 2007. (HOD 2007-151)

RECOMMENDATION: REAFFIRM WITH MODIFICATION. This policy is still germane, and the modification was to delete the reference to the 2007 AMA report on Medical Marijuana

300.947 Support Congressional Bills to FEDERAL DRUG ADMINISTRATION AUTHORITY TO Regulate Tobacco Products:
MSSNY will support federal legislation establishing the Food and Drug Administration's authority to regulate all tobacco products. (HOD 2007-163)

RECOMMENDATION: REAFFIRM WITH MODIFICATION. Previously, the FDA regulated cigarettes, cigarette tobacco, roll-your-own tobacco and smokeless tobacco, but in 2016, the FDA finalized a rule entitled, Deeming Tobacco Products to be Subject to the federal Food, Drug and Cosmetic Act, which extended the FDA’s authority to include the regulation of electronic nicotine delivery systems (such as e-cigarettes and vape pens), all cigars, hookah (waterpipe) tobacco, pipe tobacco and nicotine gels, among others. The FDA is now able to: review new tobacco products not yet on the market; prevent misleading claims by tobacco product manufacturers; evaluate the ingredients of tobacco products and how they are made; and communicate the potential risks of tobacco products. The regulation went into effect on August 8, 2016. The modification is to convey continued support of the FDA’s ability to regulate all tobacco products, including electronic nicotine delivery systems.

309.948 Tobacco Use and Smoking:

Public Health and Education ï 2017 Policy Sunset Report
MSSNY encourages its members to maintain a tobacco-free environment and prohibit all forms of tobacco use on their property and, supports efforts also, continue to educate physicians in tobacco cessation techniques based on the most recent treatment guidelines for tobacco use and dependence. (HOD 2007-162)

RECOMMENDATION: REAFFIRM WITH MODIFICATION. Policy is still germane and modification clarifies that MSSNY will support efforts to educate physicians in tobacco cessation.

312.985 Education as to the Benefits of the Human Papillomavirus (HPV) Vaccine:
MSSNY will: (1) supports educational efforts aimed at the general public regarding the Human Papillomavirus (HPV) vaccine and its benefits; and (2) supports and advocate for appropriate reimbursement rates associated with the administration, storage, and counseling of families regarding the Human Papillomavirus (HPV) vaccine. (HOD 2007-167)

RECOMMENDATION: REAFFIRM WITH MODIFICATION. This policy is still relevant and the modification was to update the wording of the policy.

312.987 Flu Vaccine Distribution:
MSSNY will: (1) seek recognition support the policy that physicians’ offices and/or clinics are the most appropriate sites for vaccinations; (2) support legislation or regulation that will ensure an adequate and timely supply of vaccines to physician offices and clinics; and (3) seek support legislation or regulation to ensure sufficient reimbursement to cover the cost of purchase, storage and administration of vaccinations, and a process for addressing the cost for, or return of, unused/outdated vaccination material. (HOD 2007-165)

RECOMMENDATION: REAFFIRM WITH MODIFICATION. This policy is still relevant and it is critical to have such policy to communicate to members of the NY Legislature and to departmental and the administration. The modification is to better articulate the MSSNY position in 2017.

SUNSET

15.958 Disclosure and Exchange of Health Information Among Providers:
MSSNY concludes that given the advances in comprehensive treatment and drug therapy of a patient with HIV/AIDS from 1986 to 2007, the exchange of HIV/AIDS information by one medical provider to another treating/consulting medical provider of the patient is routinely necessary for proper evaluation and treatment of the patient by that second treating/consulting medical provider.

In keeping with its support of the CDC’s Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Healthcare Settings – 2006, MSSNY supports the policy that general consent is sufficient for disclosure of health information, including HIV/AIDS information, through electronic means among providers for treatment purposes. (Council 6/14/07)

RECOMMENDATION: SUNSET. Accomplished. New York State laws have changed significantly to allow for easier access for medical providers to obtain HIV related information on patients. The law was changed in 2010, 2014 and 2015. These changes allow confidential HIV information may be released without a written statement prohibiting re-disclosure when routine disclosures are made to treating providers or to health insurers to obtain payment. Elimination of the requirement for written consent to conduct an HIV test and oral consent is now acceptable in all settings except for correctional facilities. There is also enhanced data sharing allowing for the sharing of surveillance data between local and state health departments and health care providers for the purpose of individual linkage and retention in care.

Public Health and Education ï 2017 Policy Sunset Report
15.959 Expanding HIV Screening: MSSNY endorses the Center for Disease Control and Prevention’s Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Healthcare Settings - 2006 and take the necessary steps to promote and implement these recommendations on the state and federal level. (Council 1/25/07; Reaffirmed HOD 2007-159)

RECOMMENDATION: SUNSET. Accomplished. New York State laws were changed in 2010, 2014, 2015, and 2016 that has implemented the bulk of the CDC’s recommendations. Testing for HIV must now be offered for individuals 13 years and older, and the law has allowed for oral consent for an HIV test.

15.960 Exchange/Disclosure of Health Information re HIV/AIDS Patients: MSSNY concludes that given the advances in comprehensive treatment and drug therapy of a patient with HIV/AIDS from 1986 to 2007, the exchange of HIV/AIDS information by one medical provider to other treating/consulting medical provider of the patient is routinely necessary for proper evaluation and treatment of the patient by that second treating/consulting medical provider.

Also, MSSNY, in keeping with MSSNY’s support of the CDC’s Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Healthcare Settings - 2006, supports the policy that general consent is sufficient for disclosure of health information, including HIV/AIDS information, through electronic means among providers for treatment purposes. (Council 6/14/07)

RECOMMENDATION: SUNSET. This is a duplicative policy of 15.958

15.961 Center for Disease Control’s Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Healthcare Settings - 2006:

MSSNY will promote and implement the following recommendations on the state and federal level:

~HIV Screening is recommended for all patients in all health-care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screenings).

~Persons at high risk for HIV infection should be screened for HIV at least annually.

~Separate written consent for HIV testing should not be required, general consent or medical care should be considered sufficient to encompass consent for HIV testing.

~Prevention counseling should not be required with HIV diagnostic testing or part of HIV screening programs in health-care settings.

~HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women. (Council 1/25/07)

RECOMMENDATION: SUNSET. Accomplished. New York State laws have changed significantly to allow for easier access for medical providers to obtain HIV related information on patients. The law was changed in 2010, 2014 and 2015. Testing for HIV must now be offered for individuals 13 years and older, and the law has allowed for oral consent for an HIV test has is now acceptable in all settings except for correctional facilities.

125.998 Use of CT Scans for Early Detection of Lung Cancer:

MSSNY to place on its website the white paper, Use of CT Scans for Early Detection of Lung Cancer, drafted by its Heart, Lung and Cancer Committee. (HOD 2007-164)

RECOMMENDATION: SUNSET. This policy has been superseded by a 2014 HOD policy 125.994 Use of CT Scans for Early Detection of Lung Cancer. The Medical Society of the State of New York supports screening for lung cancer with low dose computed tomography for
patients who meet current nationally recognized guidelines. (HOD 2014-157). Thus, Policy 125.998 is no longer needed.

195.969 Herpes Zoster Vaccine and Medicare Payment:
MSSNY will encourage Medicare to pay for the herpes zoster vaccine and the service of providing it. (HOD 2007-114)

RECOMMENDATION: SUNSET. The shingles shot isn’t covered by Medicare Part A (Hospital Insurance) or Medicare Part B (Medical Insurance), but Medicare Part D generally covers all commercially-available vaccines (like the shingles shot) needed to prevent illness. The Shingles vaccine is also covered under the Affordable Care Act if you get it during a preventive care visit.

260.929 Increasing the Blood Supply:
MSSNY will advocate to the Food and Drug Administration that its guidance is discriminatory to large populations of potential blood donors and that this policy has not kept pace with screening technology and with the spread of specific diseases; and, also, that a uniform screening of donors be put in place for all populations and that the lifetime restriction for men who have had sex with men since 1977 be eliminated. (HOD 2007-160)

RECOMMENDATION: SUNSET. The FDA’s original recommendations were outlined in the April 1992 memorandum, Revised Recommendations for the Prevention of Human Immunodeficiency Virus (HIV) Transmission by Blood and Blood Products. In December 2015, based on the new evidence, the FDA has changed its recommendation from the indefinite deferral for MSM to a 12 month blood donor deferral since last MSM contact. The FDA also changed its deferral recommendation rationale for those who have hemophilia or related clotting disorders. For other behavioral deferrals such as commercial sex workers and injection drug use, insufficient data are available to support a change to the existing deferral recommendations at this time.

260.930 Irradiation of Food Products:
MSSNY should join in supporting state and federal legislation urging the use of irradiation for appropriate food products to retard the spread of foodborne infectious disease and adopt American Medical Association Policy D-150.996, Irradiation of Foods in the United States which urges the Department of Agriculture to implement irradiation of appropriate foods in the United States prior to its distribution to the public. (HOD 2007-152)

RECOMMENDATION: SUNSET. It is unclear what legislation this policy was speaking to for MSSNY to support; however, the process is a regulatory one (begun in 1958) and those regulations were updated in 2014 which specify which food products can be irradiated. The U.S. Food and Drug Administration (FDA) allow the use of irradiation as a means for improving food safety and extending the shelf life of certain foods. Although not yet widely used, irradiation can kill the bacteria responsible for foodborne illness and food spoilage, as well as insects and parasites that may be present on food and it appears that this was the intent of the original policy.
Whereas, secondhand smoke is a major contributor to acute and chronic adverse health outcomes that affect children disproportionately; and

Whereas, according to the CDC, secondhand smoke can contribute to the following adverse medical problems in children: ear infections, more frequent and severe asthma attacks, infections of the respiratory system, and increased risk for SIDS; and

Whereas, a November, 2012 Center for Child and Adolescent Health Research and Policy study found that two out of three parents with smoke-free home policies don’t enforce the same rules in their car; and

Whereas, the AMA currently supports prohibiting smoking in vehicles that contain children and at least 15 states, including New York; therefore, be it

RESOLVED, that the Medical Society of the State of New York support legislation that prohibits smoking while operating or riding in a vehicle that contains children.

Relevant AMA Policy: H-490.410
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 – 151

Introduced by: Fifth and Sixth District Branches

Subject: Smoke-free Multi-unit Housing

Referred to: Reference Committee on Public Health and Education

Whereas, According to the National Institutes of Health National Cancer Institute, “Currently, most Americans are exposed to secondhand smoke, and children are at greatest risk; and

Whereas, According to the Centers for Disease Control and Prevention (CDC): “The main place young children are exposed to secondhand smoke is at home; and

Whereas, According to the CDC: “People with lower income and lower education are less likely to be covered by smoke free laws; and

Whereas, According to the American Lung Association: “Secondhand smoke is a threat for people with asthma and a serious indoor air pollutant that should be eliminated. Having smoke free housing is an important step to help those with lung disease; and

Whereas, According to the CDC: “There is no risk-free level of secondhand smoke exposure; even brief exposure can be harmful to health. Secondhand smoke harms children and adults, and the only way to fully protect nonsmokers is to eliminate smoking in all homes, worksites, and public places; and

Whereas, According to the CDC: “Smoke free laws can reduce the risk for heart disease and lung cancer among nonsmokers; and

Whereas, The American Lung Association states that multi-unit housing should be smoke free and advocates the passage of ordinances to require that multi-unit housing be smoke free; and

Whereas, The American Lung Association of California advocates for, “restrictions on smoking in the indoor and outdoor common areas of all types of multi-unit residences, with the option to create designated outdoor smoking areas that meet specific criteria; “Smoke free buffer zones that can expand to include neighboring property and/or balconies and patios of adjacent units to limit drifting secondhand smoke from entering nonsmoking areas; “Prohibitions on smoking inside the units of multi-unit residences, including apartments and condominiums; “Recommended procedures for designating nonsmoking units by landlords and homeowners’ associations; and “Robust enforcement mechanisms including no-smoking lease terms and options for private individuals and organizations to enforce the smoke free housing provisions; and

Whereas, Multiple municipalities have passed ordinances regulating secondhand smoke by prohibiting smoking in all multi-unit residences and common areas; therefore, be it

RESOLVED, That the Medical Society of the State of New York advocate for legislation that requires that multi-unit housing be 100 percent smoke free.
Whereas, Possession of small amounts of marijuana in New York State is supposed to be
decriminalized with the only penalty being a fine, but the person may still have to appear in court
and have a record; and

Whereas, The Governor has proposed that possession of these small amounts, even if in the
open, but not being smoked, will be only a violation with a fine; and

Whereas, Marijuana can cause significant negative effects on many regular smokers, especially
for those under age 25, but criminal records can also cause significant lifelong negative effects;
and

Whereas, The American Society of Addiction Medicine supports evaluation, education and, if
indicated, treatment for those possessing marijuana, rather than fines and punishment;
therefore, be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) support legislation or
regulation that seeks to offer those ticketed for marijuana possession the option of substance
use disorder evaluation or education rather than a fine; and be it further

RESOLVED, That in an effort to reduce substance use disorders, MSSNY support various
voluntary interventional approaches be tried and evaluated and compared for effectiveness to
simple fines.

Author COMMENTS
We realize that this is very similar to:

65.986 Treatment Rather than Arrest for Marijuana Possession
The Medical Society of the State of New York supports promotion of drug treatment to those arrested or fined for
marijuana related offenses and encourages communities to develop programs that emphasize drug treatment and
rehabilitation rather than criminalization of marijuana. (HOD 2015-165)

Our resolution addresses the current issue on the table this year, but so does 65.986. NYSAM wants to go to the
senate leaders and say, you should go along with the governor and make marijuana possession a violation but also
add this- an evaluation and education component, either as an alternative or as a requirement. If there is a question
try it as an alternative to fines and see what the success is. If MSSNY feels that 65.986 covers this then our
resolution may not need to be voted. In that case we can approach the senate now and not wait.
Whereas, Paraquat is a herbicide used to control a very broad range of weeds and other unwanted plants in more than 100 crops; and

Whereas, the US Environmental Protection Agency classifies Paraquat as a restricted use pesticide meaning that it can be used only by people who are licensed applicators; and

Whereas, Paraquat is highly toxic to animals and has serious and irreversible delayed effects if absorbed and as little as one teaspoonful of the active ingredient is fatal, with death occurring up to 30 days after ingestion; and

Whereas, while banned in 32 countries worldwide, it continues to be manufactured internationally for sale in the United States, where its use is actually on the rise; and

Whereas, in 2011, a US National Institutes of Health study showed a link between Paraquat use and Parkinson's disease in farm workers; a co-author of the paper said that people who used paraquat, or other pesticides with a similar mechanism of action, were more likely to develop Parkinson's Paraquat-induced toxicity in rats has also been linked to Parkinson's-like neurological degenerative mechanisms; a study by the Buck Institute for Research on Aging showed a connection between exposure to Paraquat and iron in infancy and mid-life Parkinson's in laboratory mice; a 2013 meta-analysis published in Neurology found that 'exposure to paraquat ... was associated with about a 2-fold increase in risk' of Parkinson's disease; therefore, be it

RESOLVED, that MSSNY seek state legislation to permanently ban the use of Paraquat in all forms in New York State, and be it further

RESOLVED, the MSNNY take this resolution to the AMA at its annual House of Delegates meeting in June, 2017, asking the AMA for appropriate legislation to permanently ban the use of Paraquat in all forms in the United States.

References:


Pezzoli, Gianni; Cereda, Emanuele (2013). "Exposure to pesticides or solvents and risk of Parkinson disease". Neurology. 80 (22): 2035–2041.
Whereas; the term "quarantine" is broadly defined as (1) a strict isolation imposed to prevent the spread of disease; (2) a period, originally 40 days, of detention or isolation imposed upon ships, persons, animals on arrival at a port (or place) when suspected of carrying some infectious or contagious disease, (3) a system of measures maintained by governmental authorities for the prevention of a disease; and

Whereas; a quarantine separates and restricts the movement of people who could have been exposed to a contagious disease; and

Whereas; quarantine stations are currently located at 20 ports of entry and land-border crossings where international travelers arrive; and

Whereas; these stations are staffed with quarantine medical and public health officers from the Centers for Disease Control (CDC); and

Whereas; these health officials decide whether possibly contagious individuals can enter the United States and what measures should be taken to prevent the spread of infectious diseases; and

Whereas; on January 19, 2017, the CDC issued new regulations that gave it broad authority to quarantine individuals; and

Whereas; these regulations outline how the federal government can restrict interstate travel during a health crisis, and establishes in-house oversight (with up to three layers of internal agency review) of whether someone should be detained, without providing a clear and direct path to challenge a quarantine order; and

Whereas; this internal review has no explicit time limit and could easily stretch on for weeks (and months) while a "possibly healthy" person remains in quarantine; and

Whereas; until now, most quarantines have been imposed by states and local governments, which have the primary responsibility for protecting the health of their population; and

Whereas; the new administration now has even more authority to detain people; and

Whereas; prompt judicial review has always been important during an epidemic, usually allowing people to challenge an order of quarantine; and

Whereas; the CDC now has clear authority to take over the quarantine role from States; and

Whereas; quarantine regulations are now being imposed based in part, on non-medical reasons, rather than scientific knowledge and findings, therefore, be it
RESOLVED, That given the recent Centers for Disease Control (CDC) guidelines granting it broad authority to impose quarantine measures, while establishing in-house oversight of whether someone should be detained and quarantined, that MSSNY urge the American Medical Association to seek legislation/regulation on a national level, that would immediately amend the federal quarantine law to ensure the availability of an expedited judicial review of all CDC imposed quarantines; and be it further

RESOLVED, That the AMA also seek legislation/regulation to guarantee that any quarantine measures being imposed be based solely upon medical/scientific knowledge and evidence and not motivated by non-medical reasons; and be it further

RESOLVED, That the AMA reaffirm its ethics policy E-2.25 “The Use of Quarantine and Isolation as Public Health Interventions” which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation intervention are based on science, and be it further

RESOLVED, That it be acknowledged that in many cases, states and local governments may be better equipped to handle quarantine situations without the need for federal government involvement.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 155

Introduced by: The Suffolk County Medical Society

Subject: Pediatric/Adolescent Informed Consent Concussion Discussion

Referred to: Reference Committee on Public Health and Education

Whereas, almost 500,000 emergency department visits for traumatic brain injury are made annually by children ages 0 to 14 years; and

Whereas, 50% of "second impact syndrome" incident brain injury caused from a premature return to activity after suffering initial concussion result in death; and

Whereas, 40% of sports-related concussions involved children between the ages of 8 and 13 year; and

Whereas, a substantial and growing body of scientific evidence exists that links repeated head trauma with degenerative brain disorders, such as early onset dementia; and

Whereas, awareness for coaches, trainers and athletes to be educated in the identification of concussions for referral to a licensed physician increases;

Whereas, Sports related concussion is a common injury likely underreported in pediatric and adolescent athletes, with the management of concussions after the diagnosis being focused on cognitive, behavioral, neurobiological; and neuropathological short and long term effects; and

Whereas, "Reduction of Sports-Related Injury and Concussion H-470.954" is an AMA adopted policy for concussion awareness promotion, with support for evidence-based, age-specific guidelines on its evaluation and management; and working along with state and specialty societies to continue education and enhance prevention, diagnosis, research and management; and

Whereas, in policy number 30.990, The Medical Society of the State of New York (MSSNY) promotes the New York State Department of Health's "When in Doubt...Take Them Out!" sports related concussion prevention campaign and the Sports Concussion Tool Kit developed by the American Academy of Neurology to its members; therefore, be it

RESOLVED, That in accordance with MSSNY's position of 30.990, which promotes sports related concussion prevention campaigns by the New York State Department of Health and the American Academy of Neurology, MSSNY seek legislation or regulation to reduce potential short and long term effects of Chronic Traumatic Encephalopathy by amending current school sporting related informed consents to include education and discussions with parents or guardians prior to pediatric and adolescent team enrollments; and be it further

RESOLVED, That MSSNY seek legislation or regulation to have embedded within school sports related informed consent permissions, clear information that states the effects of repeated head trauma which can lead to memory loss, impaired judgment, behavioral instabilities and degenerative brain disorders, including dementia later in life; and be it further

RESOLVED, That MSSNY ask the AMA to also seek legislation or regulation to include concussion discussions with parents/guardian of pediatric/adolescent children, during informed consent, prior to sport team enrollments with clearly written effects and the acknowledgement as such embedded in the consent forms.
Whereas, in "Privileging for Ultrasound Imaging" [H-230.960] of 2010:

1. Our AMA affirmed that ultrasound imaging is within the scope of practice of appropriately trained physicians;
2. AMA policy on ultrasound acknowledged that broad and diverse use and application of ultrasound imaging technologies exist in medical practice;
3. AMA policy on ultrasound imaging affirmed that privileging of the physician to perform ultrasound imaging procedures in a hospital setting should be a function of hospital medical staffs and should be specifically delineated on the Department's Delineation of Privileges form; and
4. AMA policy on ultrasound imaging states that each hospital medical staff should review and approve criteria for granting ultrasound privileges based upon background and training for the use of ultrasound technology and strongly recommends that these criteria are in accordance with recommended training and education standards developed by each physician’s respective specialty; and

Whereas, in "Diagnostic Ultrasound Utilization and Education" [H-480.950] of 2012:

1. Our AMA affirmed that ultrasound imaging is a safe, effective, and efficient tool when utilized by, or under the direction of, appropriately trained physicians and supports the educational efforts and widespread integration of ultrasound throughout the continuum of medical education; therefore, be it

RESOLVED, that the Medical Society and the AMA support 4-year, vertical instruction and training regarding the concept, implementation, and utilization in clinician-performed, point-of-care ultrasound; and be it further

RESOLVED, that the Medical Society and the AMA communicate with US medical schools urging the inclusion of clinician-performed, point-of-care ultrasound instruction and training; including didactic and practical experiences covering the application to a broad range of organ systems and procedures for a wide variety of future specialists.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017 - 157

Introduced by: Medical Society of the County of Kings

Subject: Development and Promotion of Evidence-based Ultrasound-First Radiation Mitigating Protocols

Referred to: Reference Committee on Public Health and Education

Whereas, the AMA has rich policy in both the education, avoidance, and awareness of the dangers of ionizing radiation; and

Whereas, in AMA Policy H-455.988 “Public Education on the Danger of Radiation Exposure”:

1. Our AMA encourages the appropriate federal agency to develop a nationwide public education program on the effects of radiation exposure; and

2. Our AMA supports public initiatives, such as the “Image Wisely” and “Image Gently” campaigns, which aim to increase awareness of radiation in the medical setting and reduce exposure; and

Whereas, in AMA Policy D-455.998 “Ionizing Radiation Exposure in the Medical Setting”:

1. Our AMA will convene a meeting (a) to examine the feasibility of monitoring and quantifying the cumulative radiation exposure sustained by individual patients in medical settings; and (b) to discuss methods to educate physicians and the public on the appropriate use and risks of low linear energy transfer radiation in order to reduce unnecessary patient exposure in the medical setting; and

Whereas, ultrasound does not utilize and in fact mitigates ionizing radiation exposure by reducing the use of computed tomography (CT); and

Whereas, ultrasound is less costly than both CT and magnetic resonance imaging (MRI) both in physical equipment cost and maintenance cost; therefore, be it

RESOLVED, that the Medical Society and the AMA encourages physicians to develop evidence-based Ultrasound-First Protocols using point-of-care ultrasound as the first imaging modality when deemed clinically appropriate; and be it further

RESOLVED, that the Medical Society and the AMA encourages physicians to develop evidence-based Ultrasound-First Protocols specifically to guide invasive procedures, to promote patient safety, and to enhance quality performance.
Whereas, since August 2013, most New York State prescribers are required to consult the Prescription Monitoring Program (PMP) Registry when writing prescriptions for Schedule II, III, and IV controlled substances; and

Whereas, since 2016, nearly all prescriptions written in NYS are done electronically with controlled substances requiring two step authentication; and

Whereas, the goal of decreasing the diversion and illegal sale of controlled substances is laudable, there is a hidden cost for all regulations, in this case the burden this places on hospital and physicians; and

Whereas, the intended goal is to control medications such as narcotics, these regulations also extend to include medications that do not require such tight controls; and

Whereas, pregabalin (Lyrica) is a medication used for neuropathic pain and seizures, Lacosamide (Vimpat) is a medication used predominately for seizures, and Carisoprodol (soma) is a muscle relaxant, and these medications do not have addictive qualities or any street value; and

Whereas, removing pregabalin, lacosamide and vimpat from the list of medications requiring consultation of the PMP, and two set authentication electronic prescribing would not adversely affect public health but would help remove a burden on physician; therefore, be it

RESOLVED, that Medical Society of this State New York work with all relevant agencies, including the New York State Department of Health and Bureau of Narcotic Enforcement, to make the necessary changes to allow that pregabalin, lacosamide and vimpat prescriptions can be treated like any other non-controlled medication prescriptions, and be it further

RESOLVED, that MSSNY support any legislative proposals that would accomplish the same goal.

Current MSSNY Policy: None
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Introduced by: Norman Wetterau MD, As an Individual Delegate, New York Society of Addiction Medicine

Subject: Complete Treatment of Opioid Overdoses in the Emergency Room

Referred to: Reference Committee on Public Health and Education

Whereas, 33,000 people in the US died from opioid overdose deaths in 2015, many who were teens and young adults; and

Whereas, Buprenorphine reduces the desire for other opioids, and blocks the effects of other opioids so that it is rare for patients on Buprenorphine to die of an overdose; and

Whereas, patients who go to an emergency room with a life threatening and totally treatable condition are usually connected to appropriate treatment while still in the hospital or shortly thereafter; and

Whereas, for various reasons young people who come to an emergency room with an overdose are often just given first aid with Narcan so they wake up, but are not immediately connected with additional treatment such as Buprenorphine; and

Whereas, our governmental officials and police at times appear to be more concerned with the overdose problems than some of our hospitals and emergency rooms; therefore be it

RESOLVED, That the Medical Society of the State of New York be on record that whenever possible, any opioid overdose patient seen in the emergency room who desires treatment, including Buprenorphine, be connected to substance use disorder treatment within 24 hours; and it further

RESOLVED, That hospitals, administration and medical staff leadership encourage their medical staff to become certified to prescribe Buprenorphine in the same way they encourage medical staff to prescribe other new life saving medications and treatments; and be it further

RESOLVED, That MSSNY delegates who are on staff at hospitals, share this goal with the administration of the hospitals where they have privileges.
Whereas, Supervised Injection Facilities (SIF) are places where people who inject drugs can self-administer pre-obtained drugs under the supervision of healthcare professionals or other staff; and

Whereas, facility staff members do not directly assist in injection but are present to provide sterile injection supplies, answer questions on safer injection practices, monitor for potential overdose, administer first aid if needed, and link people to healthcare and social services, such as housing, addiction treatment, and mental health support; and

Whereas, Supervised Injection Facilities (SIF) were first initiated in Switzerland in 1986; and

Whereas, Supervised Injection Facilities are now found in 11 countries with at least 100 sites functioning; and

Whereas, France opened a Supervised Injection Facility in 2016, and Vancouver, BC is rapidly expanding sites in response to a fentanyl crisis; and

Whereas, there is a growing coalition representing public health, academic, criminal justice reform, and other groups to establish a supervised injection facility in New York City; and

Whereas, in September 2016, the New York City Council agreed to fund a $100,000 study on the pros and cons of Supervised Injection Facilities; and

Whereas, The mayor of Ithaca, NY last year recommended a harm reduction program that included SIFs as a means of combatting the opioid and heroin crisis; and

Whereas, there is an extensive body of research on Supervised Injection Facilities which finds a strong association with reductions in overdose fatalities as well as potential reductions in HIV, HCV and other medical harms of injection drug use; and

Whereas, a study using this research found that opening Supervised Injection Facilities in San Francisco found that this intervention would be cost effective and potentially cost saving; and

Whereas; there has been discussion within the New York State Legislature about state funded Supervised Injection Facilities; therefore be it

RESOLVED, That the Medical Society of the State of New York advocate to the American Medical Association for a comprehensive study of Supervised Injection Facilities in the United States.

Resource:
http://prn.org/index.php/complications/article/using_supervised_injection_facilities_to_reduce_harm_and_improve_access_t o
Whereas, The resolution to have Pain as a 5th Vital sign removed from the clinical environment was discussed and passed as MSSNY policy at the 2015 HOD with very broad support; and

Whereas, Removal of Pain as a 5th vital sign from the clinical environment was also adopted by multiple other state medical societies and the AMA HOD in 2016; and

Whereas, The consensus of these representative physician groups was that pain is a patient reported symptom that can often help direct physician evaluation for potentially addressable clinical sources; and

Whereas, Many healthcare organizations and accreditation organizations, such as the Joint Commission, continue to aggressively push for the assessment and addressment of pain, and this represents a continued, misplaced emphasis on pain as a driver of clinical care and as a national patient care metric, despite the clear position of organized medicine; and

Whereas, The joint commission has pushed a national policy of Speak up (https://www.jointcommission.org/topics/speak_up_pain.aspx) in an effort to continue to focus on pain as an entity rather than a symptom of underlying pathology; and

Whereas, Several national legislators, including US senators, are pushing to address the issue of opioid use, addiction, and deaths by offering marijuana as an alternative Pain medication however, marijuana has not been demonstrated to be similarly efficacious to currently used pain medications in the management of painful conditions; therefore, be it

RESOLVED, That the Medical Society of the State of New York publically state that the ongoing focus on pain, pain assessment, and pain management is contributing to the opioid epidemic; and be it further

RESOLVED, That pain needs to be evaluated and treated within a medical model that addresses underlying pathophysiology and, when possible, addresses the source; and be it further

RESOLVED, That MSSNY support discontinuation of the use of pain as a metric to evaluate physicians and hospitals by accrediting organizations such as the Joint Commission, and be it further

RESOLVED, That MSSNY lobby the New York Legislature to have the use of pain as a 5th vital sign removed from both the clinical environment as well as all evaluator metrics in the State of New York.
Whereas, according to the Centers for Disease Control and Prevention, vaccines prevent an estimated 2.5 million deaths among children younger than age 5 every year; and

Whereas, one child dies every 20 seconds from a disease that could have been prevented by a vaccine because 1 in 5 children in the world do not have access to the life-saving immunizations that keep children healthy; and

Whereas, vaccine preventable diseases account for 90,000 adult deaths per year; and

Whereas, the appropriate use of vaccines benefits public and individual health and has resulted in the complete eradication of small pox globally and polio eradication in the Western Hemisphere; and

Whereas, there has been substantial reductions in childhood diseases due to immunizations; and

Whereas, the Medical Society of the State of New York has strongly endorsed numerous policies that support efforts to immunize the adult, adolescent, and child populations in New York State; and

Whereas, the Medical Society of the State of New York recently adopted Policy 312.973 which called for the repeal of all non-medical exemptions for childhood vaccines; and

Whereas, there is strong concern that the present federal administration may attempt to establish new vaccine policy based on unfounded and unscientific facts; and

Whereas, research has conclusively demonstrated that vaccines are not causally related to autism; therefore, be it

RESOLVED; That the Medical Society of the State of New York continue to support evidence that vaccines are an effective mechanism for controlling communicable disease and protecting public health; and be it further

RESOLVED, That the Medical Society of the State of New York continue to support vaccine guidance that is evidence-based; and be it further

RESOLVED, That the Medical Society of the State of New York oppose the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines; and be it further

RESOLVED, that a copy of this resolution be sent to the AMA for its consideration.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 163

Introduced by: Third and Fourth Districts

Subject: Survey: New York Physicians’ Attitudes toward Medical Aid in Dying

Referred to: Reference Committee on Public Health and Education

Whereas, the Medical Society of the State of New York exists to serve as a resource for its members and assist them in addressing the many issues and needs which they face in providing health care to their patients; and

Whereas, medical aid in dying is a practice that authorizes terminally ill adults in the last six months of life with decision-making capacity to request a prescription medication which they may self-administer to bring about a peaceful death if and when their suffering becomes intolerable; and

Whereas, an act to authorize medical aid-in-dying [bill # A-02382/S03151] is being considered in the New York state legislature; and

Whereas, six states (OR, WA, MT, VT, CA, CO) and the District of Columbia currently authorize medical aid in dying for terminally ill residents; and

Whereas, experience from almost two decades of rigorously observed and documented experience in Oregon demonstrates that the law has worked as intended, with no evidence of abuse; and

Whereas, public support for medical aid-in-dying is growing as evidenced by a 2015 survey of New York residents that showed 77% favor medical aid-in-dying as an end-of-life option; and

Whereas, surveys of physicians nationally, as well as in Colorado and Maryland, show majority support for medical aid-in-dying as an end-of-life option; and

Whereas, the New York State Academy of Family Physicians withdrew its opposition to medical aid in dying in favor of a neutral public policy stance at its 2016 Congress; and

Whereas, in response to a resolution introduced at the 2016 Annual House of Delegates Meeting, the American Medical Association’s Council on Ethical and Judicial Affairs is studying medical aid-in-dying as an end-of-life option, including consideration of data from states that currently authorize the practice and input from physicians who have provided medical aid-in-dying to qualifying patients; and

Whereas, MSSNY is the second-largest component of the AMA and whose AMA delegates will have the opportunity to provide input to the CEJA’s report and vote on its recommendation at the 2017 AMA Annual Meetings; therefore be it

RESOLVED, that the Medical Society of the State of New York conduct a membership (may substitute “physician”) survey to determine their attitudes toward medical aid-in-dying with a report of findings to the MSSNY House of Delegates.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 164

Introduced by: The Suffolk County Medical Society

Subject: Medical Spectrum of Gender

Referred to: Reference Committee on Public Health and Education

Whereas, The American Medical Association (AMA) policy H-295.878 addresses Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education, which promotes education among the medical community; and

Whereas, AMA policy H-65.976 addresses the Nondiscriminatory Policy for the Health Care Needs of LGBT Populations; and

Whereas, AMA policy H-295.879 addresses Improving Sexual History Curriculum in Medical School; and

Whereas, The AMA holds 36 distinct policies on LGBTQ issues; and

Whereas, The AMA and the Medical Society of the State of New York (MSSNY) focuses on correct education and understanding of medical issues and policy; gender, is currently incompletely understood as a binary selection; and

Whereas, an individual’s genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other; and

Whereas, variations in hormone receptors and hormones widen the scope of social understanding of gender, identity, and the continuum; therefore, be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) partner with appropriate medical organizations to inform and educate the community on the medical spectrum of gender identity as a complex interplay of gene expressions and biologic development.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017 - 165

Introduced by: MSSNY Medical Student Section

Subject: Development and Utilization of Clinical Decision Support Systems to Reduce Gender Disparities and Bias in Healthcare

Referred to: Reference Committee on Public Health and Education

Whereas, numerous studies have demonstrated the widespread existence of gender bias and disparities in the provision of health care; and

Whereas, it has been shown that women wait longer to receive cardiac-related diagnostic testing and care than men and are less likely than men to undergo cardiac-related treatment at all;\(^1\),\(^2\),\(^3\) and

Whereas, studies have shown significantly increased in-hospital deaths after myocardial infarctions in female patients, as compared with male patients;\(^4\) and

Whereas, there is evidence that female patients receive consistently less intensive treatment for acute myocardial infarction;\(^5\) and

Whereas, differences in mortality outcomes and provision of critical care have been found between men and women of similar age;\(^6\) and

Whereas, there exist gender disparities in referral patterns and wait times for orthopedic surgery, with evidence of women waiting longer for surgery from time of injury (20 vs. 14 months);\(^7\) and having worse pain and disability at the time of surgery;\(^8\) and

Whereas, the probability of developing somatiform or anxiety disorders is greater in women than in men and may therefore be falsely attributed to the cause of pain or illness in women, and that a gender-biased misdiagnosis may increase a patient’s anxiety and distress about an illness and further influence an incorrect somatiform or anxiety diagnosis;\(^9\),\(^10\) and

Whereas, it has been shown that patients with a feminine gender identity or presentation are at risk for gender-bias in health care regardless of biological sex;\(^11\) and

Whereas, it has been demonstrated that awareness of gender bias does not negate its effect;\(^12\) and

Whereas, it has been demonstrated that clinical decision support (CDS) systems are effective tools in diagnosis, management of disease, and improving patient safety;\(^13\) and

Whereas, a checklist CDS system has proven effective in reducing the rate of complications and mortality in surgical procedures;\(^14\) and

Whereas, prior to utilizing a CDS tool female trauma patients were prescribed appropriate venous thromboembolism (VTE) prophylaxis significantly less often than male patients (55.1% vs. 69.5%);\(^15\) and
Whereas, utilization of CDS increased prescription of VTE prophylaxis (from 76.4% to 95.6%) and completely eliminated the incidence of preventable VTE at Johns Hopkins Hospital; and

Whereas, CDS has been shown to eliminate significant differences in the appropriate prescription of VTE prophylaxis prescription for male (85.7%) and female (81.2%) patients; and

Whereas, it has been shown that an appropriate CDS tool is capable of reducing health care gender disparities through the reduction of gender bias; and

Whereas, the Commission to End Health Care Disparities seeks to ensure equitable, appropriate, effective, safe, and high quality care for all, with no gaps in services based on any medically irrelevant factor; and

Whereas the World Health Organization Commission on the Determinants of Health observed that taking action to improve gender equity in health is one of the most direct and potent ways to reduce health inequities and ensure effective use of health resources; and

Whereas, the AMA has existing policy declaring a commitment to eliminating healthcare disparities with a specific mention of racial and ethnic health disparities, but does not have a policy directly targeting gender-based health care disparities; and

Whereas, MSSNY has stated positions supporting the provision of equal health care and elimination of disparities in healthcare based on sex and gender identity, as well as a position to use EMR to prompt physicians about gaps in care of their patients and also help with clinical decision support; therefore be it

RESOLVED, that the MSSNY will support the development and implementation of clinical decision support systems designed to mitigate gender bias in diagnosis and treatment of conditions in which gender disparities are prevalent.

References:


**Relevant MSSNY Policy:**

285.992 Specialty Society Committees to Eliminate Health Care Disparities

MSSNY strongly encourages all state specialty medical societies to form a Committee to Eliminate Health Care Disparities. These committees should share ideas and work together with MSSNY’s Committee to Eliminate Health Care Disparities as a coalition. MSSNY also strongly encourages all state specialty medical societies to incorporate within their CME courses, lectures and other academic activities, relevant information about access to care, health literacy, cultural competency, workforce diversity, management options, compliance, outcomes and other factors that relate to healthcare disparities in their respective specialties, including race, ethnicity, sexual orientation and gender identity. In addition, MSSNY should develop a scientific accuracy rating system and report for all proposed New York State legislation impacting clinical services to include whether or not the legislation adheres to specialty practice guidelines and appropriateness criteria. (HOD 2013-163)

85.961 AMA Encouragement of State Medical Societies to Form Committees to Eliminate Health Care Disparities:

MSSNY’s Delegation to the American Medical Association will introduce a resolution at its next meeting requesting that the AMA (1) urge that the state medical societies that are not yet members of the AMA Commission to Eliminate Health Care Disparities join and participate in this important public health initiative and (2) strongly encourage all state medical societies to form a Standing Committee to Eliminate Health Care Disparities and that those committees share ideas and work together as a coalition. (HOD 2011-163)

285.998 Equality in the Provision of Quality Health Care:

The Medical Society of the State of New York (MSSNY) reaffirms its longstanding principle that it is unequivocally opposed to any form of discrimination in the provision of quality medical care to any individual because of race, color, religion, sex, sexual orientation, ethnic affiliation, national origin, or underlying disease process. The Society calls upon all component county medical societies as well as its entire membership to: a) be vigilant as to the existence of any such discrimination in the provision of health care in their respective areas; b) expend every effort towards eliminating such discriminatory practices wherever they may exist, regardless of the settings in which the health care is delivered. It is the position of MSSNY that the withholding of the best available care to any individual on a discriminatory basis is abhorrent to the Society, its membership, and the medical profession at large. The Society, therefore, vigorously affirms that equality of medical care should be scrupulously and compassionately afforded across the entire patient community, without exception. MSSNY’s Committee to Eliminate Health Care Disparities will continue to work with the AMA Commission to End Health Care Disparities to encourage other State Medical Societies and Specialty Societies to establish standing committees to help eliminate health care disparities wherever they exist. (Council 1/20/00; Reaffirmed HOD 2004-174; Reaffirmed Council 9/9/04; Revised and reaffirmed HOD 2014)

117.975 Recommendations of White Paper: Improve EHR Satisfaction

MSSNY adopts the following recommendations to improve implementation and satisfaction among users of Electronic Health Records (EHR)

1. Improve design and workflow so that EHR:
   1. Doesn’t take away time spent with patients
   2. Doesn’t interfere with doctor-patient relationship and
   3. Reduces total time spent on EHR per patient
   5. Workflow should be customizable not only to fulfill various needs of different specialties, but to accommodate needs of every individual physician as well.
   3. [sic] Reduce documentation that serves other than care of patients, and reconsider
   incentives and penalties.
   4. Reduce cost of EHR
   5. EHR should help generate necessary billing reports and allow e-prescription of medications
   6. EHR should prompt physicians about gaps in care of their patients and also help with clinical decision support.
   7. Improve interoperability between physicians and all healthcare providers. Peer to peer exchange should be the goal whether it’s direct or through an exchange.
8. Improve value of notes in telling the patient’s story and the thought process of the physician rather than the volume of data.
9. EHR should capture episodes of care rather than encounters.

**Relevant AMA and MSS Policy:**

**D-478.995 National Health Information Technology**

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare and Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology’s (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

**H-350.971 AMA Initiatives Regarding Minorities**

The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine; (2) Increased awareness and representation of minority physician perspectives in the Association’s policy development, advocacy, and scientific activities; (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities; (4) Response to inquiries and concerns of minority physicians and medical students; and (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.

**D-350.995 Reducing Racial and Ethnic Disparities in Health Care**

Our AMA’s initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

1. Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
2. Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
3. Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the “Doctors Back to School” program into secondary schools in minority communities.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 ï 166

Introduced by: MSSNY Committee to Eliminate Healthcare Disparities
Subject: Reinstate the AMA Commission to Eliminate Health Care Disparities
Referred to: Reference Committee on Public Health and Education

Whereas, in December 2016 the American Medical Association the Steering Committee dissolved the Commission to Eliminate Health Care Disparities (CHECD); and

Whereas, the AMA’s Steering Committee made the decision as they are responsible under CEHCD bylaws for establishing and maintaining the direction of the CEHCD, and making recommendations that are consistent with its mission, vision and functions; and

Whereas, the AMA has indicated that corporate sponsorship has waned in recent years and that the AMA is no longer collectively able to provide the resources necessary to generate income to support the CEHCD, and corporate sponsorship has waned in recent years; and

Whereas, there is a looming Congressional battle over the mechanism to provide health care which could significantly increase health disparities; and

Whereas, the Medical Society of the State of New York mission of its Committee to Eliminate Healthcare Disparities is to increase awareness of how factors such as race, ethnicity, culture and religious beliefs, sexual orientation; gender and gender identity contribute to both health and healthcare disparities, and

Whereas, the Medical Society of the State of New York’s Committee to Eliminate Health Care Disparities vision statement is call for a state healthcare system that bridges gaps and identifies potential bias in order to provide the highest quality care to all people throughout the state with respect for their race, ethnicity, culture and religious beliefs; sexual orientation, gender and gender identity; and

Whereas, there has been a recent increase in violence and discrimination amongst various people due to race, ethnicity, culture and religious beliefs, sexual orientation, gender and gender identify; and

Whereas, this violence may impact upon health and health outcomes, and

Whereas, reconstituting the AMA Commission to Eliminate Health Care Disparities is of utmost importance at this point in the history of the United States and sends a strong message to the country that medicine cares about these issues; therefore, be it

RESOLVED, that the Medical Society of the State of New York urge the American Medical Association to reinstate the Commission to Eliminate Health Care Disparities; and be it further

RESOLVED, that a copy of this resolution be sent to the AMA for its consideration at the 2017 Annual AMA House of Delegates.
INTRODUCED by Peter Liebert, MD and Robert Lerner, MD, as Individuals
Westchester County Delegates

SUBJECT: No Physicians' Organization Should Support Political Candidates Who Oppose Women's Choice

REFERRED TO: Reference Committee on Public Health and Education

WHEREAS, the Supreme Court, in Roe v. Wade, has clearly affirmed the right of women to make their own free choice of reproductive decisions; and

WHEREAS, the majority of physicians support women's decisions, consistent with physical and mental health considerations of those decisions; and

WHEREAS, associations representative of American physicians should reflect the consensus of physicians' and society's support of women's reproductive rights; and

WHEREAS, there are some politicians and political appointees who have publically declared their desire to roll back the progress of the last 100 years in regard to reproductive decisions; therefore,

BE IT

RESOLVED, that no physicians' organizations should support political candidates or appointees, including those to cabinet positions such as Secretary of Health and Human Services, who oppose women's choice and access to full reproductive services.
Introduced By: Niraj Acharya, MD, As an Individual Delegate, Kings County

Subject: Sickle Cell Anemia Research and Management Funding

WHEREAS, Sickle Cell anemia is a lifelong debilitating disease leading to significant suffering and premature death; therefore, be it

RESOLVED, MSSNY work with NY State Department of Health to increase funding for Sickle Cell Anemia research and management.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017- LATE D

Introduced By: Robert Hughes, MD, As an Individual
Past President & Trustee, MSSNY

Subject: Mandated Use of a Face Mask by those Not Receiving Flu Shots

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IF HOUSE COMMITTEE ON RULES, CREDENTIALS AND ORDER OF BUSINESS
RECOMMENDS ACCEPTANCE FOR BUSINESS, THIS WILL BECOME

Resolution 2017 - 169

Referred to: Reference Committee on Public Health and Education

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1 Whereas, there is no documented evidence to support the mandating of masks by hospital staff
2 in the hopes of restricting the spread of the influenza virus; therefore, be it
3 RESOLVED, the MSSNY oppose and ask for repeal of the regulation reading the mandatory
4 wearing of masks when an individual New Yorker chooses to not get the annual flu shot.
RECOMMENDATION:  
Madam Speaker, Your Reference Committee recommends that the policies contained in 2017 Reports of Officers and Administrative Matters Sunset Report be acted upon in the manner indicated and that the remainder of this report be filed:

REAFFIRM  
87.997 New York State Parking Placard for Physicians on Medical Call: MSSNY and county medical societies to work with New York State and local agencies in designing and implementing a dashboard parking placard, similar to those used by police and Boards of Education, to function in lieu of MD plates for member physicians for parking in restricted areas in the course of rendering medical care. (HOD 2007-158)

RECOMMENDATION: REAFFIRM. Although it seems unlikely that government agencies would support this, given current efforts to reduce the number of placards issues to government employees, there is no need to sunset it.

120.972 Association Health Insurance: MSSNY will seek legislation or regulation to enable insurers to provide association-specific health insurance alternatives for 501(c)(6) not-for-profit associations in the State of New York. (HOD 2007-211)

RECOMMENDATION: REAFFIRM. Our medical societies continue to be frustrated in this matter, but there is no reason to disavow the position statement.

267.999 Credentialing Materials: Timely Submission by Residency and Fellow Programs: MSSNY encourages: (a) residency programs and fellowship programs to submit credentialing and verification data requested on behalf of their graduating residents to the requesting agency within thirty days of the request; and (b) the Accreditation Council for Graduate Medical Education to establish an accreditation standard for residency and fellowship programs calling for submission of credentialing and re-credentialing verification data requested on behalf of their graduating residents to the requesting agency within thirty days of the request. (HOD 2007-201)

RECOMMENDATION: REAFFIRM. While not aware of current problems in this area, leaders of MSSNY’s resident and young physician sections agreed that the policy should stand, especially as no ACGME standard on this has been established.
MSSNY Task Force on Physician Stress and Burnout

Executive Summary
Highlights of Survey Findings
Fall 2016
The Impact of Clinician Burnout is Costly

Multiple Dose-related Relationships

Institutional & Patient Toll:
- Increased medical errors and malpractice claims
- Disruptive behavior
- Reduced empathy for patients, patient satisfaction
- Reduced patient adherence to treatment regimens
- Reduced career satisfaction

Financial Toll:
- 27% drop in patient satisfaction scores
- 40% of turnover costs attributed to work stress
- 114% increase of medical claims by employees
- 30% of short-term and long-term disability costs.

Personal Toll:
- Higher Suicide Rate among physicians- 400/yr.
- Substance abuse
- Divorce
- Coronary Heart Disease:
  CHD 1.4 fold up to 1.79 at high burnout levels.
  Dysregulated HPA axis
  Pro-inflammatory cytokines
  Inflammation biomarker
  Higher allostatic load

  Depression.

  54% of our MDs /DOs

Toker S. et al Psychosomatic Medicine 74:840-847)
# MSSNY STRESS AND BURNOUT TASK FORCE

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<td>Coaching resource development</td>
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<td>Outreach collaboration</td>
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<td>Liability companies</td>
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<td>Patient advocacy</td>
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<td>Hospital systems</td>
<td>Mike, Fouad, Jeff, William, Steve</td>
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<td>Medical Students Allopathic</td>
<td>Tony, Eunice</td>
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<tr>
<td>Medical Students Osteopathic</td>
<td>Art</td>
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**Burnout Task Force Members**

Atallah, Fouad  
Basile, Maria A.  
Bertin, Mark  
Dowling, Frank  
Hengerer, Arthur  
Moore, Donald  
Privitera, Michael - Chair  
Reid, Malcom  
Rothberg, Charles  
Selzer, Jeffrey  
Snitkoff, Louis  
Streck, William  
Walerstein, Steven  
Weiss, Anthony  
Zapata, Carlos

**MSSNY Staff:**

Schuh, Phil  
Donoghue, Tom  
Skelly, Eunice  
Bedient, Terrance.
MSSNY Survey to NYS Physicians

(11/16)

- **Demographics**: Age, Gender
- **Practice descriptions**: Type of area where practice, setting, location, specialty, full or part time, hours per week, academic or not.
- **Time percent breakdown**: clinical, research, administration, teaching
- **Mini-Z Burnout Survey** (Linzer et al)- Burnout incidence, satisfaction with job, stress from job, control over workload, sufficiency for time of documentation, calm vs. hectic practice atmosphere, personal value alignment with leaders, degree care team works together efficiently, perception of amount of time EMR documentation at home, proficiency of EMR use.
- **Factors that significantly contributed to stress levels** within categories: work related, legal, financial, relationship/ family, personal issues
- **Perceived barrier to getting mental health care, by reporting requirements**: License applications/ renewals, malpractice carrier applications/renewals, hospital privileging applications/renewals.
- **If could revisit career choice**, would you become a physician again?
- **Top two coping strategies** to deal with stress and burnout
- **Top two factors that sustain meaning** in professional work
- **Top two practical suggestions that MSSNY can do** to help reduce physician stress and burnout.
Key Survey Findings NYS Physicians

Â 70% of New York physicians feel a **great deal of stress** because of their job
Â 57% are **burned out**: 63% of females, 53% of males.
Â Half of New York physicians are **not satisfied with their jobs**
Â Only 58% of New York State physicians **would choose to be a physician** if they could revisit their career choice
Â **Inpatient and outpatient** docs about **same burnout**
Â **Peak Burnout**: 10-19 years out of training
Key findings MSSNY Survey

**Practice Setting:** Working in other HMO, highest burnout of 100% of docs

**Burnout and Primary (≥ 50% FTE) Professional responsibility:**
Clinical 58%
Administrative 51%
Teaching 38%
Research 31%

**Higher the hours of work per week the higher the burnout**

**Location of Practice:** North Country and Southern Tier stand out as higher Burnout

**Highest Burnout Specialties ≥ 60% Burnout**
Oncology 79%
Pain Management 75%
Neurology 73%
Urology 67%
Pediatrics 64%
Otolaryngology 64%
Emergency Medicine 64%
Vascular Surgery 60%
Family Practice 60%
Key Survey Issues cont’d

Major Drivers of Burnout
- Low Job Satisfaction
- High Stress
- Low Control
- Low Sufficiency of Time for Documentation
- Primary Work Area Hectic, Chaotic
- Lack of Value Alignment with Department Leaders
- Less Team Efficiency
- Amount of time spent on EMR at HOME

- Regardless of Proficiency with EMR Burnout rate is 53-62 % (not clearly differentiate or trend by proficiency)

- Of the Top 10 Work Stressors of NYS Docs, 80% are organizational/systemically based stressors

- Definite Barrier response on how important a barrier would it be for physicians to receive mental health care if they would have to report this on:
  - License Applications and Renewals: 67%
  - Malpractice Carrier applications and Renewals: 62%
  - Hospital Privileging applications and Renewals: 64%
## Top 10 Work Related Stressors in Physicians

**Answered:** 1,178  
**Skipped:** 13  

<table>
<thead>
<tr>
<th>Rank</th>
<th>Stressor</th>
<th>% Responses</th>
<th># Responses</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Length and degree of Documentation Requirements</td>
<td>65.99%</td>
<td>786</td>
</tr>
<tr>
<td>2</td>
<td>Extension of Workplace into Home Life (E-mail, completion of records, phone calls)</td>
<td>58.27%</td>
<td>694</td>
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<tr>
<td>3</td>
<td>Prior Authorizations for: Medications/Procedures/Admissions</td>
<td>54.74%</td>
<td>652</td>
</tr>
<tr>
<td>4</td>
<td>Dealing with difficult patients</td>
<td>51.89%</td>
<td>618</td>
</tr>
<tr>
<td>5</td>
<td>EMR functionality problems</td>
<td>51.05%</td>
<td>608</td>
</tr>
<tr>
<td>6</td>
<td>CMS/State/Federal laws and regulations</td>
<td>44.33%</td>
<td>528</td>
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<tr>
<td>7</td>
<td>Lack of voice in being able to decide what good care is</td>
<td>40.39%</td>
<td>481</td>
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<tr>
<td>8</td>
<td>Hospital/ Insurance company imposed Quality Metrics</td>
<td>38.87%</td>
<td>463</td>
</tr>
<tr>
<td>9</td>
<td>Dealing with difficult colleagues</td>
<td>31.49%</td>
<td>375</td>
</tr>
<tr>
<td>10</td>
<td>Requirement for increased CME/ Maintenance of Certification</td>
<td>31.49%</td>
<td>375</td>
</tr>
</tbody>
</table>
Higher Burnout occurs with:

Higher the **hours worked per week**

Higher the **stress on the job**

Lower the **job satisfaction**

Less control over workload
Higher Burnout occurs with:

- The less sufficient the time for documentation
- The less the alignment of professional values with department leaders
- The more hectic and chaotic the atmosphere of primary work area
- The more excessive the time spent on EMR at HOME
Importance of Sharing Data with Public

1. Public already aware of severe problem and have valid worries about the quality and safety of their care
2. Demonstrates scientific process used to solve public health crisis in healthcare
3. Transparency is important for trust and collaboration.
4. Increases confidence of public that we are being systematic, competent and responsible in solutions, drilling down to mechanisms of problems for sustainable solutions.
5. With sharing data, communication of information is paired with strategic methods of intervention, individually and organizationally.
March 31, 2017

REPORT OF THE PHYSICIAN STRESS AND BURNOUT TASK FORCE
To the 2017 House of Delegates
Michael R. Privitera, MD, Task Force Chair

INTRODUCTION

In 2015, the MSSNY House of Delegates passed resolution 2015-200, titled "Physician Health Programs and Membership Recruitment" which read as follows:

RESOLVED, That together with county medical societies, district branches and the Committee for Physician Health, the Medical Society of the State of New York develop a series of program, that may include CME credit, to assist physician in early identification and management of stress; and be it further
RESOLVED, That the programs concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties; and be it further
RESOLVED, That the Medical Society of the State of New York introduce a similar resolution to the 2015 Annual Meeting of the American Medical Association House of Delegates.

To oversee implementation of Resolution 2015-200, the MSSNY President appointed members representing various districts and specialties to the MSSNY Physician Stress and Burnout Task Force. Appointed as Chair was Michael Privitera, MD, Director of Physician Wellness at the University of Rochester Medical Center. The Task Force reviewed Resolution 2015-200 and assigned working groups to develop the key initiatives/goals. The broad stroke outline of plan of approach endorsed by Council in May follows:

1. Education of Physicians and Healthcare Systems. Causes, mechanisms, and overview on reduction. Information to help insist upon improvement at local state and national levels.
2. Website resources links, information on what to do individually and organizationally
3. Education of patient advocacy groups to understand the public health hazard of healthcare clinician burnout, effect on the healthcare system and patient wellbeing.
4. Position statement ideally jointly written with patient advocacy groups to be sent to Congress, EMR vendors, CMS, Federation of State Medical Boards, Consortium of Business Leaders and Insurance Industry (Leapfrog Group)

The Task Force concluded that MSSNY can be a leader and a voice for all sectors of physicians across New York State which could be an effective initiative to increase membership. Partnering with other organizations can be a pathway to reducing institutional factors contributing to burnout and improving the lives of physicians.

The Task Force meets monthly by conference call, supplemented by numerous subgroup meetings on specific project areas including Burnout Survey, Medical Student Engagement, Website, Peer Support, Graduate Medical Education, CME, educational programs for healthcare leaders, health insurance and malpractice insurance carriers.

**BURNOUT SURVEY INITIATIVE**

The Task Force conducted a survey through the MSSNY contact data base and had a robust response rate compared to other MSSNY surveys. The survey has appeared to strike a chord and appeared to be appreciated as per email responses. Sharing this data will make a strong case for MSSNY to be a voice for individual physicians especially in situations where they feel powerless, such as organizational and leadership issues. However, public distribution of the data should be coupled with a preliminary plan for interventions. It was noted that the most significant stressors are organizational, not clinical.

NYS Physician Top 10 significant work related stressors in rank-order are:

1. Length and degree of documentation requirements
2. Extension of workplace and a home (email, completion of records, phone calls)
3. Prior authorizations for medications/procedures/admissions
4. Dealing with difficult patients
5. EMR functionality problems
6. CMS/state/federal laws and regulations
7. Lack of voice and being able to decide what good care is
8. Hospital/insurance Company imposed quality metrics
9. Dealing with difficult colleagues
10. Requirement for his increased CME/maintenance of certification

**PEER SUPPORT INITIATIVE**

The Peer Support Work Group has been meeting since October, studying models of professional peer support programs from Stanford, Brigham and Women’s Hospital, and the NYC police organization providing peer assistance (POPPA). The Group is incorporating into its analysis a survey of the literature. Essential guiding principles are that a peer support program would be voluntary, confidential, timely, sustainable, peer-driven, independent, autonomous, focused on
empathy, compassion, and resilience. The Group concluded that (1) MSSNY develop a specific CME program on peer support and recruit a cadre of doctors to do such CME presentations (2) MSSNY develop a POPPA-type peer support entity to assist doctors when they need to reach out for help before it progresses to mental health or substance use disorders, and (3) MSSNY seek grant or other funding to develop a peer support program and bring to all hospitals practices in an ongoing way.

RECOMMENDATIONS

The Task Force submitted its recommendations for MSSNY Council action on 1-19-2017 and on 3-7-2017. After extensive discussion and reconsideration, Council approved the following Task Force recommendations:

1. MSSNY distribution of burnout survey data coupled with a preliminary plan for interventions; beginning with distribution of survey results at the House of Delegates and CME presentations during the annual meeting weekend.
2. Development of CME programs on physician stress and burnout, as well as the peer support model and recruit a cadre of doctors to do such CME presentations, presentations to leaders and other stakeholders.
3. Seeking grant or other funding to support CME, burnout study and program activities in an enduring way.
4. Continued collaboration with other organizations on burnout reduction and wellness efforts.
5. Development of a program to assist doctors when they need to reach out for help to sustain their wellness before it progresses to mental health or substance use disorder; charge MSSNY legal team and MSSNY staff to devise a solution which meets the needs of our members and maintains the legal and financial integrity of the MSSNY organization.
6. Recommend seeking a grant or other funding to help develop bring a peer support model to all county societies, hospitals and hospital systems, and practices in an ongoing way.

Respectfully submitted,

Michael R. Privitera, MD
Chair
MSSNY Physician Stress and Burnout Task Force

Task Force Members: Michael Privitera MD (8th District), Fouad Atallah MD (1st District), Maria Basile MD (2nd District), Mark Bertin MD (9th District), Frank Dowling MD (2nd District), Arthur Hengerer MD (7th District), Donald Moore MD (1st District), Malcolm Reid MD (1st District), Jeffrey Selzer MD (2nd District), Louis Snitkoff MD (3rd District), William Streck MD (3rd District), Steven Walerstein MD (2nd District), Antony Weiss MD (5th District), Carlos Zapata MD (2nd District), Charles Rothberg MD (2nd District).
MSSNY Task Force on Physician Stress and Burnout

Survey Findings

Fall 2016
Q1. What is your Age?

Age Group Vs. Burnout

Mean Age (Years): 53.4
Median Age (Years): 55.00
Q1. Age Group Vs. Burnout

The chart illustrates the distribution of burnout across different age groups. The y-axis represents the number of individuals, while the bars indicate whether they are burned out (NO), not burned out (YES), or have N/A information. The age groups are [0-24], [25-34], [35-44], [45-54], [55-64], [65-75], and [76-99]. The chart shows that the highest number of individuals in the [55-64] age group are burned out, followed by the [65-75] age group. The [0-24] age group has the lowest number of burned out individuals.
Q2. Gender

Answered: 1,177  Skipped: 14

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<thead>
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<th>Responses</th>
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</thead>
<tbody>
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<tr>
<td><strong>Male</strong></td>
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Q2. Gender

Answered: 1,177  
Skipped: 14

- Transgender/gender variant: 100% Burned Out, 0% Not Burned Out, 0% No Response
- Male: 53% Burned Out, 47% Not Burned Out, 1% No Response
- Female: 63% Burned Out, 37% Not Burned Out, 0% No Response
- Choose not to answer: 57% Burned Out, 36% Not Burned Out, 7% No Response
Q3. In what area do you primarily practice?
Answered: 1,179 Skipped: 12

![Bar chart showing the percentage of respondents who chose each area and whether they were burned out or not.](chart.png)

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<tr>
<td>Not Burned Out</td>
<td>41.22%</td>
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<tr>
<td>Not Burned Out</td>
<td>37.61%</td>
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**Total:** 1,191 responses
Q3. In what area do you primarily practice?

Answered: 1,179  Skipped: 12
Q4. What is your practice Setting (please check all that apply)?

Answered: 1,188  Skipped: 3

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<thead>
<tr>
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<th>Responses</th>
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<td>58%</td>
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<tr>
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<td>42%</td>
</tr>
<tr>
<td>11-50 Group Practice</td>
<td>8%</td>
</tr>
<tr>
<td>Burned out</td>
<td>68%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>32%</td>
</tr>
<tr>
<td>50-Larger Group Practice</td>
<td>6%</td>
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<tr>
<td>Hospital-Based Practice</td>
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<tr>
<td>Not Burned Out</td>
<td>47%</td>
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<tr>
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<td>46%</td>
</tr>
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<tr>
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<td>Burned out</td>
<td>62%</td>
</tr>
<tr>
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<td>38%</td>
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<tr>
<td>Training (Resident)</td>
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<tr>
<td>Other HMO model (contracted)</td>
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<td>100%</td>
</tr>
<tr>
<td>Not Burned Out</td>
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<tr>
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<td>Burned out</td>
<td>68%</td>
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<tr>
<td>Not Burned Out</td>
<td>32%</td>
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<tr>
<td>Unemployed</td>
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</tr>
<tr>
<td>Burned out</td>
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</tr>
<tr>
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<td>0%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0%</td>
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<tr>
<td>Other (Please specify)</td>
<td>8%</td>
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<tr>
<td>Burned out</td>
<td>96%</td>
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<tr>
<td>Not Burned Out</td>
<td>52%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>50%</td>
</tr>
<tr>
<td>Chose not to answer</td>
<td>0%</td>
</tr>
<tr>
<td>Burned out</td>
<td>96%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>0%</td>
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</tbody>
</table>

Total: 1,191
Q4. What is your practice setting (please check all that apply)?
Answered: 1,188   Skipped: 3

- Unemployed: 0%
- Training (Resident): 4%
- Training (Fellow): 2%
- Staff-Model HMOs (employed): 2%
- Private practice (solo): 21%
- Other HMO model (contracted): 0%
- Other (please specify): 8%
- Integrated Delivery System: 2%
- Hospital-Based Practice: 29%
- Choose not to answer: 0%
- 50-Larger Group Practice: 6%
- 2-10 Group Practice: 19%
- 11-50 Group Practice: 8%
- Other (please specify)
Q4. What is your practice setting (please check all that apply)?

Answered: 1,188   Skipped: 3

- Unemployed: 50% (No Response), 50% (Not Burned Out), 0% (Burned Out)
- Training (Resident): 62% (Not Burned Out), 38% (Burned Out)
- Training (Fellow): 53% (Not Burned Out), 47% (Burned Out)
- Staff-Model HMOs (employed): 68% (Not Burned Out), 32% (Burned Out)
- Private practice (solo): 53% (Not Burned Out), 46% (Burned Out)
- Other HMO model (contracted): 100% (Not Burned Out)
- Other (please specify): 52% (Not Burned Out), 45% (Burned Out)
- Integrated Delivery System: 48% (Not Burned Out)
- Hospital-Based Practice: 53% (Not Burned Out), 47% (Burned Out)
- Choose not to answer: 100% (Not Burned Out)
- 50-Larger Group Practice: 67% (Not Burned Out), 32% (Burned Out)
- 2-10 Group Practice: 58% (Not Burned Out), 42% (Burned Out)
- 11-50 Group Practice: 68% (Not Burned Out), 32% (Burned Out)
Q5. Are you in an academic setting?

Answered: 1,182 Skipped: 9

Choose not to answer

Yes

No

42%

57%

Choose not to answer

Answer Choices

In Academic Setting

Burned out

Not Burned Out

Did not Answer

NOT in Academic Setting

Burned out

Not Burned Out

Did not Answer

Choose not to answer

Total

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<td>22.22%</td>
</tr>
<tr>
<td>Total</td>
<td>1191</td>
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</tbody>
</table>
Q5. Are you in an academic setting?

Answered: 1,182 Skipped: 9

Choose not to answer
- No Response: 22%
- Not Burned Out: 33%
- Burned Out: 44%

No
- Not Burned Out: 40%
- Burned Out: 60%

Yes
- Not Burned Out: 47%
- Burned Out: 53%
Q6. On Each type of Professional responsibility, what % of your total time is spent? Total Should be 100% whether Full or Part Time

Answered: 1,176  Skipped: 15

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<tr>
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<th>Skipped</th>
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<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
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<td>63%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical</td>
<td>0%</td>
<td>42%</td>
<td>58%</td>
<td></td>
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<tr>
<td>Administrative</td>
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<td>41%</td>
<td>51%</td>
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<td>Clinical</td>
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<td>Burned Out</td>
<td>58.04%</td>
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<td>0.00%</td>
</tr>
<tr>
<td>Total</td>
<td>1,191</td>
</tr>
</tbody>
</table>

Q6 Definitions by % FTE

% Total should be 100% whether Full or Part time

Research/Scholarly activities ≥ 50% = Academic
Clinical activities ≥ 50% = Clinician
Teaching activities ≥ 50% = Teacher
Administrative activities ≥50% = Administrator

Consider Average Burnout % in each of these 4 cohorts.
Q7. In a typical week, how many hours do you work per week (please include work performed during on-call hours)?

Answered: 1,160  Skipped: 31

Mean: 60.14
Median: 55.00

Did Not Answer

Burned Out

Not Burned Out
Q7. In a typical week, how many hours do you work per week (please include work performed during on-call hours)?

Answered: 1,160  Skipped: 31

Mean: 60.14
Median: 55.00
MP1

Suggest just histograms of # of docs that work so many hours per week in each cohort and not break down by Burnout or No Burnout, as the previous slide (#14) presents that data well.

Privitera, Michael, 1/16/2017
Q8. Where do you spend the majority of your clinical time?

Answered: 1,145   Skipped: 46

**Bar Chart**

- **Outpatient**: 73%
- **Inpatient**: 23%
- **N/A**: 4%

**Answer Choices**

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<th>Responses</th>
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<td>Choose not to Answer</td>
<td></td>
</tr>
<tr>
<td>Burned out</td>
<td>3.86%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>50.00%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>39.13%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>
Q8. Where do you spend the majority of your clinical time?

Answered: 1,145  Skipped: 46

- **Outpatient**: 42% Not Burned Out, 57% Burned Out
- **N/A**: 39% Not Burned Out, 50% Burned Out
- **Inpatient**: 45% Not Burned Out, 55% Burned Out

- 0% No Response
Q9. Where is your practice located?

Answered: 1,167  
Skipped: 24

- Western New York: 0% Not Burned Out, 45% Burned Out
- Southern Tier: 2% Not Burned Out, 29% Not Burned Out, 55% Burned Out
- Central New York: 0% Not Burned Out, 44% Burned Out
- The North Country: 0% Not Burned Out, 29% Not Burned Out, 56% Burned Out
- Capital District: 0% Not Burned Out, 37% Not Burned Out, 63% Burned Out
- Hudson Valley: 1% Not Burned Out, 36% Not Burned Out, 63% Burned Out
- Long Island: 0% Not Burned Out, 47% Not Burned Out, 53% Burned Out
- NYC: 0% Not Burned Out, 45% Not Burned Out, 54% Burned Out

- No Response and Burned Out categories are not shown in the chart.
Q9. Where is your practice located?

Answered: 1,167  Skipped: 24

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
<th>Y/N</th>
</tr>
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<tbody>
<tr>
<td><strong>NYC</strong></td>
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<tr>
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<td></td>
<td>54.42%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td></td>
<td>45.35%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td></td>
<td>0.23%</td>
</tr>
<tr>
<td><strong>Long Island</strong></td>
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<tr>
<td>Burned out</td>
<td></td>
<td>52.60%</td>
</tr>
<tr>
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<tr>
<td><strong>Hudson Valley</strong></td>
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<td>63.39%</td>
</tr>
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<td>36.71%</td>
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<tr>
<td><strong>Capital District</strong></td>
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<td>63.29%</td>
</tr>
<tr>
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<td></td>
<td>36.71%</td>
</tr>
<tr>
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<td>0.00%</td>
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<td><strong>The North Country</strong></td>
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<td>70.59%</td>
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<td>55.91%</td>
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<tr>
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<td>44.09%</td>
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<td>0.00%</td>
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<td>1.82%</td>
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<td>45.34%</td>
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<td>45.83%</td>
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<td>16.67%</td>
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Q10. What is your specialty?
Answered: 1,163  Skipped: 28

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<td>Urology</td>
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<tr>
<td>Thoracic Surgery</td>
<td>1%</td>
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<tr>
<td>Rheumatology</td>
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<td>Radiology</td>
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<td>Plastic Surgery</td>
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<td>Physical Medicine and...</td>
<td>1%</td>
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<tr>
<td>Pediatric Care</td>
<td>9%</td>
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<tr>
<td>Pathology</td>
<td>1%</td>
</tr>
<tr>
<td>Pain Management</td>
<td>1%</td>
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<tr>
<td>Otolaryngology</td>
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<tr>
<td>Orthopedic Surgery</td>
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<tr>
<td>Ophthalmology</td>
<td>4%</td>
</tr>
<tr>
<td>Oncology</td>
<td>4%</td>
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<tr>
<td>OB-GYN</td>
<td>5%</td>
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<tr>
<td>No Answer</td>
<td>5%</td>
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<tr>
<td>Neurosurgery</td>
<td>0%</td>
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<tr>
<td>Neurology</td>
<td>2%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>2%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>2%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>4%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>5%</td>
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<tr>
<td>Dermatology</td>
<td>2%</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>0%</td>
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<tr>
<td>Cardiology</td>
<td>3%</td>
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<tr>
<td>Anesthesiology</td>
<td>4%</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>18%</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13%</strong></td>
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</table>
Q10. What is your specialty?

Answered: 1,163  Skipped: 28

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
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</thead>
<tbody>
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<td>Anesthesiology</td>
<td>3.53%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>2.94%</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>0.08%</td>
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<tr>
<td>Dermatology</td>
<td>2.10%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>4.87%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>12.68%</td>
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<tr>
<td>Gastroenterology</td>
<td>2.18%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>4.03%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>18.05%</td>
</tr>
<tr>
<td>Neurology</td>
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<tr>
<td>Neurosurgery</td>
<td>0.42%</td>
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<tr>
<td>OB-GYN</td>
<td>5.12%</td>
</tr>
<tr>
<td>Oncology</td>
<td>1.60%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>4.20%</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>4.53%</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>2.10%</td>
</tr>
<tr>
<td>Pain Management</td>
<td>0.67%</td>
</tr>
<tr>
<td>Pathology</td>
<td>0.84%</td>
</tr>
<tr>
<td>Pediatric Care</td>
<td>9.24%</td>
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<tr>
<td>Physical Medicine and Rehabilitation</td>
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</tr>
<tr>
<td>Plastic Surgery</td>
<td>1.76%</td>
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<tr>
<td>Psychiatry</td>
<td>5.96%</td>
</tr>
<tr>
<td>Radiology</td>
<td>3.44%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0.59%</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>0.50%</td>
</tr>
<tr>
<td>Urology</td>
<td>1.76%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>0.84%</td>
</tr>
<tr>
<td>No Answer</td>
<td>2.35%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>
Q10. What is your specialty?
Answered: 1,163  Skipped: 28
Q11. Are you still in training?

Answered: 1,180  Skipped: 11

- In Training: 5%
- Not In Training: 95%

**Answer Choices**

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes - In Training</td>
<td>5.00%</td>
</tr>
<tr>
<td>Burned Out</td>
<td>66.10%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>33.90%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00%</td>
</tr>
<tr>
<td>No - Not In Training</td>
<td>95.00%</td>
</tr>
<tr>
<td>Burned Out</td>
<td>56.47%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>43.26%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.27%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>
Would show as two graphs
One is % in Training and % not in training
Other is within those in training 56% Burned out, 43% not burned out
Not in training 66% Bured out, 34% not burned out.
Q11. Are you still in training?
Answered: 1,180  Skipped: 11

![Bar chart showing the percentage of respondents still in training and not in training.](chart.png)
Q12. If you answered NO to Q11, how many years have you been out of training?
Answered: 1,117
Skipped: 74
Q12. If you answered NO to Q11, how many years have you been out of training?

Answered: 1,117  Skipped: 74

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>[50+]</td>
<td>1.18% 14</td>
</tr>
<tr>
<td>Burned out</td>
<td>28.57% 4</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>71.43% 10</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>[40-49]</td>
<td>5.12% 61</td>
</tr>
<tr>
<td>Burned out</td>
<td>14.75% 9</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>81.97% 50</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>3.28% 2</td>
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<tr>
<td>[30-39]</td>
<td>23.51% 280</td>
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<tr>
<td>Burned out</td>
<td>51.07% 143</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>48.93% 137</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>[20-29]</td>
<td>25.10% 299</td>
</tr>
<tr>
<td>Burned out</td>
<td>59.53% 178</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>40.47% 121</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>[10-19]</td>
<td>18.98% 226</td>
</tr>
<tr>
<td>Burned out</td>
<td>67.26% 152</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>32.30% 73</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.44% 1</td>
</tr>
<tr>
<td>[0-9]</td>
<td>15.03% 179</td>
</tr>
<tr>
<td>Burned out</td>
<td>60.34% 108</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>39.66% 71</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>[In Training]</td>
<td>4.87% 58</td>
</tr>
<tr>
<td>Burned out</td>
<td>65.52% 38</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>34.48% 20</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>6.21% 74</td>
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<tr>
<td>Burned out</td>
<td>58.11% 43</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>36.49% 27</td>
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<tr>
<td>Did not Answer</td>
<td>5.41% 4</td>
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<tr>
<td>Total</td>
<td>1191</td>
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</table>
Q12. If you answered NO to Q11, how many years have you been out of training?

Answered: 1,117     Skipped: 74
Would not divide into burnout and not burned out, but just histograms of # of docs in each cohort.
Privitera, Michael, 1/16/2017
Q13. Are you working Full or Part Time?

Answered: 1,168  Skipped: 23

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
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</thead>
<tbody>
<tr>
<td>Full Time</td>
<td>85.79%</td>
</tr>
<tr>
<td>Burned Out</td>
<td>49.91%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>35.70%</td>
</tr>
<tr>
<td>No Answer</td>
<td>0.17%</td>
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<tr>
<td>Part Time</td>
<td>14.21%</td>
</tr>
<tr>
<td>Burned Out</td>
<td>7.02%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>7.19%</td>
</tr>
<tr>
<td>No Answer</td>
<td>0.00%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>
Two graphs
One is histogram of % full time and % Part time (not divided burnout or not burnout)
Other graph should be
Among those that are Part time 82/166 = 49% Burned out and 84/166 = 51% not burned out
Among Full Time.
583/1002 = 58% Burned out
417/1002 = 42% Not Burned out
Privitera, Michael, 1/16/2017
Q13. Are you working Full or Part Time?

Answered: 1,168  Skipped: 23

- **Part Time**
  - Not Burned Out: 51%
  - Burned Out: 49%

- **Full**
  - Not Burned Out: 42%
  - Burned Out: 58%
Q14. Overall, I am satisfied with my current job:

Answered: 1,184  Skipped: 7

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>12.33%</td>
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<tr>
<td>Agree</td>
<td>37.92%</td>
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<tr>
<td>Neutral</td>
<td>18.16%</td>
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<tr>
<td>Disagree</td>
<td>22.21%</td>
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<tr>
<td>Strongly Disagree</td>
<td>9.38%</td>
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<td>Total</td>
<td>100%</td>
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</table>

Responses: 146, 449, 215, 263, 111, 1,184
Q14. Overall, I am satisfied with my current job:
Answered: 1,184  Skipped: 7

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<tr>
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<th>Responses</th>
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</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>12%</td>
</tr>
<tr>
<td>Burned out</td>
<td>15%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>85%</td>
</tr>
<tr>
<td>Agree</td>
<td>38%</td>
</tr>
<tr>
<td>Burned out</td>
<td>46%</td>
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<tr>
<td>Not Burned Out</td>
<td>53%</td>
</tr>
<tr>
<td>Neutral</td>
<td>18%</td>
</tr>
<tr>
<td>Burned out</td>
<td>60%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>40%</td>
</tr>
<tr>
<td>Disagree</td>
<td>22%</td>
</tr>
<tr>
<td>Burned out</td>
<td>82%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>18%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>9%</td>
</tr>
<tr>
<td>Burned out</td>
<td>88%</td>
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<tr>
<td>Not Burned Out</td>
<td>12%</td>
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<tr>
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Q15. I feel a great deal of stress because of my job:
Answered: 1,185  Skipped: 6

Answer Choices

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<tr>
<td>Not Burned Out</td>
<td>185</td>
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<tr>
<td>Did not Answer</td>
<td>0</td>
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<tr>
<td>Neutral</td>
<td>200</td>
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<td>51</td>
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<tr>
<td>Not Burned Out</td>
<td>149</td>
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<tr>
<td>Did not Answer</td>
<td>0</td>
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<tr>
<td>Disagree</td>
<td>117</td>
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<tr>
<td>Burned out</td>
<td>8</td>
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<tr>
<td>Not Burned Out</td>
<td>109</td>
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<tr>
<td>Did not Answer</td>
<td>0</td>
</tr>
<tr>
<td>Strongly Disagree</td>
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<td>32</td>
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<tr>
<td>Did not Answer</td>
<td>51</td>
</tr>
<tr>
<td>Total</td>
<td>1,185</td>
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</tbody>
</table>

- Strongly Agree: 29.54% (350)
- Burned out: 90.00% (315)
- Not Burned Out: 9.71% (34)
- Did not Answer: 0.29% (1)
- Agree: 39.41% (467)
- Burned out: 60.39% (282)
- Not Burned Out: 39.61% (185)
- Did not Answer: 0.00% (0)
- Neutral: 16.88% (200)
- Burned out: 25.50% (51)
- Not Burned Out: 74.50% (149)
- Did not Answer: 0.00% (0)
- Disagree: 9.87% (117)
- Burned out: 6.84% (8)
- Not Burned Out: 93.16% (109)
- Did not Answer: 0.00% (0)
- Strongly Disagree: 4.30% (51)
- Burned out: 35.29% (18)
- Not Burned Out: 62.75% (32)
- Did not Answer: 1.96% (51)
Q15. I feel a great deal of stress because of my job:

Answered: 1,185  Skipped: 6

- Strongly Disagree: 35% (Burned Out), 63% (Not Burned Out), 2% (No Response)
- Disagree: 7% (Burned Out), 93% (Not Burned Out), 0% (No Response)
- Neutral: 26% (Burned Out), 75% (Not Burned Out), 0% (No Response)
- Agree: 60% (Burned Out), 40% (Not Burned Out), 0% (No Response)
- Strongly Agree: 90% (Burned Out), 10% (Not Burned Out), 0% (No Response)
MP6  a little misleading and harder to follow the percents
Privitera, Michael, 1/16/2017

MP7  See notes on scanned notes
% breakdown of burnout in each category SD, D, N, A, SA
SA: 90%/10% (BO/NBO)
A: 60%/40%
N 26%/ 74%
D: 7%/93%
SD: 35%/63%
Privitera, Michael, 1/16/2017
Q16. Using your own definitions of "burnout", please select one of the answers below:

Answered: 1,184  
Skipped: 7

I enjoy my work. I have no symptoms of burnout.  

I am under stress, and don’t always have as much energy as I did, but I don’t feel burned out.

I am definitely burning out and have one or more symptoms of burnout, e.g., emotional exhaustion.

The symptoms of burnout that I am experiencing won’t go away. I think about work frustrations a lot.

I feel completely burned out. I am at the point where I may need to seek help.

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I enjoy my work. I have no symptoms of burnout.</td>
<td>10.05% 119</td>
</tr>
<tr>
<td>2. I am under stress, and don’t always have as much energy as I did, but I don’t feel burned out.</td>
<td>32.94% 390</td>
</tr>
<tr>
<td>3. I am definitely burning out and have one or more symptoms of burnout, e.g., emotional exhaustion.</td>
<td>34.29% 406</td>
</tr>
<tr>
<td>4. The symptoms of burnout that I am experiencing won’t go away. I think about work frustrations a lot.</td>
<td>19.68% 233</td>
</tr>
<tr>
<td>5. I feel completely burned out. I am at the point where I may need to seek help.</td>
<td>3.04% 36</td>
</tr>
</tbody>
</table>

Total Burnout Rate NYS Physician Respondents = 3.04% + 19.68% + 34.29% = 57.01%
SEE NUMBERS BELOW IN BLACK WHICH I COPIED OVER FROM THE SLIDE SET SENT TO YOU. Positive burnout is answer #3, 4 or 5, so the addition 34.29% + 19.68% + 3.04% = 57.01%
I took my numbers from the Survey Monkey printout which still added up to 57.01%. Just can put in the numbers you came up with to match the table %'s.
Privitera, Michael, 1/16/2017
Q17. My control over my workload is:

Answered: 1,183  Skipped: 8

<table>
<thead>
<tr>
<th>Control Level</th>
<th>Answers</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal</td>
<td>4.65%</td>
<td>55</td>
</tr>
<tr>
<td>Burned out</td>
<td>5.45%</td>
<td>3</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>92.73%</td>
<td>51</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>1.82%</td>
<td>1</td>
</tr>
<tr>
<td>Good</td>
<td>16.48%</td>
<td>195</td>
</tr>
<tr>
<td>Burned out</td>
<td>24.62%</td>
<td>48</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>75.38%</td>
<td>147</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>26.46%</td>
<td>313</td>
</tr>
<tr>
<td>Burned out</td>
<td>44.41%</td>
<td>139</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>55.59%</td>
<td>174</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Marginal</td>
<td>37.36%</td>
<td>442</td>
</tr>
<tr>
<td>Burned out</td>
<td>74.21%</td>
<td>328</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>25.57%</td>
<td>113</td>
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<tr>
<td>Did not Answer</td>
<td>0.23%</td>
<td>1</td>
</tr>
<tr>
<td>Poor</td>
<td>15.05%</td>
<td>178</td>
</tr>
<tr>
<td>Burned out</td>
<td>87.08%</td>
<td>155</td>
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<tr>
<td>Not Burned Out</td>
<td>12.92%</td>
<td>23</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>1,183</strong></td>
</tr>
</tbody>
</table>
Q17. My control over my workload is:

Answered: 1,183  Skipped: 8

- Poor: 87% Burned Out, 13% Not Burned Out, 0% No Response
- Marginal: 74% Burned Out, 26% Not Burned Out, 0% No Response
- Satisfactory: 44% Burned Out, 56% Not Burned Out, 0% No Response
- Good: 25% Burned Out, 75% Not Burned Out, 0% No Response
- Optimal: 5% Burned Out, 93% Not Burned Out, 2% No Response
SEE COMMENTS I WROTE ON SLIDE 31. YOU COULD PRESENT LIKE THE SUGGESTIONS I WROTE THERE [KIND OF LIKE THE WAY YOU DID SLIDE #5 OR SLIDE #3.

Privitera, Michael, 1/16/2017
Q18. Sufficiency of time for documentation is:

Answered: 1,180  Skipped: 11

**Answer Choices**

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal</td>
<td>1.44%</td>
</tr>
<tr>
<td>Burned out</td>
<td>17.65%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>82.35%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00%</td>
</tr>
<tr>
<td>Good</td>
<td>8.47%</td>
</tr>
<tr>
<td>Burned out</td>
<td>24.00%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>76.00%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00%</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>21.69%</td>
</tr>
<tr>
<td>Burned out</td>
<td>39.06%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>60.94%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00%</td>
</tr>
<tr>
<td>Marginal</td>
<td>36.02%</td>
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<tr>
<td>Burned out</td>
<td>36.29%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>40.71%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00%</td>
</tr>
<tr>
<td>Poor</td>
<td>32.37%</td>
</tr>
<tr>
<td>Burned out</td>
<td>76.44%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>23.04%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.52%</td>
</tr>
<tr>
<td>Total</td>
<td>1,180</td>
</tr>
</tbody>
</table>

**Diagram**

- **Poor**: 32%
- **Marginal**: 36%
- **Satisfactory**: 22%
- **Good**: 8%
- **Optimal**: 1%
Q18. Sufficiency of time for documentation is:

Answered: 1,180  Skipped: 11

- Poor: Burned Out 76%, Not Burned Out 23%, No Response 1%
- Marginal: Burned Out 59%, Not Burned Out 41%
- Satisfactory: Burned Out 39%, Not Burned Out 61%
- Good: Burned Out 24%, Not Burned Out 76%
- Optimal: Burned Out 18%, Not Burned Out 82%
SAME ISSUES AS SLIDE #31 AND SLIDE #34 WITH SAME SUGGESTIONS.
Q19. Which number best describes the atmosphere in your primary work area?

Answered: 1,182  Skipped: 9

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hectic, chaotic</td>
<td>29.19%</td>
<td>345</td>
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<td>Burned out</td>
<td>79.42%</td>
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<tr>
<td>Not Burned Out</td>
<td>20.29%</td>
<td>70</td>
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<td>0.29%</td>
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<tr>
<td>Busy, but reasonable</td>
<td>63.87%</td>
<td>755</td>
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<tr>
<td>Burned out</td>
<td>50.07%</td>
<td>378</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>49.93%</td>
<td>377</td>
</tr>
<tr>
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<td>0</td>
</tr>
<tr>
<td>Calm</td>
<td>6.94%</td>
<td>82</td>
</tr>
<tr>
<td>Burned out</td>
<td>23.17%</td>
<td>19</td>
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<tr>
<td>Not Burned Out</td>
<td>75.61%</td>
<td>62</td>
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<tr>
<td>Choose not to Answer</td>
<td>1.22%</td>
<td>1</td>
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<tr>
<td>Total</td>
<td></td>
<td>1,182</td>
</tr>
</tbody>
</table>

Hectic, chaotic: 29.19% (345 responses)
Busy, but reasonable: 63.87% (755 responses)
Calm: 6.94% (82 responses)
Q19. Which number best describes the atmosphere in your primary work area?

- Calm: 23% Burned Out, 76% Not Burned Out, 1% No Response
- Busy, but reasonable: 50% Burned Out, 50% Not Burned Out, 0% No Response
- Hectic, chaotic: 79% Burned Out, 20% Not Burned Out, 0% No Response

Answered: 1,182 Skipped: 9
SAME SUGGESTIONS AS #31 AND #34
Privitera, Michael, 1/16/2017
Q20. My professional values are well aligned with those of my department leaders:

Answered: 1,174  Skipped: 17

- Strongly agree: 11%
- Agree: 29%
- Neither agree nor disagree: 32%
- Disagree: 19%
- Strongly disagree: 10%

- Burned out: 35% (116, 156, 213, 223, 73%)
- Not Burned Out: 65% (82, 180, 42%, 27%, 19%)
Q20. My professional values are well aligned with those of my department leaders:

Answered: 1,174  Skipped: 17

Strongly disagree: 81% Burned Out, 19% Not Burned Out, 0% No Response

Disagree: 73% Burned Out, 27% Not Burned Out, 0% No Response

Neither agree nor disagree: 58% Burned Out, 42% Not Burned Out, 0% No Response

Agree: 46% Burned Out, 53% Not Burned Out, 0% No Response

Strongly Agree: 35% Burned Out, 65% Not Burned Out, 0% No Response

Burned Out
Not Burned Out
No Response
SAME SUGGESTIONS AS #31 AND #34
Privitera, Michael, 1/16/2017
Q21. The degree to which my care team works efficiently together.
Answered: 1,178
Skipped: 13

Answer Choices

<table>
<thead>
<tr>
<th></th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal</td>
<td>7.13%</td>
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<tr>
<td>Burned out</td>
<td>22.62%</td>
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<td>77.38%</td>
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<td>0.00%</td>
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<tr>
<td>Good</td>
<td>37.86%</td>
</tr>
<tr>
<td>Burned out</td>
<td>48.65%</td>
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<tr>
<td>Not Burned Out</td>
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<tr>
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<td>0.22%</td>
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<tr>
<td>Satisfactory</td>
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<tr>
<td>Burned out</td>
<td>60.89%</td>
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<tr>
<td>Not Burned Out</td>
<td>39.11%</td>
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<tr>
<td>Marginal</td>
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<td>73.83%</td>
</tr>
<tr>
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</tr>
<tr>
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<td>0.47%</td>
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<tr>
<td>Poor</td>
<td>4.50%</td>
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<tr>
<td>Burned out</td>
<td>84.91%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>15.09%</td>
</tr>
<tr>
<td>Choose not to Answer</td>
<td>0.00%</td>
</tr>
<tr>
<td>Total</td>
<td>1,178</td>
</tr>
</tbody>
</table>
Q21. The degree to which my care team works efficiently together.
Answered: 1,178  Skipped: 13

- Poor: 85% Burned Out, 15% Not Burned Out
- Marginal: 74% Burned Out, 26% Not Burned Out
- Satisfactory: 61% Burned Out, 39% Not Burned Out
- Good: 49% Burned Out, 51% Not Burned Out
- Optimal: 23% Burned Out, 77% Not Burned Out

Legend:
- Blue: Burned Out
- Red: Not Burned Out
- Green: No Response
SAME SUGGESTIONS AS #31 AND #34
Privitera, Michael, 1/16/2017
Q22. The amount of time I spend on the electronic health record (EHR) at home is:

Answered: 1,177  Skipped: 14

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal/none</td>
<td>29%</td>
</tr>
<tr>
<td>Modest</td>
<td>11%</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>9%</td>
</tr>
<tr>
<td>Moderately high</td>
<td>25%</td>
</tr>
<tr>
<td>Excessive</td>
<td>26%</td>
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</table>

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive</td>
<td>25.91%</td>
</tr>
<tr>
<td>Burned out</td>
<td>75.41%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>24.26%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.33%</td>
</tr>
<tr>
<td>Moderately high</td>
<td>24.89%</td>
</tr>
<tr>
<td>Burned out</td>
<td>60.07%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>39.59%</td>
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</tr>
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<td>Satisfactory</td>
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</tr>
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<td>Burned out</td>
<td>47.71%</td>
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<tr>
<td>Not Burned Out</td>
<td>52.29%</td>
</tr>
<tr>
<td>Did not Answer</td>
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</tr>
<tr>
<td>Modest</td>
<td>10.79%</td>
</tr>
<tr>
<td>Burned out</td>
<td>49.61%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>50.39%</td>
</tr>
<tr>
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<td>57.43%</td>
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<tr>
<td>Did not Answer</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Total: 1,177
Q22. The amount of time I spend on the electronic health record (EHR) at home is:

Answered: 1,177  Skipped: 14

- Minimal/none: 43% Burned Out, 57% Not Burned Out, 0% No Response
- Modest: 50% Burned Out, 50% Not Burned Out, 0% No Response
- Satisfactory: 48% Burned Out, 52% Not Burned Out, 0% No Response
- Moderately high: 60% Burned Out, 40% Not Burned Out, 0% No Response
- Excessive: 75% Burned Out, 24% Not Burned Out, 0% No Response
SAME SUGGESTIONS AS #31 AND #34
Privitera, Michael, 1/16/2017
Q23. My Proficiency with EHR use is:

Answered: 1,171  Skipped: 20

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal</td>
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<tr>
<td>Burned out</td>
<td>59.65%</td>
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<tr>
<td>Not Burned Out</td>
<td>40.35%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00%</td>
</tr>
<tr>
<td>Good</td>
<td>38.43%</td>
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<tr>
<td>Burned out</td>
<td>58.22%</td>
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<tr>
<td>Not Burned Out</td>
<td>41.56%</td>
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<tr>
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</tr>
<tr>
<td>Satisfactory</td>
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</tr>
<tr>
<td>Burned out</td>
<td>53.29%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>46.39%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.31%</td>
</tr>
<tr>
<td>Marginal</td>
<td>10.93%</td>
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<tr>
<td>Burned out</td>
<td>53.91%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>46.09%</td>
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<tr>
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</tr>
<tr>
<td>Poor</td>
<td>8.80%</td>
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<tr>
<td>Burned out</td>
<td>62.14%</td>
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<td>Not Burned Out</td>
<td>37.86%</td>
</tr>
<tr>
<td>Did not Answer</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Total: 1,171
Q23. My Proficiency with EHR use is:

Answered: 1,171  Skipped: 20

- Poor: 62% Burned Out, 38% Not Burned Out, 0% No Response
- Marginal: 54% Burned Out, 46% Not Burned Out, 0% No Response
- Satisfactory: 53% Burned Out, 46% Not Burned Out, 0% No Response
- Good: 58% Burned Out, 42% Not Burned Out, 0% No Response
- Optimal: 60% Burned Out, 40% Not Burned Out, 0% No Response
SAME SUGGESTIONS AS #31 AND #34
Q24. Work Related Issues:

Answered: 1,178  Skipped: 13

Dealing with difficult patients: 52%
Dealing with difficult colleagues: 31%
Lack of voice in being able to decide what good care is: 40%
Lack of personal accomplishment or career advancement: 24%
Requirement for increased CME/Maintenance of Certification: 31%
Prior authorizations for medications/procedures/admissions: 55%
CMS/State/federal laws and regulations: 44%
Hospital/insurance company imposed quality metrics: 39%
Extension of workplace into home life (E-mail, completion of records, phone calls): 58%
EMR functionality problems: 51%
Length and degree of documentation requirements: 66%
Teaching responsibilities (supervision, lecture preparation): 8%
Administrative duties (e.g. staff issues, meetings/committee work): 30%
Recent job change: 6%
On-call responsibilities: 21%
Q24. Work Related Issues:
Answered: 1,178  Skipped: 13

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-call responsibilities</td>
<td>21.33% 254</td>
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<tr>
<td>Recent job change</td>
<td>5.96% 71</td>
</tr>
<tr>
<td>Administrative duties (e.g. staff issues, meetings/committee work)</td>
<td>30.31% 361</td>
</tr>
<tr>
<td>Teaching responsibilities (supervision, lecture preparation)</td>
<td>8.40% 100</td>
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<tr>
<td>Length and degree of documentation requirements</td>
<td>65.99% 786</td>
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<tr>
<td>EMR functionality problems</td>
<td>51.05% 608</td>
</tr>
<tr>
<td>Extension of workplace into home life (E-mail, completion of records, phone calls)</td>
<td>58.27% 694</td>
</tr>
<tr>
<td>Hospital/insurance company imposed quality metrics</td>
<td>38.87% 463</td>
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<tr>
<td>CMS/State/federal laws and regulations</td>
<td>44.33% 528</td>
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<tr>
<td>Prior authorizations for medications/procedures/admissions</td>
<td>54.74% 652</td>
</tr>
<tr>
<td>Requirement for increased CME/ Maintenance of Certification</td>
<td>31.49% 375</td>
</tr>
<tr>
<td>Lack of personal accomplishment or career advancement</td>
<td>23.51% 280</td>
</tr>
<tr>
<td>Lack of voice in being able to decide what good care is</td>
<td>40.39% 481</td>
</tr>
<tr>
<td>Dealing with difficult colleagues</td>
<td>31.49% 375</td>
</tr>
<tr>
<td>Dealing with difficult patients</td>
<td>51.89% 618</td>
</tr>
<tr>
<td>Other</td>
<td>13.18% 157</td>
</tr>
<tr>
<td>Total Respondents 1,178</td>
<td>21.33%</td>
</tr>
</tbody>
</table>
### Q24. Work Related Issues:

Answered: 1,178  
Skipped: 13

<table>
<thead>
<tr>
<th>Rank order</th>
<th>Description</th>
<th>%Responses</th>
<th># Responses (Total # Respondents = 1183)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Length and degree of documentation requirements</td>
<td>65.99%</td>
<td>786</td>
</tr>
<tr>
<td>2</td>
<td>Extension of workplace into home life (E-mail, completion of records, phone calls)</td>
<td>58.27%</td>
<td>694</td>
</tr>
<tr>
<td>3</td>
<td>Prior authorizations for medications/procedures/admissions</td>
<td>54.74%</td>
<td>652</td>
</tr>
<tr>
<td>4</td>
<td>Dealing with difficult patients</td>
<td>51.89%</td>
<td>618</td>
</tr>
<tr>
<td>5</td>
<td>EMR functionality problems</td>
<td>51.05%</td>
<td>608</td>
</tr>
<tr>
<td>6</td>
<td>CMS/State/federal laws and regulations</td>
<td>44.33%</td>
<td>528</td>
</tr>
<tr>
<td>7</td>
<td>Lack of voice in being able to decide what good care is</td>
<td>40.39%</td>
<td>481</td>
</tr>
<tr>
<td>8</td>
<td>Hospital/insurance company imposed quality metrics</td>
<td>38.87%</td>
<td>463</td>
</tr>
<tr>
<td>9</td>
<td>Dealing with difficult colleagues</td>
<td>31.49%</td>
<td>375</td>
</tr>
<tr>
<td>10</td>
<td>Requirement for increased CME/ Maintenance of Certification</td>
<td>31.49%</td>
<td>375</td>
</tr>
<tr>
<td>11</td>
<td>Administrative duties (e.g. staff issues, meetings/committee work)</td>
<td>30.31%</td>
<td>361</td>
</tr>
<tr>
<td>12</td>
<td>Lack of personal accomplishment or career advancement</td>
<td>23.51%</td>
<td>280</td>
</tr>
<tr>
<td>13</td>
<td>On-call responsibilities</td>
<td>21.33%</td>
<td>254</td>
</tr>
<tr>
<td>14</td>
<td>Other</td>
<td>13.18%</td>
<td>157</td>
</tr>
<tr>
<td>15</td>
<td>Teaching responsibilities (supervision, lecture preparation)</td>
<td>8.40%</td>
<td>100</td>
</tr>
<tr>
<td>16</td>
<td>Recent job change</td>
<td>5.96%</td>
<td>71</td>
</tr>
</tbody>
</table>
Q25. Legal Issues:

Answered: 840  
Skipped: 351

<table>
<thead>
<tr>
<th>Legal Issues:</th>
<th>Responses</th>
</tr>
</thead>
</table>
| Fear of litigation  | 78.93%    | 663  
| Number of active lawsuits | 7.02% | 59  
| One major lawsuit   | 11.67%    | 98   
| Other               | 16.31%    | 137  
| Total Respondents   | 840       |      

Number of active lawsuits: 7%
One major lawsuit: 12%
Other: 16.31%
Q26. Financial Issues:
Answered: 887  Skipped: 304

<table>
<thead>
<tr>
<th>Financial Issue</th>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loan Payment</td>
<td>Burned out</td>
<td>167</td>
</tr>
<tr>
<td></td>
<td>Not Burned Out</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>Did not Answer</td>
<td>0</td>
</tr>
<tr>
<td>Financial obligations for family members</td>
<td>Burned out</td>
<td>233</td>
</tr>
<tr>
<td></td>
<td>Not Burned Out</td>
<td>120</td>
</tr>
<tr>
<td></td>
<td>Did not Answer</td>
<td>0</td>
</tr>
<tr>
<td>Cost of Living in the region where I work</td>
<td>Burned out</td>
<td>300</td>
</tr>
<tr>
<td></td>
<td>Not Burned Out</td>
<td>194</td>
</tr>
<tr>
<td></td>
<td>Did not Answer</td>
<td>0</td>
</tr>
<tr>
<td>Malpractice costs</td>
<td>Burned out</td>
<td>135</td>
</tr>
<tr>
<td></td>
<td>Not Burned Out</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>Did not Answer</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>Burned out</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>Not Burned Out</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Did not Answer</td>
<td>1</td>
</tr>
<tr>
<td>Total Respondents: 887</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q26. Financial Issues
Answered: 887
Skipped: 304

- Loan payment: 69% Burned Out, 31% Not Burned Out, 0% No Response
- Financial obligations for family members: 66% Burned Out, 34% Not Burned Out, 0% No Response
- Cost of living in the region where I work: 61% Burned Out, 39% Not Burned Out, 0% No Response
- Malpractice costs: 62% Burned Out, 38% Not Burned Out, 0% No Response
- Other: 58% Burned Out, 41% Not Burned Out, 1% No Response
SUGGESTIONS LIKE #31 AND #34
Privitera, Michael, 1/16/2017
Q27. Relationship/Family-related issues:

Answered: 933  
Skipped: 258

- Finding time to spend with significant other/children/family/friends: 82%
- Relationship difficulty with significant other/children/family/friends: 30%
- Separation/divorce: 6%
- Caring for an ill loved one: 15%
- Death of a loved one: 7%
- Other: 3%
## Q27. Relationship/Family-related issues:

Answered: 933  
Skipped: 258

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finding time to spend with significant other/children/family/friends</td>
<td>81.67%</td>
</tr>
<tr>
<td>Burned out</td>
<td>65%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>35%</td>
</tr>
<tr>
<td>Choose not Answer</td>
<td>0%</td>
</tr>
<tr>
<td>Relationship difficulty with significant other/children/family/friends</td>
<td>30.01%</td>
</tr>
<tr>
<td>Burned out</td>
<td>71%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>29%</td>
</tr>
<tr>
<td>Choose not Answer</td>
<td>0%</td>
</tr>
<tr>
<td>Separation/divorce</td>
<td>6.11%</td>
</tr>
<tr>
<td>Burned out</td>
<td>75%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>25%</td>
</tr>
<tr>
<td>Choose not Answer</td>
<td>0%</td>
</tr>
<tr>
<td>Caring for an ill loved one</td>
<td>15.11%</td>
</tr>
<tr>
<td>Burned out</td>
<td>71%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>28%</td>
</tr>
<tr>
<td>Choose not Answer</td>
<td>1%</td>
</tr>
<tr>
<td>Death of a loved one</td>
<td>7.40%</td>
</tr>
<tr>
<td>Burned out</td>
<td>61%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>39%</td>
</tr>
<tr>
<td>Choose not Answer</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>2.79%</td>
</tr>
<tr>
<td>Burned out</td>
<td>65%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>35%</td>
</tr>
<tr>
<td>Choose not Answer</td>
<td>0%</td>
</tr>
</tbody>
</table>

Total Respondents: 933
Q27. Relationship/Family-related issues:
Answered: 933  
Skipped: 258

- Finding time to spend with significant other/children/family/friends
  - Burned Out: 0%
  - No: 35%
  - Yes: 65%

- Relationship difficulty with significant other/children/family/friends
  - Burned Out: 0%
  - No: 29%
  - Yes: 71%

- Separation/divorce
  - Burned Out: 0%
  - No: 25%
  - Yes: 75%

- Caring for an ill loved one
  - Burned Out: 1%
  - No: 28%
  - Yes: 71%

- Death of a loved one
  - Burned Out: 0%
  - No: 39%
  - Yes: 61%

- Other
  - Burned Out: 0%
  - No: 35%
  - Yes: 65%
28. Personal Issues

Answered: 1,042
Skipped: 149

- Problems with your own health: 24.86%
- Recent or near retirement: 20.63%
- Change in living location/condition: 6.33%
- Finding Enough Time to do ...: 81.48%
28. Personal Issues

Answered: 1,042  Skipped: 149

Problems with your own health
- [0-24]: 6.95%
- [25-34]: 17.76%
- [35-44]: 20.08%
- [45-54]: 36.68%
- [55-64]: 15.83%
- [65-75]: 1.93%
- [76-99]: 0.00%

Finding Enough Time to do...
- [0-24]: 7.89%
- [25-34]: 18.14%
- [35-44]: 26.38%
- [45-54]: 33.57%
- [55-64]: 11.54%
- [65-75]: 0.35%
- [76-99]: 0.00%

Recent or near retirement
- [0-24]: 2.79%
- [25-34]: 46.51%
- [35-44]: 42.33%
- [45-54]: 6.98%
- [55-64]: 0.47%
- [65-75]: 0.00%
- [76-99]: 0.00%

Change in living location/condition
- [0-24]: 7.58%
- [25-34]: 19.70%
- [35-44]: 25.76%
- [45-54]: 24.24%
- [55-64]: 18.18%
- [65-75]: 3.03%
- [76-99]: 1.52%
28. Personal Issues
Answered: 1,042 Skipped: 149

- Change in living location/condition
- Recent or near retirement
- Finding Enough Time to do ...
- Problems with your own health

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Change in living condition</th>
<th>Recent or near retirement</th>
<th>Finding Enough Time to do</th>
<th>Problems with your own health</th>
</tr>
</thead>
<tbody>
<tr>
<td>[0-24]</td>
<td>5%</td>
<td>5%</td>
<td>82%</td>
<td>9%</td>
</tr>
<tr>
<td>[25-34]</td>
<td>5%</td>
<td>2%</td>
<td>73%</td>
<td>20%</td>
</tr>
<tr>
<td>[35-44]</td>
<td>6%</td>
<td>0%</td>
<td>72%</td>
<td>22%</td>
</tr>
<tr>
<td>[45-54]</td>
<td>6%</td>
<td>2%</td>
<td>75%</td>
<td>17%</td>
</tr>
<tr>
<td>[55-64]</td>
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<td>20%</td>
<td>57%</td>
<td>19%</td>
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<td>[65-75]</td>
<td>5%</td>
<td>38%</td>
<td>40%</td>
<td>17%</td>
</tr>
<tr>
<td>[76-99]</td>
<td>8%</td>
<td>60%</td>
<td>12%</td>
<td>20%</td>
</tr>
</tbody>
</table>
# 28. Personal Issues

Answered: 1,042  
Skipped: 149

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problems with your own health</strong></td>
<td>24.86%</td>
</tr>
<tr>
<td>[0-24]</td>
<td>0.19%</td>
</tr>
<tr>
<td>[25-34]</td>
<td>1.73%</td>
</tr>
<tr>
<td>[35-44]</td>
<td>4.41%</td>
</tr>
<tr>
<td>[45-54]</td>
<td>4.99%</td>
</tr>
<tr>
<td>[55-64]</td>
<td>9.12%</td>
</tr>
<tr>
<td>[65-75]</td>
<td>3.93%</td>
</tr>
<tr>
<td>[76-99]</td>
<td>0.48%</td>
</tr>
<tr>
<td><strong>Finding enough time to do hobbies / activities outside work / fun and recreation</strong></td>
<td>81.48%</td>
</tr>
<tr>
<td>[0-24]</td>
<td>1.73%</td>
</tr>
<tr>
<td>[25-34]</td>
<td>6.43%</td>
</tr>
<tr>
<td>[35-44]</td>
<td>14.78%</td>
</tr>
<tr>
<td>[45-54]</td>
<td>21.50%</td>
</tr>
<tr>
<td>[55-64]</td>
<td>27.35%</td>
</tr>
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<td>[65-75]</td>
<td>9.40%</td>
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<tr>
<td>[76-99]</td>
<td>0.29%</td>
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<tr>
<td><strong>Recent or near retirement</strong></td>
<td>20.63%</td>
</tr>
<tr>
<td>[0-24]</td>
<td>0.10%</td>
</tr>
<tr>
<td>[25-34]</td>
<td>0.19%</td>
</tr>
<tr>
<td>[35-44]</td>
<td>0.00%</td>
</tr>
<tr>
<td>[45-54]</td>
<td>0.58%</td>
</tr>
<tr>
<td>[55-64]</td>
<td>9.60%</td>
</tr>
<tr>
<td>[65-75]</td>
<td>8.73%</td>
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<td>[76-99]</td>
<td>1.44%</td>
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<tr>
<td><strong>Change in living location / conditions</strong></td>
<td>6.33%</td>
</tr>
<tr>
<td>[0-24]</td>
<td>0.10%</td>
</tr>
<tr>
<td>[25-34]</td>
<td>6.43%</td>
</tr>
<tr>
<td>[35-44]</td>
<td>14.78%</td>
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<td>[45-54]</td>
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</tr>
<tr>
<td>[65-75]</td>
<td>1.15%</td>
</tr>
<tr>
<td>[76-99]</td>
<td>0.19%</td>
</tr>
<tr>
<td><strong>Total Responses: 1,042</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>66.00%</td>
</tr>
</tbody>
</table>

Total Responses: 1,042
### 28. Personal Issues

**Answered:** 1,042  
**Skipped:** 149

#### Problems with your own health
- Burned Out: 17.27%  
- Not Burned Out: 7.49%  
- No Response: 0.10%

#### Finding enough time to do hobbies / activities outside work / fun and recreation
- Burned Out: 52.88%  
- Not Burned Out: 28.41%  
- No Response: 0.19%

#### Recent or near retirement
- Burned Out: 11.23%  
- Not Burned Out: 9.40%  
- No Response: 0.00%

#### Change in living location / conditions
- Burned Out: 3.17%  
- Not Burned Out: 3.17%  
- No Response: 0.00%

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems with your own health</td>
<td></td>
</tr>
<tr>
<td>Burned Out</td>
<td>24.86%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>7.49%</td>
</tr>
<tr>
<td>No Response</td>
<td>0.10%</td>
</tr>
<tr>
<td>Finding enough time to do hobbies / activities outside work / fun and recreation</td>
<td></td>
</tr>
<tr>
<td>Burned Out</td>
<td>81.48%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>28.41%</td>
</tr>
<tr>
<td>No Response</td>
<td>0.19%</td>
</tr>
<tr>
<td>Recent or near retirement</td>
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</tr>
<tr>
<td>Burned Out</td>
<td>20.63%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>9.40%</td>
</tr>
<tr>
<td>No Response</td>
<td>0.00%</td>
</tr>
<tr>
<td>Change in living location / conditions</td>
<td></td>
</tr>
<tr>
<td>Burned Out</td>
<td>6.33%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>3.17%</td>
</tr>
<tr>
<td>No Response</td>
<td>3.17%</td>
</tr>
<tr>
<td><strong>Total Responses:</strong> 1,042</td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
</tr>
</tbody>
</table>
OK TO LEAVE AS IS, IF HAVE TIME, THEN COULD TRY PRESENTING LIKE SUGGESTIONS OF #31 AND #34

Privitera, Michael, 1/16/2017
29. License Applications /Renewals?

Answered: 1,174  Skipped: 17

- Definitely not a barrier: 10%
- Not sure: 24%
- Definitely would be a barrier: 67%

Answer Choices

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely not a barrier</td>
<td>66.70%</td>
</tr>
<tr>
<td>Not Sure</td>
<td>23.59%</td>
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<tr>
<td>Definitely would be a barrier</td>
<td>9.71%</td>
</tr>
<tr>
<td>Total</td>
<td>66.70%</td>
</tr>
</tbody>
</table>
30. Malpractice Carriers’ applications/renewals?

Answered: 1,172  Skipped: 19

Answer Choices

<table>
<thead>
<tr>
<th>Definitely not a barrier</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely would be a barrier</td>
<td>62% 725</td>
</tr>
<tr>
<td>Not Sure</td>
<td>28% 325</td>
</tr>
<tr>
<td>Devinitely would be a barrier</td>
<td>10% 122</td>
</tr>
</tbody>
</table>

Total 1,172
Q31. Hospital Privilege credentialing applications / renewals?

Answered: 1,171  Skipped: 20

Definitely not a barrier: 12%
Not sure: 25%
Definitely would be a barrier: 64%

Answer Choices

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely not a barrier</td>
<td>63.96%</td>
</tr>
<tr>
<td>Not Sure</td>
<td>24.51%</td>
</tr>
<tr>
<td>Definitely would be a barrier</td>
<td>11.53%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

66
Q32. If you could revisit your career choice, would you choose to become a physician again?

Answered: 1,178  Skipped: 13

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely Not</td>
<td>8%</td>
</tr>
<tr>
<td>Burned Out</td>
<td>87%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>13%</td>
</tr>
<tr>
<td>No Response</td>
<td>0%</td>
</tr>
<tr>
<td>Probably Not</td>
<td>17%</td>
</tr>
<tr>
<td>Burned Out</td>
<td>75%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>25%</td>
</tr>
<tr>
<td>No Response</td>
<td>0%</td>
</tr>
<tr>
<td>Not Sure, Neutral</td>
<td>17%</td>
</tr>
<tr>
<td>Burned Out</td>
<td>70%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>30%</td>
</tr>
<tr>
<td>No Response</td>
<td>0%</td>
</tr>
<tr>
<td>Probably Yes</td>
<td>29%</td>
</tr>
<tr>
<td>Burned Out</td>
<td>55%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>45%</td>
</tr>
<tr>
<td>No Response</td>
<td>0%</td>
</tr>
<tr>
<td>Definitely Yes</td>
<td>29%</td>
</tr>
<tr>
<td>Burned Out</td>
<td>31%</td>
</tr>
<tr>
<td>Not Burned Out</td>
<td>68%</td>
</tr>
<tr>
<td>No Response</td>
<td>1%</td>
</tr>
</tbody>
</table>

Total                  | 1,178   |
Q32. If you could revisit your career choice, would you choose to become a physician again?

Answered: 1,178    Skipped: 13

- Definitely not: 0% Definitely not, 13% Not Burned Out, 87% Burned Out
- Probably not: 0% Definitely not, 25% Not Burned Out, 75% Burned Out
- Not sure, neutral: 0% Definitely not, 30% Not Burned Out, 70% Burned Out
- Probably yes: 0% Definitely not, 45% Not Burned Out, 55% Burned Out
- Definitely yes: 1% Definitely not, 31% Not Burned Out, 68% Burned Out
Q33. Please tell us about the top two coping strategies or tactics that help you cope with stress and burnout at work (N = 1,791)
Q33. Please tell us about the top two coping strategies or tactics that help you cope with stress and burnout at work.

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>%</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>*: negative coping e.g. denial, none, alcohol, depression, looking to retire, ...</td>
<td>7%</td>
<td>133</td>
</tr>
<tr>
<td>C: counseling, talking to peers, therapy</td>
<td>6%</td>
<td>109</td>
</tr>
<tr>
<td>D: diet-related: eating, coffee</td>
<td>2%</td>
<td>31</td>
</tr>
<tr>
<td>E: exercise/activity/hobby</td>
<td>28%</td>
<td>510</td>
</tr>
<tr>
<td>G: spiritual, meditational, introspection, outlook</td>
<td>15%</td>
<td>261</td>
</tr>
<tr>
<td>I: proactive, who try to do something about it</td>
<td>2%</td>
<td>28</td>
</tr>
<tr>
<td>M: mission-driven, focusing on their work and patients</td>
<td>4%</td>
<td>78</td>
</tr>
<tr>
<td>O: social activity outside work with family and friends</td>
<td>13%</td>
<td>227</td>
</tr>
<tr>
<td>P: practice change in setting or conditions</td>
<td>8%</td>
<td>137</td>
</tr>
<tr>
<td>S: sleep or rest</td>
<td>2%</td>
<td>40</td>
</tr>
<tr>
<td>T: time management</td>
<td>7%</td>
<td>123</td>
</tr>
<tr>
<td>V: vacation/time off/travel</td>
<td>5%</td>
<td>95</td>
</tr>
<tr>
<td>NS: non-specific</td>
<td>1%</td>
<td>18</td>
</tr>
<tr>
<td>U: Unknown</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>1791</td>
</tr>
</tbody>
</table>
Q34. Please tell us about top two factors that most sustain your sense of meaning in your professional work (N = 1,680)

1. Clinical/Patient Work (42%)
2. Teamwork (15%)
3. Scholarship/Research (4%)
4. Teaching (7%)
5. Respect (4%)
6. Autonomy (3%)
7. Medicine as Calling (6%)
8. Patient Satisfaction/Good Care (3%)
9. Financial (2%)
10. Leadership/Advocacy (1%)
11. Religion (1%)
12. Other (4%)
Q34. Please tell us about top two factors that most sustain your sense of meaning in your professional work

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>%</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Clinical/Patient Work</td>
<td>42%</td>
<td>699</td>
</tr>
<tr>
<td>2: Teamwork</td>
<td>7%</td>
<td>125</td>
</tr>
<tr>
<td>3: Scholarship/Research</td>
<td>4%</td>
<td>74</td>
</tr>
<tr>
<td>4: Teaching</td>
<td>7%</td>
<td>120</td>
</tr>
<tr>
<td>5: Resect</td>
<td>4%</td>
<td>68</td>
</tr>
<tr>
<td>6: Autonomy</td>
<td>3%</td>
<td>54</td>
</tr>
<tr>
<td>7: Medicine as Calling</td>
<td>6%</td>
<td>103</td>
</tr>
<tr>
<td>8: Patient Satisfaction/Good Care</td>
<td>15%</td>
<td>258</td>
</tr>
<tr>
<td>9: Financial</td>
<td>3%</td>
<td>52</td>
</tr>
<tr>
<td>10: Leadership/Advocacy</td>
<td>2%</td>
<td>40</td>
</tr>
<tr>
<td>11: Religion</td>
<td>1%</td>
<td>15</td>
</tr>
<tr>
<td>12: Other</td>
<td>4%</td>
<td>72</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100%</td>
<td>1680</td>
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</table>
Q35. Please let us know the top two practical suggestions you have that MSSNY can do to help reduce physician stress and burnout.

### CLASS

<table>
<thead>
<tr>
<th>Class</th>
<th>Percentage</th>
<th>Count</th>
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<tbody>
<tr>
<td>Adm: Administrative issues</td>
<td>14%</td>
<td>115</td>
</tr>
<tr>
<td>Aut: autonomy</td>
<td>6%</td>
<td>52</td>
</tr>
<tr>
<td>Col: collaboration/teamwork</td>
<td>2%</td>
<td>20</td>
</tr>
<tr>
<td>Emo: emotional support</td>
<td>11%</td>
<td>95</td>
</tr>
<tr>
<td>Reg: regulation issues</td>
<td>43%</td>
<td>357</td>
</tr>
<tr>
<td>Sou: resources</td>
<td>10%</td>
<td>86</td>
</tr>
<tr>
<td>NS: non-specific/off topic</td>
<td>14%</td>
<td>115</td>
</tr>
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</table>

**Total:** 100% 840
Q35. Please let us know the top two practical suggestions you have that MSSNY can do to help reduce physician stress and burnout.

**TOPIC**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Percentage</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>$: reimbursements/payment</td>
<td>16%</td>
<td>55</td>
</tr>
<tr>
<td>Doc: documentation issues</td>
<td>6%</td>
<td>20</td>
</tr>
<tr>
<td>EMR: electronic medical records</td>
<td>23%</td>
<td>79</td>
</tr>
<tr>
<td>INS: insurance companies issues</td>
<td>17%</td>
<td>61</td>
</tr>
<tr>
<td>MAL: malpractice issues</td>
<td>19%</td>
<td>67</td>
</tr>
<tr>
<td>MOC: Maintenance of certification</td>
<td>3%</td>
<td>11</td>
</tr>
<tr>
<td>SYS: healthcare system issues</td>
<td>17%</td>
<td>58</td>
</tr>
</tbody>
</table>

100% 351
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 – 200

Introduced by: New York County Medical Society
New York State Society of Plastic Surgeons

Subject: MSSNY Request for MLMIC to Release Information on Proposed Sale

Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, For approximately forty years, the Medical Liability Mutual Insurance Company (MLMIC) has been a physician policy holder-owned and run Mutual Insurance Company and has enjoyed a close and mutually supportive relationship with the Medical Society of the State of New York, the State's County Medical Societies, and the State's Specialty Societies; and

Whereas, The Board of Directors of MLMIC has voted to propose sale of the company to Berkshire Hathaway, a decision which would need to be approved by current MLMIC policyholders and which would "mutualize" the company; and

Whereas, The MLMIC Board announced its endorsement of the sale in July, 2016; and

Whereas, Some policyholders have expressed concern about having sufficient time to consider the advantages and disadvantages of the proposal before policyholder hearings, especially as more than six months have passed since the initial announcement; and

Whereas, Requests for information sufficient to be an active participant in such hearings have not yet been fulfilled; and

Whereas, MLMIC representatives have said that the New York State Department of Financial Services (DFS) is preventing release of information, although sources at the DFS have said that the Department is not setting such limits; and

Whereas, The fact that the MLMIC Board of Directors was provided with evidence convincing enough such that it has endorsed the proposal, indicates that the same information sufficient to the policyholders should be available; and

Whereas, The only group of people whose relationship to the Company definitely will be changed with approval of the sale will be the policy shareholders, who will no longer be owners, although it is presumed that MLMIC management and its Board will continue their roles with the new version of the Company; and

Whereas, The owners of the Company, who have depended on it and valued their ownership, and whose status will change dramatically with the sale, should have the option of asking independent counsel questions about the proposal and its effects on them, as their position will change substantially with the sale; and

Whereas, This new position of the policyholders as a result of the Board's decision is radically different than other decisions that the Board makes on behalf of the policyholders, and this difference requires additional representation; and

Whereas, Consulted law firms have said that it is not unusual for there to be additional counsel in such circumstances; and
Whereas, The magnitude of the proposed deal is such that an additional expense to satisfy the policyholder owners should not be prohibitive; and

Whereas, In spite of the many positive attractions of the proposal, prudent owners should be expected to carefully consider their options and the repercussions before making irrevocable decisions; therefore be it

RESOLVED, That the Medical Society of the State of New York ask for the immediate release of the term sheet for the proposed sale of MLMIC to Berkshire Hathaway; and be it further

RESOLVED, That the Medical Society of the State of New York ask for immediate release of the independent appraisal of MLMIC used to establish the terms of sale; and be it further

RESOLVED, That the Medical Society of the State of New York ask MLMIC to provide and finance independent counsel to represent the policyholders in determining their interests in the proposed sale; and be it further

RESOLVED, That the Medical Society of the State of New York should assist the policyholders in convening a policyholders' meeting to address issues of concern about the sale if MLMIC does not respond positively to immediate request for information and general counsel.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 ï 201

Introduced by: MSSNY Committee for Physician Health Advisory Committee

Subject: Development of Burnout Programs

Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, physicians who may have burnout may feel they cannot get help without the potential of negative consequences such as being reported to OPMC or New York State in some way; and

Whereas, this possibility also creates hesitation for physicians or colleagues and even patients who may want to suggest potentially helpful steps to such physicians; therefore be it

RESOLVED, that MSSNY formulate a process that can offer counseling to physicians concerned about the possibility of experiencing burnout while also being entirely confidential and not reportable, absent a practice-interfering substance abuse or serious psychiatric disorder.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 202

Introduced by:  
Eighth District Branch, MSSNY  
Seventh District Branch, MSSNY

Subject:  
Management of Physician and Medical Student Stress

Referred to:  
Reference Committee on Reports of Officers & Administrative Matters

Whereas, the overall physical health of physicians is quite good, a significant proportion experience distress associated with mental or emotional issues; and

Whereas, MSSNY believes that optimal physician health crosses over state boundaries and licensing agencies; and

Whereas, the stated goals and vision of our AMA are to redesign and improve medical education, improve health care outcomes, and create an environment of personal and professional satisfaction for our members and all physicians; and

Whereas, multiple surveys and studies have demonstrated higher incidence of stress related problems and burnout, psychiatric illnesses, substance use disorders, increased risk for suicide, and decreased resiliency which begins within the first two years of medical school; and

Whereas, a University of Washington study in 2012 found that 1 in 6 surgeons met criteria for an alcohol use disorder; and

Whereas, experts have estimated up to 8,000 physicians may be practicing with significant cognitive impairment due to neurodegenerative disease; and

Whereas, patient health outcomes, patient satisfaction, physician productivity, physician satisfaction, and practice sustainability have been demonstrated to be significantly reduced by physician stress and burnout; and

Whereas, many potential causes of physician impairment such as mental illness or substance use disorders are treatable, and early identification and treatment may prevent the progression to impairment; and

Whereas, a physician may be unaware of their stress related problems, psychiatric illness or substance use disorders, or reluctant to seek treatment due to fear of stigmatization, embarrassment, or consequential work related problems or disciplinary action; therefore be it

RESOLVED, that the Medical Society of the State of New York (MSSNY) request the American Medical Association (AMA) produce a report summarizing current research and efforts to address physician practice sustainability and satisfaction; and be it further

RESOLVED, that the MSSNY request that the AMA report on fitness for duty assessments in other professions with safety sensitive duties; and be it further

RESOLVED, that subsequent to the production of the report on physician satisfaction and fitness for duty assessments, the MSSNY request that the AMA convene a workgroup which would create a systemic approach to ensure fitness for duty be applied periodically, uniformly, confidentially and in the least intrusive fashion and which would help all medical students and physicians maintain their highest level of competence and service to their patients.
References:

JAMA 2015 Dec 8:314(22) 2373-2383
Archives Surgery 2012 Feb 147(2) 168-174
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 203

Introduced by: Gregory Pinto, MD
Third and Fourth District Branches

Subject: Physician Burnout

Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, physicians are generally resourceful people who cope effectively with a myriad of stressors while continuing to perform effectively in their work; and

Whereas, because of a high stress load, physicians have always been at risk of succumbing to the effects of stress in various ways, including burning out; and

Whereas, there appears to have been an increase in physician stress, burn-out, depression and suicide in recent years; and

Whereas, much of the increase in physician burn-out has coincided with an increase in the administrative and regulatory burden forced upon physicians by insurers and others; and

Whereas, studies have demonstrated that the administrative and regulatory burden has, in fact, increased the incidence of physician burn-out; and

Whereas, addressing the symptoms of a problem is more effective when the underlying causes are also addressed; therefore be it

RESOLVED, that when MSSNY discusses or communicates about physician burn-out, the term "Physician Burn-Out" be changed to "Physician Burn-Out and Abuse"; and be it further

RESOLVED, that funds be dedicated to a public relations campaign describing the abusive regulatory and administrative burdens that are increasing physician burn-out and abuse, depression and suicide; and be it further

RESOLVED, that the MSSNY Task Force on Physician Burnout and Stress continue to meet and expand its work to include the development of information about the administrative and regulatory burdens placed on physicians and recommendations to reduce these burdens that may also then reduce physician burnout and abuse, depression and suicide and report back to Council or the HOD; and be it further

RESOLVED, that the New York delegation to the AMA bring this resolution to the AMA Annual Meeting in 2017.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 – 204

Introduced by: New York County Medical Society

Subject: MOC Should Not Contribute to Physician Burnout

Refereed to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, Current medical practice has become high volume and rushed; no longer do we have to know everything at the bedside; we have to have the humility and self-awareness to know what we don’t know and take the time to look it up; knowing what one doesn’t know and ability to look up possible answers is the essential skill measured in an open book examination; and

Whereas, Demands on physician time have increased: writing increasingly detailed clinical notes, billing the patient, dealing with patient insurance, filing claims, preauthorizing medications, paperwork relating to being credentialed with insurance companies, credentialing with malpractice, DEA, state, electronic records, electronic prescribing, secretarial/staff supervision, office related issues, hospital/agency requirements (risk management, CPR/ACLS, health maintenance, e.g., immunizations, etc.), required training modules, uncompensated time: returning phone calls, e-mails, forms, trying to explain incomprehensible bills and EOBs, etc. to which are added required CME requirements and MOC closed book, high stakes periodical examinations; and

Whereas, Physician “burnout” is worse than the population at large and getting worse; burnout has increased from 2011 to 2014 with 54.3 percent of physicians showing at least one sign of burnout (http://www.mayoclinicproceedings.org/article/S0025-6196(15)00716-8/abstract); and

Whereas, Burnout leads to physicians of all ages working fewer hours per week (http://www.mayoclinicproceedings.org/article/S0025-6196(16)00101-4/abstract), thus depriving our patients of care; and

Whereas, Reporting on “quality improvement measures” has become so onerous as to be mentioned particularly as contributing to burden on physicians; the time and financial burden of dealing with health plans has increased since this 2009 study (average 3 hrs/wk, cost $231 billion/year: http://content.healthaffairs.org/content/28/4/w533, as can be inferred from this 2016 study of four specialties: http://www.physiciansfoundation.org/uploads/default/US_Physician_Practices_Spend_More_Than_15.4_Billion_Annually_To_Report_Quality_Measures.pdf; and

Whereas, Press reports (e.g., http://www.newsweek.com/2015/03/27/ugly-civil-war-american-medicine-312662.html) on MOC of a self-serving examination/educational elite and examinee reports of irrelevant questions have led many physicians to wonder if they are on a physicians’ exploiting other physicians’ money making educational treadmill; and

Whereas, Use of open book examinations eliminates the need and expense of examination proctoring, examination centers, and travel thereto, therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) ask the American Medical Association (AMA), and partner specialty societies that nominate candidates to bodies concerned with maintenance of certification (MOC), to nominate only those candidates who
agree that MOC should be accomplished only through open book examinations or other innovative methods that meet with widespread approval by physicians.
Whereas, there has been a troubling trend in recent years whereby hospitals, insurance companies and other organizations are using board certification as a sole measure of quality, competency and excellence; and

Whereas, these same groups are dismissing from employment, denying admitting privileges, not allowing participation in insurance companies and denying privileges to ambulatory surgery facilities to those physicians that are not board certified or have allowed their "Maintenance of Certification" to lapse; and

Whereas there are many reasons for physicians of excellent quality and character to not be board certified or to not maintain their certification; and

Whereas, there was a "grandfather clause" whereby if a physician had met the board preparation requirements that it was understood to be in perpetuity, it is viewed that the reversal of this "promise" is in violation of the condition that these board examinations were initially taken; therefore, be it

RESOLVED, that MSSNY requests that the American Board of Medical Specialties (ABMS), hospitals and insurance companies consider that the duly licensed physician should be the only requirement for practice of medicine; and be it further

RESOLVED, that MSSNY request that the ABMS keep their promise of the "grandfather" clause; and be it further

RESOLVED, that MSSNY propose that there should be more than one pathway to participation in insurance companies, hospital privileges and other organizations (e.g. ambulatory surgery centers) and that the ABMS work with the other societies to find alternate pathways to ensure physician competency and pursuit of lifelong learning.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 206

Introduced by: Medical Society of the County of Queens
Subject: Affiliation of MSSNY with the New York State AFL-CIO
Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, the percentage of physicians in private practice in New York State has decreased from 75% to 25% since 2000; and

Whereas, the reasons most often cited for this decrease in private practice physicians are the lack of negotiating leverage with payors and expensive liability insurance cost; and

Whereas, conferring upon private practice physicians the right to collectively bargain with payors and achieving meaningful tort reform would help restore the viability of the private practice model, and

Whereas, private practice physicians have been relegated to de-facto employees of health insurance companies, who impose unreasonable, unfair and burdensome conditions upon physicians, dismiss physicians from network panels or deny physicians access to panels without due process and unilaterally determine physician compensation; and

Whereas, in New York State, three health insurers cover over 70% of enrollees, making physician participation in these networks essential to survival of private practice; and

Whereas, despite the best efforts of organized medicine to attain collective bargaining rights and to change New York State's extreme medical liability environment these goals remain elusive; and

Whereas, the National Guild for Medical Professionals, Office and Professional Employees International Union, a labor organization affiliated with the AFL-CIO has expressed interest in affiliating with MSSNY for the purpose of achieving collective bargaining rights for private practice physicians and medical liability reform in addition to other benefits; and

Whereas, the New York State AFL-CIO represents 2.5 million workers, retirees and their families and has a track record as a powerful voice in New York State; therefore, be it

RESOLVED, that MSSNY open talks with the National Guild for Medical Professionals, Office and Professional Employees Union to ascertain if membership in this union would further the interests of New York State physicians.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Introduction:

Young Physicians Section

Subject:

Supporting International Medical Graduates and Students

Referred to:

Reference Committee on Reports of Officers & Administrative Matters

Whereas, on January 27, 2017, President Trump signed Executive Order 13769, which banned citizens/nationals of seven Middle Eastern countries from entering the United States; and

Whereas, the aforementioned executive order prevented many of our colleagues from returning to the United States to practice; and

Whereas, the order was issued in the middle of residency application season after most interviews were complete, ruining the chances of many international medical graduates from entering residencies and fellowships for the foreseeable future and potentially resulting in unfilled residency spots which will decrease the quality of care for our patients; and

Whereas, according to studies performed by the Association of American Medical Colleges (AAMC) there is currently a shortage of physicians in America, which will likely be worsened if fewer IMGs are allowed to immigrate to the USA; and

Whereas, several other medical societies including the American College of Physicians and the Association of American Medical Colleges have come out in opposition to Executive Order 13769; and

Whereas, on March 6, 2017, President Trump rescinded Executive Order 13769, and replaced it with Executive Order 13780, which still bans the issuance of new visas for citizens/nationals of six Middle Eastern countries; therefore, be it

RESOLVED, That the Medical Society of the State of New York oppose policies that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion; and be it further

RESOLVED, That the Medical Society of the State of New York oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion; and be it further

RESOLVED, That this resolution be immediately forwarded to the American Medical Association.

Sources:


https://www.acponline.org/acp-newsroom/acp-comprehensive-statement-us-immigration-policy

MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 208

Introduced by: Bronx County Medical Society
Subject: The Right to Health and Healthcare
Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, article 25 of the Universal Declaration of Human Rights (UDHR) states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including medical care; and

Whereas, the United States of America, as a Member State of the United Nations, voted in favor of the UDHR in 1948, ratifying our commitment to the ethics therein; and

Whereas, the United States is also a Member State of the World Health Organization (WHO); and

Whereas, WHO resolution WHA58.33, passed in 2005, urges all member states to contribute to meeting the needs of the population for health care; and

Whereas, the United States makes good on these promises via the Medicare and Medicaid programs which assure basic levels of medical care for all Americans who have attained the age of 65 and whose income and resources are not sufficient to meet their medical costs; respectively; and

Whereas, the Emergency Medical Treatment and Active Labor Act (EMTALA), passed in 1986, furthers these goals by assuring that our country's infirmed always receive care at emergency rooms, regardless of insurance and economic status; and

Whereas, the philosophical root of these policies, from the UDHR onward, is the right of citizens in a free and just society to basic levels of health and healthcare; and

Whereas, the very mission statement of the AMA is to promote the art and science of medicine and the betterment of public health; and

Whereas, Chapter 11 of the AMA Code of Medical Ethics explicitly states that health care is a fundamental human good and society has an obligation to make access to an adequate level of care available to all its members, regardless of ability to pay; and

Whereas, there is an entire body of AMA policy that exists under the heading Civil and Human Rights; and

Whereas, many of these policies support the fundamental concepts of human rights; and

Whereas, all American-trained physicians and, therefore, many members of the AMA, committed themselves to those very same ethics when they took their Hippocratic or Maimonides Oath; and

Whereas, these covenants require them to care for all people without exception for social or economic status; and
Whereas, there exist insurmountable barriers to patients receiving this healthcare, be them unaffordable premiums, high deductibles, lack of competitive markets, expensive medications, or exclusions for pre-existing conditions;\textsuperscript{11,12,13,14} and

Whereas, these barriers limit the freedom of hardworking Americans to pursue the health and well-being of himself and of his family, including medical care; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) advance the right to health and wellbeing of all Americans, including medical care; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) reaffirm its commitment to removing those barriers to healthcare that limit citizens in life, liberty and the pursuit of happiness; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) publicly state that basic levels of health and healthcare are human rights; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) forward to our American Medical Association (AMA) that it advance the right to health and wellbeing of all Americans, including medical care; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) forward to our American Medical Association (AMA) that it reaffirm its commitment to removing those barriers to healthcare that limit citizens in life, liberty and the pursuit of happiness; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) forward to our American Medical Association (AMA) that it publicly state that basic levels of health and healthcare are human rights.

References:
RELEVANT AMA AND AMA-MSS POLICY:

**Human Rights H-65.997**


**International Strategy G-630.070**

Our AMA recognizes the importance of the involvement of the medical profession in this country in influencing the standards utilized by other nations with regard to ethics, medical education and medical practice, and the commitment to the patient-physician relationship. BOT Rep. 21 and Res. 618, A-97; Consolidated: CLRPD Rep. 3, I-01; Modified: CC&B Rep. 2, A-11

**AMA and Public Health in Developing Countries H-250.986**

Our AMA will adhere to a focused strategy that channels and leverages our reach into the global health community, primarily through participation in the World Medical Association and the World Health Organization. BOT Rep. 5, A-07

**World Health Organization H-250.999**

Our AMA supports the position of the U.S. government to preserve the integrity of the World Health Organization (WHO) and opposes any attempts to politicize the WHO. Res. 56, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CLRPD Rep. 1, A-10

**World Health Organization H-250.992**

The AMA: (1) continues to support the World Health Organization as an institution; (2) advocates full funding as understood by the United States Government for the World Health Organization; (3) will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization; and (4) encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible. BOT Rep. 31, A-96; Reaffirmed: CLRPD Rep. 2, A-06; Reaffirmed: CEJA Rep. 03, A-16

**A Declaration of Professional Responsibility H-140.900**

Our AMA adopts the Declaration of Professional Responsibility

**DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE’s SOCIAL CONTRACT WITH HUMANITY**

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

**Declaration**

We, the members of the world community of physicians, solemnly commit ourselves to:

1. Respect human life and the dignity of every individual.
2. Refrain from supporting or committing crimes against humanity and condemn any such acts.
3. Treat the sick and injured with competence and compassion and without prejudice.
4. Apply our knowledge and skills when needed, though doing so may put us at risk.
5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
7. Educate the public and politity about present and future threats to the health of humanity.
8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
9. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor. CEJA Rep. 5, I-0; Reaffirmation A-07

**Professionalism and Medical Ethics H-140.951**

The AMA reaffirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state cannot legislate ethical standards or excuse physicians from their
ethic obligations; and urges all physicians and other appropriate health professional organizations to make their views known to their state legislatures and governors. Res. 4, A-95; Reaffirmed: CEJA Rep. 2, A-05; Reaffirmation I-09

**Patient Advocacy H-140.997**
Our AMA believes that physicians are the primary patient advocates, are not rationers of medical care, and will continue to utilize diagnostic and therapeutic measures and facilities in the best interest of the individual patient. Res. 146, A-84; Reaffirmed: BOT Rep. I-93-25; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CEJA Rep. 2, A-04; Reaffirmation A-05; Reaffirmed: CEJA Rep. 5, A-15

**Planning and Delivery of Health Care Services H-160.975**
(1) Planning agencies should utilize policies, educational programs and incentives to develop and maintain individual lifestyles that promote good health. The planning process should identify incentives for the providers and participants in the health care system to encourage the development and introduction of innovative and cost-effective health care services. Government at all levels, as a provider, purchaser and consumer of health services, should play an integral role in the planning process, including the provision of adequate funding and ensuring that government policies and/or regulations facilitate and do not unduly restrict the planning process. The authority to impose sanctions on those who take actions that are inconsistent with developed plans should be separated from the planning process. Funding for the planning process should be developed by the participants.

(2) The planning process should seek to ensure the availability and the coordination of a continuum of support health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals, hospices, and rehabilitation facilities.

(3) Decisions concerning the use of health care services, including the selection of a health care provider or delivery mechanism, should be made by the individual.

(4) Both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing short-comings in the current public system for providing access need to be addressed.

(5) Health care facilities should have or should establish review bodies (such as hospital ethics committees) to resolve conflicts over access to scarce health care technologies. In the event that a conflict over delivery of scarce health care technologies cannot be mediated satisfactorily, individuals should be able to seek redress through appropriate appeal mechanisms. BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07

**Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874**
Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students’ appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students’ cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models. CME Rep. 11, A-06; Reaffirmation A-11; Modified in lieu of Res. 908, I-14; Reaffirmed in lieu of Res. 306, A-15

**Health System Reform Legislation H-165.838**
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
   a. Health insurance coverage for all Americans
   b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
   c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
   d. Investments and incentives for quality improvement and prevention and wellness initiatives
   e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors’ access to care
   f. Implementation of medical liability reforms to reduce the cost of defensive medicine
   g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees’ access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
   a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
   b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
   c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
   d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
   e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
   f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA’s position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a “call to action” with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.


Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

   A. Physicians maintain primary ethical responsibility to advocate for their patients’ interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.

C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.

D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.

F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.

H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.


Elimination of Health Care Disparities Resulting from Insurance Status 65.016MSS
AMA-MSS (1) supports the elimination of health care disparities caused by differential treatment based on insurance status of Americans; (2) encourages the Commission to End Health Care Disparities to specifically address in its mission, advocacy and actions, the contribution of differences in insurance status to health care disparities; and (3) supports efforts by the Agency for Healthcare Research and Quality to specifically investigate the impact of insurance-based segregation of Medicaid patients in different settings on racial and ethnic health care disparities and make appropriate evidence-based recommendations. MSS Sub Res 29, A-11

Reducing Barriers to Preventive Health Care Delivery and Compensation 160.022MSS
AMA-MSS will ask the AMA to (1) support both the reduction of financial barriers to the delivery of cost effective preventive health care services, and the implementation of financial incentives for cost-effective preventive medical care; and (2) conduct a study examining the effects of improvements in financial incentives for the delivery of cost-effective preventive care, and to make information from such study available through avenues including but not limited to the AMA web site to better educate physicians and the public about the benefits of preventive health care services. MSS Res 20, I-11; Reaffirmed Existing Policy in Lieu of AMA Res 107, A-12
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017 - 209

Introduced By: Joseph R. Maldonado, Jr., MD, MSc, MBA
Immediate Past President

Subject: Decision Making in Signing on to Amici and Letters/Position Statements

Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, the Medical Society’s House of Delegates and Council are empowered by the Society’s Bylaws to set policy for the Medical Society; and

Whereas, the Society’s Bylaws prohibit any officer, councilor, board, commission, committee or employee from committing the Society to any policy unless said policy has been expressly approved by the House of Delegates or Council; and

Whereas, the brand and reputation of the Society is well respected; and

Whereas, the Society is often sought out by the media and legal community as well as other bodies of organized medicine, to use the brand and reputation to strengthen a particular view or policy position being advanced by said party; and

Whereas, such support often comes in the form of a request for sign-on to a letter or position statement or an amicus; and

Whereas, financial liability and legal complications can arise for the Society and its officers, councilors, board, commissions, committees or employees where these may have acted on behalf of the Society with or without the House of Delegates or Council having set policy on the referenced matter; therefore, be it

RESOLVED, that MSSNY institute as policy a four-step process which aims to better protect the Society and its officers, councilors, board commissions, committees and employees from liability and misrepresentation in regards to requests for sign-ons, support, amici or public statement of positions in the following manner:

1) All requests for sign-ons, support, amici or public statement of positions must be submitted to the Society in writing and must include a date by which the Society must submit a response to the requesting party;

2) All requests which can be addressed by the House of Delegates by that date shall be the purview of the House for decision;

3) All requests outside of the meeting time of the House of Delegates shall be decided by the Council except where the Council is not in session in which case the Executive Committee shall have the final say as to support for such sign-ons, support, amici or public statement of position;

4) The President shall include in his/her report to Council at its meetings, a report of all requests made of the Society since the last Council meeting including the decision taken by Council or the Executive Committee on any such request.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017 - 210

Introduced by: Jerome C. Cohen, MD, Delegate for Delaware County
Broome County Medical Society
Fifth District Branch of MSSNY
Sixth District Branch of MSSNY

Subject: Process for Amending the AMA Code of Medical Ethics

Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, The AMA Council on Ethical and Judicial Affairs (CEJA) recently concluded a difficult and years-long project to modernize the AMA Code of Medical Ethics; and

Whereas, The modernized AMA Code of Medical Ethics (the Code) was approved by the AMA House of Delegates; and

Whereas, During the AMA Interim 2016 House of Delegates meeting, CEJA amended the Code by filing a CEJA Opinion which is not subject to any vote of approval by the House of Delegates, instead of submitting a CEJA Report which would have been subject to Reference Committee review and a vote by the House; and

Whereas, The process that was utilized by CEJA is not subject to any oversight or approval by the AMA House of Delegates, and therefore subject to abuse; and

Whereas, AMA Policy G-615.040 does not provide any special protections for the AMA Code of Medical Ethics; and

Whereas, The AMA Bylaws specifies the process by which the Principles of Medical Ethics of the AMA may be amended; and

Whereas, The AMA Bylaws is silent regarding the AMA Code of Medical Ethics; therefore, be it

RESOLVED, That our American Medical Association Bylaws be amended to reflect the following statements about the AMA Code of Medical Ethics:

1) The AMA Code of Medical Ethics shall be included in the Bylaws in the same manner that the AMA Principles of Medical Ethics is included;

2) The Bylaws shall specify the process by which the AMA Code of Medical Ethics may be altered, amended, or changed in any way;

3) The process for amending the AMA Code of Medical Ethics shall be that the AMA Council on Ethical and Judicial Affairs (CEJA) would first submit a CEJA Report to the House of Delegates with proposed new language, and if the House of Delegates votes to approve the Report, then CEJA will issue a CEJA Opinion containing the same language of the Report; and be it further

RESOLVED, That the Medical Society of the State of New York direct its AMA Delegation to submit this resolution to the AMA Annual 2017 House of Delegates meeting.
AMA policy on opinions and reports of CEJA includes the following: (1) CEJA will inform the House of Delegates of an ethical Opinion adopted by the Council by presenting the Opinion to the House. The Council: (a) will identify the Opinion as informational; (b) may provide a description or discussion of the underlying facts and circumstances leading to the adoption of the ethical Opinion, and also an explanation of the Opinion and the reasons for its adoption by the Council. This explanatory material is neither the opinion of the Council nor policy of the Association; (c) will identify one or more Principles of Medical Ethics that form the basis for issuing the ethical Opinion; and (d) will provide the text of the ethical Opinion.

(2) The House’s process for considering opinions of CEJA may include the following elements: (a) Opinions of CEJA will be placed on the consent calendar for informational reports, but may be withdrawn from the consent calendar on motion of any member of the House of Delegates and referred to a Reference Committee. (b) The members of the House may discuss an ethical Opinion fully in Reference Committee and on the floor of the House. (c) After concluding its discussion, the House shall file the Opinion. (d) The House may adopt a resolution requesting CEJA to reconsider or withdraw the Opinion. CEJA shall respond to such a request in due course, after reconsidering the issues presented. The Opinion of CEJA that responds to such a request will be considered as informational, and therefore shall be filed.

(3) Reports of CEJA which respond to requests from the House or which make recommendations to the House may be adopted, not adopted, or referred, as may be appropriate. A report may not be amended, except for amendments that clarify the meaning of the report and only with the concurrence of the Council.

AMA Constitution and Bylaws
12—Amendments
12.1 Bylaws. These Bylaws may be amended by a two-thirds vote of delegates present and voting, provided an amendment shall not be acted on sooner than the day following that on which it was introduced.

12.2 Principles of Medical Ethics. The Principles of Medical Ethics of the AMA may be amended at any meeting by a two-thirds vote of delegates present and voting, provided that the proposed amendment shall have been introduced at the preceding meeting.

12.3 Articles of Incorporation. The Articles of Incorporation of the AMA may be amended at any regular or special meeting of the House of Delegates by the approval of two-thirds of the voting members of the House of Delegates registered at the meeting, provided that the Board of Trustees shall have approved the amendment and submitted it in writing to each member of the House of Delegates at least 5 days, but not more than 60 days, prior to the meeting of the House of Delegates at which the amendment is to be considered.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017 - 211

Introduced By: Nassau County Medical Society
Subject: Relocation of the Annual MSSNY HOD meeting to Albany
Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, there has been a reduction in numbers of members of the MSSNY; and
Whereas, there has also been a reduction in the number of those interested in leadership and advocacy initiatives due in part to increasing work demands; and
Whereas, advocacy for medical issues remains a very important function of the MSSNY; and
Whereas, the attendance for the annual Advocacy Day in Albany has deteriorated due to a variety of issues, including but not limited to, taking time from busy medical practices; and
Whereas, multiple advocacy initiatives (state/national as well as specialties) compete for physician time; and
Whereas, locating the meeting to Albany for 3-5 days will allow officials to appear at the HOD; and
Whereas, that action will impress upon our legislature, department of health and insurance commissioner that the MSSNY highly values an interactive relationship with those officials; therefore, be it

RESOLVED, that the annual House of Delegates be held in Albany; and be it further
RESOLVED, that the MSSNY arrange for panel discussions, and presentations by elected officials and others to be part of the annual HOD meeting; and be it further
RESOLVED, that dates and timing of the meeting be coordinated with the legislative schedule in Albany; and be it further
RESOLVED, that time be created during the HOD meeting to visit with legislative representatives.

Resolution 2016-200 referred to LRP
Whereas, There are many nonaffiliated groups of physicians, e.g. Sports Medicine, Health and Wellness, Nutrition, outpatient cosmetic surgery, basic research, etc., who do not practice in the usual settings and therefore do not have group representation in MSSNY and the opportunity for group dues; and

Whereas, While these individuals may join MSSNY as individual members, their specific interests may be underrepresented; therefore be it

Resolved, That the Medical Society of the State of New York seek to identify and enumerate nonaffiliated groups of physicians, e.g. Sports Medicine, Health and Wellness, Nutrition, outpatient cosmetic surgery, basic research, etc.; and be it further

RESOLVED, That groups of nonaffiliated physicians be offered a dues reduction; and be it further

RESOLVED, That groups of nonaffiliated physicians be offered representation in the MSSNY HOD; and be it further

RESOLVED, That MSSNY leadership consider group size as an alternative to percentage of members in establishing eligibility requirements for dues and representation.
Whereas; the opening of the House of Delegates traditionally begins with an invocation delivered by a spiritual leader of various denominations; i.e. rabbis, priests, ministers, members of the clergy, etc.; and

Whereas; there may be members of the House who, given their background and philosophical beliefs, do not think that the Medical Society should be associated with religious beliefs; and

Whereas; the Medical Society of the State of New York (MSSNY), to the best of its ability, should honor and respect the wishes and followings of all its members; therefore, be it

RESOLVED, That the Medical Society of the State of New York take cognizance of the teachings, beliefs and religious/philosophical postures of its members and allow both the incoming and outgoing presidents to select a noted poet, or other appropriate literary figure in lieu of a spiritual leader, to deliver a nondenominational poem or other such address as the invocation presented at the opening of the House of Delegates.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017- LATE F

Introduced By: Paul Hamlin, MD, MSSNY Trustee  
Daniel Koretz, MD, Seventh District Branch Delegate  
Leah McCormack, MD, Chair, MSSNY Board of Trustees  
Gregory Pinto, MD, Fourth District Branch Delegate  
As Individuals

Subject: AMA Policy on American Health Care Act

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IF HOUSE COMMITTEE ON RULES, CREDENTIALS AND ORDER OF BUSINESS  
RECOMMENDS ACCEPTANCE FOR BUSINESS, THIS WILL BECOME

Resolution 2017 – 214

Referred to: Reference Committee on Reports of Officers and Administrative Matters

Whereas the United States healthcare system has been in a state of flux since the introduction of PPACA; and

Whereas the AMA chose to support PPACA in its early stages so that physicians could have a seat at the table as policies were being negotiated; and

Whereas the AMA maintained its support for PPACA despite rising premiums, increasing deductibles and narrowed physician networks; and

Whereas the newly elected Congress and President of the United States recently proposed the American Healthcare Act (AHCA), intended to replace PPACA; and

Whereas the AMA issued a statement in opposition to the AHCA, even though the final points of same had not yet been determined; and

Whereas the AMA spent a significant amount of money in this campaign of opposition; and

Whereas physicians and patients would more likely benefit from having the AMA maintain its seat at the table as any alternative to PPACA is developed; be it therefore

Resolved, that MSSNY call on the AMA to immediately desist from its campaign of opposition to any replacement of PPACA; and be it further

Resolved, that MSSNY call on the AMA to issue a public statement disavowing its previous opposition to AHCA; and be it further

Resolved, that MSSNY encourage the AMA to engage in negotiations with the current leadership of the United States in crafting healthcare policy that is in keeping with MSSNY and AMA values; and be it further

Resolved, that MSSNY's delegation to the AMA bring this resolution to the AMA Annual Meeting in 2017.
RECOMMENDATION:
Madam Speaker, Your Reference Committee recommends that the policies contained in 2017 the Socio-Medical Economics Sunset Report be acted upon in the manner indicated and that the remainder of this report be filed:

REAFFIRM
60.997 New York State Department of Health’s Task Force on Life and the Law: MSSNY to seek to have more representation on the New York State Department of Health’s existing Task Force on Life and the Law; and MSSNY’s representatives to: (1) make an effort to set guidelines on discontinuing or not initiating treatment, which might then be used to aid treating physicians on a voluntary basis in discussion with a patient and/or his/her family; and (2) advocate that an appropriate mechanism for adjudication in end-of-life questions in the hospital setting be available for treating physicians. (HOD 2007-261)

RECOMMENDATION: REAFFIRM; still relevant

120.971 Medical Outsourcing:
MSSNY will request legislation to prevent insurance companies from incentivizing subscribers in this state to have to go overseas for medical treatment that could be provided locally and, through the American Medical Association, request federal legislation to prevent insurance companies from incentivizing subscribers to go overseas for medical treatment that could be provided locally. (HOD 2007-263)

RECOMMENDATION: REAFFIRM; still relevant

165.894 Tracking Electronic Claims:
MSSNY will seek legislation or regulation mandating health payment plans that require electronic claims submission be required to make available the means of tracking the claim electronically as it is processed. (HOD 2007-265)

RECOMMENDATION: REAFFIRM, although this is being done in the marketplace.

165.895 Requirement for MCOs to Provide Education and Training Initiatives:
MSSNY will legislation that would require: (1) each third-party insurer to develop and implement a formal Local Provider Education and Training (LPET) Initiative, designed to give panel physicians all the information they need now and in the future about the carrier’s policies, procedures, and coverage issues, in order to receive appropriate reimbursement; and (2) third-party insurers to provide dedicated and identifiable staff, telephone lines, and e-mail addresses, whereby physicians can contact the carrier in order to fully understand and abide by the carrier’s policies and procedures. (HOD 2007-256)

RECOMMENDATION: REAFFIRM; still relevant
165.896 Retraction Letters and Erroneous Termination Letters:
MSSNY will work with the appropriate New York State regulatory agency to draft regulations requiring managed care organizations (MCOs) to issue letters of retraction when the MCO has erroneously informed patients that a physician is no longer participating, when the physician has merely filed a request to change the demographic information in the plan’s Provider File. (HOD 2007-254)

**RECOMMENDATION:** REAFFIRM; still relevant

165.897 MCOs Use of Pre-Payment Claim Reviews to Circumvent the New York State Prompt Payment Law:
MSSNY will:
1. using the Hassle Factor Form, solicit and compile examples of prepayment claim reviews initiated by managed care organizations where the physician has received no prior notification of aberrant coding or claim submission practices;
2. review these examples to determine whether the managed care organizations are in violation of the New York State Prompt Payment Law or related regulatory directives, such as the New York State Insurance Department Regulation # 178 (11 NYCRR 217) (Prompt Payment of Health Insurance Claims) or Article 26 of the Unfair Claim Settlement Practices law (Section 2601); and
3. urge the New York State Insurance Department to take appropriate action against these managed care organizations if it is determined that the MCOs are indeed in violation of the relevant statutes or regulations through their use of erroneous pre-payment reviews. (HOD 2007-253)

**RECOMMENDATION:** REAFFIRM; still relevant

165.907 Clarification of the New York State Current Procedural Terminology Uniformity Law:
MSSNY should take all the steps, including legislation, necessary to assure that health plans comply with and abide by the American Medical Association coding policy statements that are contained in the yearly AMA CPT coding manual. (HOD 2007-61)

**RECOMMENDATION:** REAFFIRM; still relevant

165.910 Codification and Access of All Formularies:
MSSNY will: (1) advocate for the creation of a unified industry-supported website that lists the formularies of all health plans and Part D plans; (2) explore the feasibility of requiring a plan to format their formularies in a nationally recognized standard that would facilitate physician Electronic Medical Record interfaces; and (3) seek to assure that health plan prior authorization rules for prescribing medications be clear and concise. (HOD 2007-55)

**RECOMMENDATION:** REAFFIRM; still relevant

165.953 Accountability for HMO Termination of a Physician by Mistake:
MSSNY will actively seek legislation or regulation which holds an HMO or managed care plan accountable for all damages incurred by a physician as the result of termination notification which was made in error, to the physician’s patients. MSSNY will take all action necessary to assure that physicians are informed of their rights when terminated by a plan or when patients are inappropriately notified of a physician’s termination from the plan. (HOD 1999-53; Reaffirmed HOD 2007-254)

**RECOMMENDATION:** REAFFIRM; still relevant
265.911 **ERISA Plans and the United States Department of Labor:** MSSNY will seek the support of the American Medical Association in proposing an amendment to federal legislation that would modify ERISA law to incorporate a clause that addresses timely payment of medical claims of health care practitioners who provide treatment in good faith to the members of self-funded group employer-sponsored health plans; and

When the federal law is amended, the Medical Society of the State of New York will work with the United States Department of Labor to devise and implement a formalized appeal process at the United States Department of Labor, with a specific dedicated service center and contact persons. (HOD 2007-251)

**RECOMMENDATION:** REAFFIRM; still relevant

**AMEND**

195.968 **Medicare Opt Out Physicians and Secondary Insurers:** In conjunction with the New York State Insurance Department of Financial Services, MSSNY will:

(1) draft legislation to develop and implement a mechanism to: a) require secondary insurers to identify Medicare opt out situations; b) allow physicians and patients who have executed a Medicare Opt Out agreement (yet still participate with the secondary private or managed care insurer) to have their claims processed correctly by making the secondary insurer primary as Medicare is no longer the primary insurer and no Medicare explanation of benefits exists; and

(2) draft legislation to: a) identify Medicare Opt Out situations; and b) include the requirement that the secondary insurer access the Medicare fee schedules posted on the carrier websites in order for the secondary insurer to calculate their payment responsibility in the event that present insurance law cannot be changed and the secondary insurer can reduce the benefit paid based on what Medicare would have covered. (HOD 2007-250)

**RECOMMENDATION:** AMEND. The New York State Insurance Department is now called the New York State Department of Financial Services.

265.910 **Publicizing the Hassle Factor Form:** MSSNY will take whatever steps it can to maximize use of the Hassle Factor form and disseminate its findings to all concerned. (HOD 2007-264)

**RECOMMENDATION:** AMEND by deletion with addition to MSSNY Policy 265.915, see the following -

265.915 **Insurance Companies and Publicizing the Hassle Factor Form:** That MSSNY monitor unfair business practices of health plans though the use of the new MSSNY Hassle Factor Form (HFF), creating or joining with a coalition of stakeholders (to include physician groups and leaders of industry and business who bear the burden of health care costs) and dependent upon the anticipated reports culminating from the use of the HFF and the work of the coalition seek passage of state regulation and/or legislation to rectify these unfair business practices. (HOD 2006-269; Reaffirmed Council 12/13/07) In addition, MSSNY will take whatever steps it can to maximize use of the Hassle Factor Form and disseminate its findings to all concerned. (HOD 2007-264)

**RECOMMENDATION:** AMEND by addition of MSSNY Policy 265.910
SUNSET
85.971 Health Promotion Visits:
MSSNY should seek to assist in the education of members on the appropriate coding for clinical prevention services. (HOD 2007-152)

RECOMMENDATION: SUNSET; already part of annual visit paid currently by CMS and others

120.973 Health Promotion Visits:
MSSNY should seek legislation and/or regulation exempting the cost of an annual physician clinical preventive services visit, as defined in current MSSNY policy 120.983, from inclusion as deductible expenses. (HOD 2007-156)

RECOMMENDATION: SUNSET; already part of annual visit paid currently by CMS and others

120.983 Payment for Clinical Preventive Services:
MSSNY will seek the introduction of state legislation, as well as federal legislation through the AMA, requiring all insurance companies (Indemnity and ERISA Health Plans) to pay for at least one visit a year for clinical prevention services, and that no other diagnosis be required for payment to the physician. (HOD 1999-264; Reaffirmed HOD 2007-156)

RECOMMENDATION: SUNSET; already part of annual visit paid currently by CMS and others

195.967 Postponement of National Provider Identifier (NPI) Implementation Date:
In view of the Centers for Medicare & Medicaid Services (CMS) failure to appropriately address data dissemination concerns relating to the security and protection of physician issued National Provider Identifier (NPI) numbers, MSSNY to request that the May 23, 2007 NPI implementation date be postponed, at least until CMS has appropriately developed and published their Data Dissemination Policy in the Federal Register. (HOD 2007-257)

RECOMMENDATION: SUNSET, it is done.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 250

Introduced by: The Suffolk County Medical Society

Subject: Treatment of Onychomycosis

Referred to: Reference Committee on Socio-Medical Economics

Whereas, the population of the U.S. is aging, 10,000 people turn 65 daily; and

Whereas, the ability to move around effectively and safely in the environment, is fundamental to the health and wellbeing of older adults; and

Whereas, impaired mobility can and is associated with several health problems, including depression, cardiovascular disease, injuries secondary to falls and automobile crashes. These illnesses can lead to increased risk of death; and

Whereas, Onychomycosis (a fungal infection of the nail plate, nail bed or both) affects 10% of the population, with a much higher prevalence over the age of 60; and

Whereas, Dystrophic nails are more common in people with Diabetes Mellitus, or other risk for cellulitis and patients with compromised distal circulation; and

Whereas, wearing poorly fitted shoes or having pain due to pressure can lead to falls, ulcerations and other related conditions; and

Whereas, as the population ages there are likely co-morbid conditions (arthritis, back pain, poor vision) which makes it difficult for the elderly to care for their own dystrophic nails; and

Whereas, there are many medications with potential lethal side effects for the treatment of onychomycosis; therefore, be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) recognizes onychomycosis of the toenails as an infectious disease that may cause pain, reduce mobility, create ulcerations, and may cause secondary infections leading to serious health complications; and be it further

RESOLVED, That MSSNY recognizes fungal infections of the toenail have a high incidence in the general public, and specifically at-risk diabetic patients, creating a public health issue; and be it further

RESOLVED, That MSSNY supports the treatment of onychomycosis by a qualified physician or doctor of podiatric medicine.
Whereas, insurance companies and governmental insurers have set fees for medications; and
Whereas, the cost of many medications has risen; and
Whereas, third party payers have set limits often below the cost of medications; and
Whereas, it is not possible to balance bill patients for medications; and
Whereas, many of these medications need to be administered by a healthcare provider; and
Whereas, the medication can be the only choice for treatment -such as intravesical therapy with mitomycin; therefore, be it
RESOLVED, that MSSNY take the necessary steps to insure that health care in-office provider-administered medications be reimbursed at no less than the cost of the medication; and be it further
RESOLVED, that in addition to the reimbursement for the medication there be payment for purchase, storage of said medications, and additional monies to pay for all supplies, staff and professional efforts.
Whereas, physicians are inundated with a variety of pre authorization approvals for many radiographic procedures as well as a variety of lab, procedural and medication requests; and

Whereas, the provider remains the best judge of the clinical needs of patients in his/her care; and

Whereas, requests by insurers for information to determine need has already overwhelmed the workflow of medical practices; and

Whereas, the request for information and the determination is often in the hands of persons with minimal medical training; and

Whereas, the need for the ordering physician to discuss his/her clinical decisions with a representative of the payor where the payor representative often has minimal if any experience in the area of specific area of clinical concern; and

Whereas, the arbiter is often one with minimal or any experience in the specialty of the ordering physician; and

Whereas, the process is time consuming due to difficulty reaching the payor’s representative; and

Whereas, it also interferes with patient care during the attempts to reach and discuss with the payor’s representative; therefore be it

RESOLVED, that MSSNY seek changes in the peer to peer reviews by insurers so that they be limited only to unusual requests, that the payor representative be board certified in the specialty in question, and that peer to peer requests be a written communication that can be responded to electronically or via fax.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 ñ 253

Introduced by: New York County Medical Society

Subject: Violation of HIPAA Electronic Transaction Standards by Insurer
Failure to Upload ICD-10 Revisions

Referred to: Reference Committee on Socio-Medical Economics

Whereas, When insurers deny claims improperly, physicians suffer severe financial
consequences ñ and this improper behavior by insurers needs to be recognized and stopped,
with penalties if possible; and

Whereas, As a prime example: A number of major insurers failed for several months to upload
the October 1, 2016, version of ICD-10 (which is significantly different from the original ICD-10
of October 1, 2015) ñ so that claims from those months were improperly denied and physicians
were forced to resubmit them; and

Whereas, Some insurers even required the physicians to appeal the claims, even though the
errors were the insurersô and

Whereas, The affected practices experienced undue hardships, and the insurers should be held
accountable; and

Whereas, To hold the insurers accountable, it is significant to note that they were in violation of
the HIPAA Electronic Transaction Standards, one of which requires insurers to process claims
using the appropriate ICD-10 codes (if not, the insurer is ripe for complaintô; and

Whereas, The CMS Office of E-Health Standards & Services ô which, in the past, has acted on
other HIPAA EDI (Electronic Data Interchange) issues ô has asked to be informed of these
violations, and has encouraged physicians to file complaints about them; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) survey its members
asking whether they have experienced claim denials, claims resubmission, or appeals because
the insurer (federal, state or commercial) failed to upload the October 1, 2016, version of ICD-10
in a timely fashion; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) urge the American
Medical Association (AMA) to present information on ICD-10 improper claim denials to the
Centers for Medicare and Medicaid Services (CMS) and its Office of E-Health Standards &
Services, to determine whether the insurersô failure to properly update their claims processing
systems has constituted a violation of the HIPAA Electronic Transaction Standards and should
trigger disciplinary or corrective actions to prevent these occurrences in the future.
Whereas; the implementation of ICD-10 occurred just 1 ½ years ago; and
Whereas; the implementation of ICD-10 was itself a major disruption to physician work-flow and productivity; and
Whereas; ICD-10 codes coexist in the medical record along with ICD-9 codes that relate to episodes of care before October 1, 2015 — a redundancy that diminishes the utility of the medical record by filling fields such as the problem list; and
Whereas; ICD codes are more specific than the underlying condition that they specify (such as initial vs. subsequent encounter, laterality, etc.) — a redundancy that further diminishes the utility of the medical record by unnecessarily filling fields such as the problem list; and
Whereas; in 2016 new codes were introduced, and existing ones deemed obsolete causing a second a major disruption to physician work-flow, cash flow and productivity; and
Whereas; implementation of ICD-10 has not been demonstrated to improve health outcomes, therefore, be it
RESOLVED, That the Medical Society of the State of New York (MSSNY) seek legislation and/or regulation to eliminate regular updates to ICD (including creation of new codes and the obsolescence of existing ones) in order to minimize the unnecessary disruption to physician practice work flow; and be it further
RESOLVED, That the MSSNY delegation introduce a similar resolution at the AMA Annual House of Delegates meeting in June 2017.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017 - 255

Introduced By: Richmond County Medical Society

Subject: Office Based Surgery Reimbursement

Referred to: Reference Committee on Socio-Medical Economics

Whereas, Office Based Surgery (OBS) policy mandates accreditation and sometimes cost-prohibitive expenses relative to procedures, high-value supplies and overhead; and

Whereas, since the implementation of OBS in 2007, studies show that OBS facilities operate with higher safety ratings than Ambulatory Surgery Centers and Hospitals, both of which are reimbursed facility fees; and

Whereas, OBS facilities do not receive reimbursements, but are nevertheless charged a prohibitive cost to maintain their accreditation; and

Whereas, the building of OBS facilities to specification necessitates near-cost prohibitive expense; and

Whereas, OBS facilities were denied reimbursement for facility fees for non-licensure, though OBS facilities were not required to be licensed; and

Whereas, OBS operations provide Ambulatory Surgery Centers and Hospitals in-kind cost savings through accepting minor cases requiring minimal procedure; and these are cases on which hospital and ambulatory surgery centers will lose money and recognizing that the resources could be better utilized in more complicated cases; and

Whereas, OBS practices provide patients high quality and high-touch continuity of care in familiar settings that provide value-added behavioral health outcomes with minimized staff resources; therefore, be it

RESOLVED, that payment for office based surgery (OBS) facility fees be made retroactive to 3 years from the last case performed by the practitioner at the OBS Facility and that the reimbursement be at least 50% of the reimbursement made to the hospital facility for a similar procedure-both retroactively as well as going forward; and be it further

RESOLVED, that based on long term past inequities in payments for facility reimbursement fees between the hospital, ambulatory surgery centers and office based surgery by the insurance providers, we call for action by the Medical Society of the State of New York to establish legislative priorities based on this resolution that can inform state legislators to enact into law said resolution.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 256

Introduced by: Ninth District Branch

Subject: Arbitrary Deadlines for New York State Workers’ Compensation Peer Review Response

Referred to: Reference Committee on Socio-Medical Economics

Whereas, The New York State Workers’ Compensation system is tasked with timely, appropriate provision of medical care to injured workers in order to optimize restoration of health and return to work; and

Whereas, physicians and other providers wish to obtain expedient authorizations for diagnosis and treatment of injured workers to achieve the goal of returning injured workers to the work place as soon as possible; and

Whereas, peer review is a necessary accepted process that ensures the integrity of the Workers’ Compensation (WC) system to ensure the appropriateness of care; and

Whereas, a new practice by which Workers’ Compensation peer reviewers are requiring responses to request for peer review within unrealistic arbitrary timelines; for example, requiring a call back by the end of the same business day; and

Whereas, many physicians and other providers may not be available to complete the requested peer review call on the same day because of scheduling conflicts; for example, in surgery, day off, vacation, busy patient schedule or other emergencies; and

Whereas, lack of opportunity to complete peer review within the arbitrary timeframes set by the WC insurers, may lead to inappropriate denial of requested care, and this denial may ultimately lead to increased costs for the carriers and employers from requiring expensive hearings, increased lost wages and increased lost productivity; therefore, be it

RESOLVED, that the Medical Society State of New York require that if a Workmen’s Compensation peer review is requested by either party that the peer review be scheduled at a mutually acceptable time.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 257

Introduced by: Bronx County Medical Society

Subject: Registered Supervising Physician Testimony Sufficiency in Workers Compensation Cases

Referred to: Reference Committee on Socio-Medical Economics

Whereas, the current Workers’ Compensation standard of care permits registered physicians to delegate care to non-registered health care providers such as PAs, residents, and nurse practitioners under their legal supervision; and

Whereas, depositions now prevent registered providers from testifying on behalf of their legally supervised staff; and

Whereas, this requirement of each member of the staff to testify to their findings represents a tremendous cost to the practice; therefore, be it

RESOLVED, that the Medical Society of the State of New York petition the Workers’ Compensation Board to recognize that the registered, supervising physician, as head of the treatment team, and whose scope can include assessment of the competency and experience of their staff, should be the sole provider of testimony to the Workers’ Compensation Board.
WHEREAS; it is an unfortunate reality that during an initial encounter, patients often neglect to identify that the reason for the visit is Workers' Compensation related, even when physicians make a good faith effort to determine if the condition is Workers' Compensation related; and

WHEREAS; intentional fraud by the patient by failing to inform the physician of Workers' Compensation involvement, is also all too common; and

WHEREAS; acting in good faith, many physicians, either Workers' Compensation authorized or not, will treat a patient without the knowledge that there may be a Workers' Compensation case, and with the expectation of billing the patient or a third party payer other than Workers' Compensation; and

WHEREAS; even when it is likely that intentional fraud or other irregularities may have been committed by the patient, the physician is often held responsible for refunding the patient the amount billed even when the physician is not authorized by Workers' Compensation; and

WHEREAS; according to the Workers' Compensation Law Section 110-a, Subsection 1 (a) which says in part, "Except upon the order or subpoena of a court of competent jurisdiction, or subpoena of a law enforcement agency, or subpoena properly issued under the authority of an administrative agency, or in accordance with subdivision two or three of this section, no workers’ compensation record shall be disclosed, redisclosed, released, disseminated or otherwise published by an officer, member, employee or agent of the board to any other person," which is currently being interpreted by Workers' Compensation judges and the Workers' Compensation Board to mean that the physician in question cannot communicate with anyone from the Workers' Compensation Board about obvious fraud committed by the patient or other irregularities that may be relevant to the Workers' Compensation Board; therefore, be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) seek appropriate legislation or regulation to modify the Workers' Compensation Law, Section 110-a, Subsection 1 (a), which would allow a physician, or his legal representative, the ability to communicate with a member of the Workers' Compensation Board, in instances when there is apparent fraud committed by a Workers' Compensation claimant or other important information or irregularities relevant to the case; and be it further

RESOLVED, That the MSSNY seek legislation or regulation to strengthen NYS Workers' Compensation Law and reduce potential fraud and abuse by amending Workers' Compensation Law 110-a Part h to enable physicians to report alleged discrepancies or apparent fraudulent activities by patients and allow the Workers' Compensation Board staff to annotate the WC Case file and alert the Workers' Compensation Fraud Inspector General.
Whereas, the New York State Insurance Fund, NYC law department, amongst other insurers, who arrange for Workers’ Compensation care has been contracting with specific groups for specific services, e.g. electrodiagnostic testing, which is an invasive procedure (only provided by PM&R physicians and neurologists); and

Whereas, several vendors are contracted with workers compensation insurance to provide all non-emergency radiologic imaging for the entire state; and

Whereas, physicians who take care of patients covered by Workers’ Compensation are required to send their patients to these vendors; and

Whereas, the end result is these outsourced groups collect percentages of the entire fee schedule; and

Whereas, effectively physicians accepting patients covered by Workers’ Compensation are reimbursed as low as 50% of the published Workers’ Compensation fee schedule; and

Whereas, this is another example of how physicians in New York are being asked to see patients while receiving ever decreasing reimbursement; therefore, be it

RESOLVED, that MSSNY investigate the Workers’ Compensation fee schedules by third party vendors; and be it further

RESOLVED, that MSSNY advocate for physicians to be paid the entire amount set by the Workers’ Compensation fee schedule.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 260

Introduced by: Fifth and Sixth Districts

Subject: Correcting Workers’ Compensation Board Policy

Referred to: Reference Committee on Socio-Medical Economics

Whereas, A Workers Compensation Law Judge (WCLJ), by ruling in agreement with Independent Medical Examiners (IMEs) and other Insurance Carrier advocates, is ordering treatment decisions to be carried out outside the doctor-patient relationship; and

Whereas, By ordering discontinuation of treatment regimens, in opposition to the ordering physician, the Workers Compensation Board is at odds with its own stated mission: [The New York State Workers’ Compensation Board protects the rights of employees and employers by ensuring the proper delivery of benefits to those who are injured], specifically by eliminating the role of the patient’s personal treating physician; and

Whereas, IMEs and other Insurance Carrier advocates are using the ruling of the WCLJ in order to reduce treatment expenses, thereby creating a conflict of interest, again, outside the traditional doctor-patient relationship; and

Whereas, It is unprecedented that an officer of the Court can rule in favor of an insurance carrier and against a treating physician in order to enforce treatment guidelines not believed to be in the best interests of the patient; and

Whereas, The Workers’ Compensation Board has neither the authority nor the expertise to design treatment plans for injured workers because these plans are the sole responsibility of the treating physician, who must maintain broad authority to accept or reject guidelines based on patient response, safety, availability of effective alternative treatments, etc.; therefore, be it

RESOLVED, That in accordance with longstanding principles of patient advocacy and treatment autonomy, in order to preserve the autonomous nature of the doctor-patient relationship, the Medical Society of the State of New York seek legislative action to ensure that non-physician personnel such as Workers’ Compensation Administrative Law Judges and/or the courts not interfere with the doctor/patient relationship regarding medical judgment for treating an injured worker; and be it further

RESOLVED, That MSSNY seek legislation to ensure that the decision to issue denials is not made by non-physician clerical personnel.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017 - 261

Introduced By: Nassau County Medical Society

Subject: New York State Insurance Fund Unfair Rule Changes

Referred to: Reference Committee on Socio-Medical Economics

Whereas, most work related injuries in New York State are covered by Workers Compensation; and

Whereas, Workers Compensation rules and procedures are far more complicated than regular medical insurance, making compliance far more difficult for patients and physicians; and

Whereas, Workers Compensation carriers have historically provided to the physician prior to the patient being seen, whether the case is active and the body parts involved in the case. This allows the physician to know what exactly they are allowed to treat for under Workers Compensation. Often patients don't understand this and will tell the physician about other issues out of ignorance of how the system works; and

Whereas, to avoid such confusion, it is routine before the patient is seen, for the physician office to inquire of the Workers Compensation carrier whether the case is active and what body parts are listed; and

Whereas, New York State Insurance Fund (NYSIF) changed their policy in 2016 stating that they will not provide this information, telling providers to use their portal to find out who the adjuster is, but when you call that adjuster, if can reach anyone, that you need to check the portal; and

Whereas, physicians offices can call the Workers Compensation Board to check on the body part but often it is not uncommon for the insurance to have different body part. For example if the board states can treat for neck and back, NYSIF may only list the back, then will reject all claims related to the neck. The Workers Compensation Board will not confirm that status of the claim itself; and

Whereas, if the physician treats a patient in which the claim is not active or for the wrong body part, it may be impossible for the physician to get compensated and the patients may accrue medical debt that could have been avoided; therefore, be it

RESOLVED, that Medical Society of the State of New York work with all relevant agencies, including Workers Compensation Board, to force New York State Insurance Fund to return to the policy of providing physician offices both the status of the claim and body parts under that claim prior to the consultation occurring.
Whereas, Certain laws are designed to protect patients (and sometimes physicians) against
managed-care contract clauses favoring the insurer, and

Whereas, Examples exist in which a contract clause, such as one favoring a managed care
company, have negated the dictates of a federal regulation protecting patients and physicians; and

Whereas, Many Medicare Advantage Plans (MAOs – Medicare Advantage Organizations) have
denied claims for visits and diagnostic tests that would have been covered under fee-for-service
Medicare, and

Whereas, Staff of CMS (the Centers for Medicare and Medicaid Services) have refused to deal
with these coverage discrepancies, saying the issues were strictly contractual and physicians
could only challenge the denials through arbitration or legal action; and

Whereas, The CMS position calling coverage discrepancies contractual contradicts federal law
(42 C.F.R.422.101(a)), which states that:

1. MAOs are required to provide to their Medicare enrollees, those services that are
covered under Medicare and are available to other fee-for-service Medicare
beneficiaries in the geographic area covered by the plan; and

2. MAOs are required to abide by CMS regulations, national coverage decisions (NCDs),
and the local coverage determinations (LCDs) made by the Medicare Administrative
Contractors (MACs) that have claims jurisdiction in the MAO’s geographic area; and

Whereas, Because CMS is abrogating its responsibility to regulate and monitor the MAOs, the
CMS position has the effect of blatantly discriminating against the MAO enrollees as a
beneficiary class; and

Whereas, An investigation of this question by the legal counsel of the Medical Society of the State of New York (MSSNY) would benefit patients and physicians; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) examine the legality
of the position taken by the Centers for Medicare and Medicaid Services (CMS), that if a
Medicare Advantage Organization (MAO) has denied payment for services that would have
been covered by fee-for-service Medicare, a physician’s only recourse is arbitration or legal
action despite the provisions in 42 C.F.R.422.101(a), which state that:

1. MAOs are required to provide to their Medicare enrollees, those services that are
covered under Medicare and are available to other fee-for-service Medicare
beneficiaries in the geographic area covered by the plan; and
2. MAOs (both risk and cost plans) are required to abide by CMS regulations, national coverage decisions (NCDs), and local coverage determinations (LCDs) made by the Medicare Administrative Contractors (MACs) that have claims jurisdiction in the MAO’s geographic area;

and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) seek case law or precedent requiring MAOs to fully adhere to 42 C.F.R 422.101(a) regardless of contract terms or in-house claims processing policies and bring such findings to the attention of the Centers for Medicaid & Medicare Services; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) bring this resolution to the American Medical Association and ask it to seek recourse from the Centers for Medicaid and Medicare Services to resolve discrimination against Medicare Advantage patients and the physicians who care for them.
MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017- LATE A

Introduced By: Nina I. Huberman as an individual Delegate, Bronx County

Subject: Changes in Insurance Accepted by Pharmacies

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IF THE HOUSE COMMITTEE ON RULES, CREDENTIALS AND ORDER OF BUSINESS RECOMMENDS ACCEPTANCE FOR BUSINESS, THIS WILL BECOME

Resolution 2017 - 263

Referred to: Reference Committee on Socio-Medical Economics

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1 Whereas, Multiple mergers or purchases of major pharmacy chains have occurred over the past few years; and
2 Whereas, Many patients who have utilized the same pharmacies for many years are unaware that their pharmacies no longer accept their insurance plans; and
3 Whereas, Physicians and other providers are not informed of these changes by the companies; and
4 Whereas, Patients are inconvenienced as their refills are no longer valid, except for the ability to transfer one refill, and physicians must resend new prescriptions for all pending refills; therefore be it
5 RESOLVED, That the Medical Society of the State of New York (MSSNY) work with the necessary entities to require that the pharmacies contact all providers who have sent them prescriptions within the past year with ample notification that they are no longer accepting certain insurance plans; and be it further
6 RESOLVED, That MSSNY recommend that regulations be passed to allow for the transfer of all pending prescription refills to a pharmacy that accepts their insurance.
Whereas, it is critical that when a physician requests service authorization for a patient needing services like, homecare, nursing home care etc., response from plan is prompt and if service is denied, physician has recourse to a fair appeal process; therefore, be it

RESOLVED, that MSSNY work with New York State Department of Financial Services to create laws and/or regulations requiring all insurance plans to respond to requests for services for the patient in one business day and if such response is not in affirmative, then the response includes physician’s option to access a fair appeal process.
Whereas, there is no documented evidence to support the mandating of masks by hospital staff in the hopes of restricting the spread of the influenza virus; therefore, be it

RESOLVED, the MSSNY oppose and ask for repeal of the regulation reading the mandatory wearing of masks when an individual New Yorker chooses to not get the annual flu shot.