POLICY STATEMENTS OF
THE MEDICAL SOCIETY OF DELAWARE

(General topic areas are listed alphabetically. Subject matter within the topic area is listed alphabetically.)

Policy	Position	Adopted	Review Date/Sunset Date
AMERICAN MEDICAL ASSOCIATION			
AMA Emeritus Delegate	Resolution 09-2 (Excerpts) Whereas, the Medical Society of Delaware has had a reduction in allotted Delegates and Alternates to the AMA due to declining AMA membership from Delaware; and Whereas, Dr. Marvel's former delegation seat was eliminated with the reduction in allotment for AMA representation; and Whereas, there are times when Delaware does not field a full delegation to the AMA House of Delegates; and Whereas, the Society's Budget normally provides for a full delegation to the AMA House of Delegates Annual and Interim meetings; and Whereas, there exists no such official elected status within the Medical Society of Delaware or the American Medical Association as a Delegate Emeritus; and Whereas, I. Favel Chavin, MD had served in a similar capacity as a Delegate Emeritus beginning in 1995 until his passing; and Whereas, it would be appropriate to allow Dr. Marvel to be seated as an Alternate Delegate when one of the Delaware elected Delegates or Alternate Delegates cannot attend an AMA House of Delegates meeting; now therefore be it <u>Resolved</u>, that James P. Marvel, Jr., MD, be named an Emeritus Delegate from the State of Delaware to the AMA House of Delegates.	Approved by House of Delegates October 24, 2009	
AMA Guidelines for Reporting Physician Data (Reporting Guidelines)	MSD reaffirmed its support for using the AMA guidelines for Reporting Physician Data (Reporting Guidelines) as a tool, for entities that report data to physicians, to create data reports that physicians can more easily understand and use to enhance data-driven decision-making.	June 2012	

	"Physician Guide to Reviewing and Using Claims Data to Improve Your Profile, Practice, and Payment" is available (www.ama-assn.org/go/physiciandata), which instructs physicians on how to identify the important data in a physician data report and use it for practice improvement.		
MSD OMSS Representative	Motion was approved to fund an MSD OMSS representative beginning with the June 2013 AMA Annual Meeting through the November 2013 AMA Interim Meeting. During this time, the OMSS representative is responsible for providing information to the MSD hospital medical staff employed physician representatives from the AMA meetings. The Executive Board had approved funding for an OMSS representative for one year, ending in 2013. It was requested that ongoing funding for this position be considered for the budget, as it is extremely helpful to have an additional person to cover reference committees. Future funding could be considered to come from the physician representative's hospital organized medical staff or all Delaware hospital medical staff sections paying a portion.	OMSS position approved at the June 14, 2012 Executive Board meeting. Reaffirmed support of continued funding in the budget for an OMSS representative at the July 11, 2013 Executive Board meeting.	
CONTINUING MEDICAL EDUCATION			
CME Transcription Service	As a requirement of the ACCME, any health care professional who attends an MSD accredited continuing medical education event and completes the necessary paperwork to earn CME Category 1 credit will be logged in the MSD database system as attending the event. MSD provides a transcription tracking service that MSD members can opt-in to. The service keeps track of all CME credit earned by the member and MSD notifies the member periodically of the total number of credits logged within the licensing period.	In 2013 – changed the opt-in to an annual process to eliminate those who decide not to continue with the service.	
CME Charges	Non-members requesting CME certificates for attendance at MSD-sponsored CME events are charged $10 for each certificate produced. (Certificates are available to all attendees at the time of an individual session.) There continues to be no charge to members.	February 2005	
CME Mission Statement	1) Based on a need determined by Delaware doctors, the purpose of the Society's CME program is to provide educational activities that serve to maintain, develop, and increase the knowledge, competence, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The program will identify professional practice gaps, the cases of the gaps, and provide educational activities that result in achievable and	Adopted with revisions by the Public and Professional Education Committee	

	measureable outcomes for physician improvements in competence, performance, or patient outcomes. 2) Educational activities which assist physicians in carrying out their professional responsibilities more effectively and efficiently are CME. Educational activities must incorporate educational needs underlying learner professional practice gaps; be designed to change competence, performance, or patient outcomes; match learners' current or potential scope of professional activities; utilize appropriate educational formats; address desirable physician attributes; be independent of commercial interests; appropriately manage commercial support; maintain separation of promotion from education; and actively promote improvements in health care. 3) Educational activities are designed primarily to meet the needs of physicians in Delaware. MSD will also consider sponsoring out-of-state activities, provided the activity meets the criteria outlined in the CME Mission Statement and is primarily aimed at Delaware physicians. All activities present a level of knowledge appropriate to physicians; however, the target audience may include other health care professionals, as well as other interested members of the public. 4) Activities may be directly sponsored or presented through joint-sponsorship with noncommercial interests include non-accredited hospitals, community health organizations, specialty societies, and other health care organizations that share a common educational objective as determined by the Public and Professional Education Committee. Types of activities include: live activities (ex. symposia, conferences, seminars, regularly scheduled conferences, grand rounds, teaching rounds, departmental scientific meetings, simulation workshops, structured learning activities presented during committee meetings, and live internet webinars); enduring materials; and journal based CME. MSD will not sponsor or joint sponsor with commercial entities. 5) CME activities sponsored by MSD are expected to provide the opportunity for physicians in the state to maintain state licensure, as well as achieve measureable improvements in physician competence, performance, and patient outcomes. Physicians are expected to incorporate these improvements into their practices and ultimately to improve medical care in Delaware and the surrounding states. MSD will analyze changes in learner competence, performance, or patient outcomes that are achieved as a result of its CME program.	January 2012. Ratified by the Executive Board February 2012.	
Maintenance of Licensure (MOL)	MOL is a process for licensed physicians to provide, as a condition of license renewal, evidence of active participation in a program of continuous professional development relevant to their area of practice, aimed at improving performance over time. In 2010 the FSMB adopted a proposal to establish MOL for licensed physicians to ensure these	Motions adopted at the January 10, 2013 Executive Board meeting.	

	physicians are keeping current in their area of practice. MSD adopted a motion at its 1/10/13 Executive Board meeting not to engage in the MOL pilot for Delaware. A second motion was adopted for MSD to oppose MOL in Delaware at this time and support a data collection process on physician education and quality measures. The Federation of State Medical Boards (FSMB) provided a draft report of the MOL Task Force recommendations at the beginning of the year (2014). The Executive Board reviewed the recommendations at its meeting on February 20, 2014 and did not have any significant concerns. MSD responded to the draft report in a letter dated February 28, 2014 to the FSMB. The letter stated that generally speaking, MSD is supportive of the recommendations and concurs with the position of the AMA that the MOL guidance contained in this and prior MOL reports will allow the large majority of physicians to comply with MOL by demonstrating participation in Continuous Professional Development (CPD) and quality improvement they are already engaged in for other regulatory purposes including CME with performance improvement or CPD focus. In addition, MSD stated its support for: MOC exemption for MOL; and allowing grandfathering when a physician is board certified, as these physicians should be considered exempt from MOL. MSD also recommended clarity around the time frame for physicians who are not currently board certified but wish to become board certified and thus MOL exempt.	Letter to FSMB reviewed at 5/8/2014 Executive Board meeting.	
ETHICS			
Artificial Nutrition and Hydration (ANH)	Resolved, that the Medical Society of Delaware support the use of ANH as a form of medical intervention that should be evaluated by weighing the risks and benefits of implementation with respect to the patient's goals of care and clinical circumstances; and be it further Resolved, that the Medical Society of Delaware acknowledge that ANH, like other medical interventions, can ethically and legally be withheld or withdrawn, consistent with the patient's wishes and the clinical situation; and be it further Resolved, that the Medical Society of Delaware encourage the establishment of open communication between patients, families, and caregivers to assure that their concerns are heard; and be it further Resolved, that the Medical Society of Delaware support physicians and other health care providers to encourage their patients to complete Advance Directives to include decisions on ANH.	Resolution 08-3, Adopted by HOD 10/11/08 with no discussion.	
Capital Punishment	Committee on Ethics recommended that the Society's opinion on physician participation in capital punishment be consistent with the current AMA opinion, opposing physician participation in executions (H-140.898) because it is a clear violation of medical ethics	12/10/2009 Board of Trustees approved	

	codes.	recommendation made by Committee on Ethics at its September 2009 meeting.	
Chaperones	Committee on Ethics discussed House Bill 456 which was passed, enacting a law for having a chaperone present with minors. Hospitals were granted the privilege to develop their own policies, as timely inpatient care may be impeded by the chaperone policy. The committee agreed that the chaperone law appears reasonable for the protection of both the physician and the patient. A recommendation from the committee was presented to the Board of Trustees at its meeting on September 9, 2010. The Board adopted a modified version of the original Ethics Committee recommendation to be: *MSD is in support of the chaperone minor law with the inclusion of all health care practitioners having the responsibility of abiding by the established rules.*	9/9/2010 Board of Trustees approved modified recommendation submitted by Committee on Ethics from its meeting on September 1, 2010.	
Conscience Right of Refusal	The Medical Society of Delaware believes in the rights of physicians to defer from providing care that violates personal beliefs when they do not feel they can, in good conscience, provide services which patients request. The Society believes that the physician has a duty to provide patients with accurate notice of their personal moral commitments and to refer patients in a timely manner to other professionals in these situations for the patient to obtain the help they need. MSD signed on to AMA Letter sent to the Obama Administration on April 4, 2009 supporting the rescission of the Bush Administration December 2008 final rule (final rule includes those not involved in direct care of the patient). Pre-existing statutes (Civil rights laws and Church laws) stay in place continuing to offer protections if Bush Administration ruling is rescinded.	By Board of Trustees at its meeting on March 12, 2009	
Discount Coupon Use for Physician Marketing	Committee on Ethics discussed whether it was ethical for physicians to market through the use of discount coupons (such as Groupon or Living Social) or whether use of such coupons could be construed as fee splitting which is not considered an ethical practice. The AMA policy does not specifically address the use of discount coupons. The question hinges on whether the arrangement between the physician and the discount coupon company has more the character of an advertising relationship or a referral relationship. There are no restrictions on advertising by physicians except those to protect the public from deceptive practices. *The use of discount coupons by physicians does not appear to be a situation of fee splitting. Physicians should not market medical services and caution should be taken that whatever fees are accepted for a medical practice, they are required to conform to federal and state laws.*	At its meeting on 9/13/2012, the Executive Board adopted the recommendation by the Committee on Ethics from its meeting held on March 21, 2012.	
Embryo Implantation Guidelines	The Board approved support of 2008 guidelines established by the Practice Committees of the Society for Assisted Reproductive Technology and American Society for Reproductive Medicine and encourages: 1) specialty organizations establish fertility guidelines for utilization; and 2)	By Board of Trustees at its meeting on March	

	seeking counsel with an Ethics Committee prior to moving forward should a physician and patient plan on treatment outside established guidelines.	12, 2009	
Embryo Screening	Discussion held at the September 26, 2007 and March 26, 2008 meetings of the Committee on Ethics. Committee made the following recommendation to the Board of Trustees for approval: *In IVF pre-implantation embryo screening, the committee recommends support for embryo screening limited to medical reasons and accompanied by appropriate genetic counseling*.	Adopted by Board of Trustees at its meeting June 12, 2008.	
Emergency Medical Care Standards (in situations such as with Hurricane Katrina)	Committee on Ethics recommended that immunity should be granted to health care professionals working and present within a catastrophic disaster, but not where there is clear willful misconduct.	12/10/2009 Board of Trustees approved recommendation made by Committee on Ethics from its meeting held September 2009.	
End of Life Discussions with Patients	Committee on Ethics discussed law in New York State mandating end-of-life discussions, and agreed that MSD be supportive of physicians having end of life discussions with terminally ill patients regarding palliative care alternatives, including pain management and Hospice. The committee encourages MSD to support the MOLST form for use in Delaware to help clarify the preferences of the patient with advanced illness.	9/9/2010 Board of Trustees approved recommendation by Committee on Ethics from its meeting on September 1, 2010.	
Ethics Checklist	Committee on Ethics recommended that, while an ethics checklist may have some merit for its use, there are concerns as to whether use of an ethics checklist would improve outcomes, as there is not enough information at this time to make any discernable decisions on this matter.	12/10/2009 BOT approved recommendation by Committee on Ethics from its meeting in September 2009.	
Honesty with Patients	Committee on Ethics discussed the 2012 survey by Massachusetts researchers and published in the February 2012 "Health Affairs" indicating half of the doctors responding to the survey admitted describing someone's prognosis in a way they knew was too rosy; nearly 20% admitted not fully disclosing a medical mistake for fear of being sued; and 1 in 10 indicated they had told a patient something that wasn't true in the past year. Should physicians be completely honest, admit mistakes, say they are sorry, or exaggerate health care findings to entice patients into compliance?	At its meeting on 9/13/2012, the Executive Board adopted the recommendation by the Committee on Ethics from its meeting held on	

	Physicians are obliged to be honest, especially when impacting the health of a patient. The physician must evaluate the entire situation and place the welfare of the patient above the needs of the physician. It should also be noted that it is not always easy for a physician to identify a mistake when it first happens.	March 21, 2012.	
Retainer Practices (Boutique Medicine)	Leonard Morse, MD, Chair of the AMA Council on Ethical and Judicial Affairs: "Retainer practices provide an opportunity for patients to develop a more personalized relationship with their physician. But physicians should also make sure that all patients including those who do and do not pay retainer fees continue to receive the same quality of care." The following are the guidelines of the MSD on Retainer Practices: 1. The patient has the freedom to select and supplement insurance for their health care on the basis of what appears to them to be an acceptable tradeoff between quality and cost; 2. When entering into a retainer contract, both parties must be clear about the terms of the relationship and must agree to them. Patients must be able to opt out of a retainer contract without undue inconveniences or financial penalties; 3. Physicians must always ensure that medical care is provided only on the basis of scientific evidence, sound medical judgment, relevant professional guidelines and concern for economic prudence. A retainer contract is not to be promoted as a promise for more or better diagnostic and therapeutic services; 4. Physicians converting their traditional practices into retainer practices must facilitate the transfer of their non-participating patients to other physicians, with no extra fee for transmission of their medical records; 5. Physicians who enter into retainer contracts will usually receive reimbursement from their patients' health care plans for medical services. Physicians are ethically required to be honest in billing for reimbursement; 6. Physicians have a professional obligation to provide care to those in need, particularly those in need of urgent care. Physicians who engage in retainer practices should seek specific opportunities to fulfill this obligation.	December 11, 2003 Executive Committee recommendation to Board of Trustees. Board of Trustees adopted at its meeting on January 8, 2004	
Social Media and Professionalism	Committee on Ethics discussed that the internet has created the ability for physicians to communicate and share information quickly and to reach millions of people easily. However, social media has created new challenges to the patient/physician relationship. Medical licensing applicants are being turned down because the licensing boards are finding improper social networking content. As an administrative tool, social networking is excellent. As a medical tool, the needed safeguards for privacy are not there. Patients expect that if they email a physician, the email is read quickly, which may not always be the case. Encrypted email must be used when communicating with patients and patients need to understand that email is not monitored continuously. Breeches in security may also occur.	At its meeting on 9/13/2012, the Executive Board adopted the recommendation by the Committee on Ethics from its meeting held on March 21, 2012.	

	Physicians are taking advantage of the power of social media, but there needs to be limits and physicians must keep personal and professional networking separate.		
Social Media and Sharing Information about Patients	The Committee on Ethics, at its February 5, 2014 meeting, recommended to the Executive Board its opinion that, it is responsibility of the person using social media (Twitter, FaceBook, etc.) for the purpose of communicating about a patient and his/her condition, and also the responsibility of the patient to inform those who want to share the patient's information on social media of their wishes about what they permit to be shared on social media about the patient. The patient and the person doing the communicating a responsible for having a clear understanding of what is or is not to be shared and to know the consequences of sharing the information. The Committee on Ethics also felt it is important that hospital administration and physicians be aware that patient information sharing on social media can and does happen (possibly without the patient's knowledge) and to provide guidance in situations where it is inappropriate to provide patient information through social media. At its meeting on February 20, 2014, the MSD Executive Board approved the February 5, 2014 minutes of the Committee on Ethics acknowledging its support of the Committee's opinion on social medial use in this regard.	2/5/14 Recommended opinion from Cmte on Ethics. 2/20/14 - accepted by Executive Board	
Stem Cell Research	Resolved, that the Medical Society of Delaware does not support human reproductive cloning; and be it further Resolved, that the Medical Society of Delaware does not support the use of aborted fetuses for use in stem cell research; and be it further Resolved, that the Medical Society of Delaware is supportive of the use of adult stem cells in research; and be it further Resolved, that the Medical Society of Delaware is supportive of gathering blood cells from the umbilical cord at the time of birth for use in stem cell research; and be it further Resolved, that the Medical Society of Delaware is supportive of the use of already existent IVF cells targeted for destruction, with proper consent, but is not supportive of the creation of IVF cells for use in stem cell research; and be it further Resolved, that the Medical Society of Delaware supports the use of somatic cell nuclear transfer technology in biomedical research (referred to as therapeutic cloning) with appropriate guidelines in place as outlined by the AMA, but opposes the use of somatic cell nuclear transfer technology for the specific purpose of producing a human child (human reproductive cloning); and be it further Resolved, that the Committee on Ethics will continue to re-evaluate and address the issues related to stem cell research as more information becomes available.	Resolution 07-1, Adopted with changes by HOD 10/20/07 This HOD adopted resolution modifies the Board of Trustees-approved/ Committee on Ethics recommendations submitted in 2005.	

Treatment of Family Members by Physicians	Committee on Ethics (September 2009 meeting) recommended that, while there are circumstances that may be unavoidable, physicians generally should not treat themselves or members of their immediate family. At its December 10, 2009 meeting, the Board of Trustees concluded that treatment provided to a family member should not be the sole treatment provided and the patient needs to have a designated physician care giver other than the family member physician. The Board approved the recommendation made by the Committee on Ethics.	12/10/2009 Board of Trustees adopted recommendation by Committee on Ethics from its meeting held in September 2009 with additional comment.	
Walk-In Clinics Incorporating Telemedicine for Patients to Communicate with Physicians	Committee on Ethics (March 21, 2012) discussed a merger of multiple trends focused on providing convenience to patients than a physician's office can deliver. Rite Aid is incorporating virtual visits-nurses and physicians seeing patients via a computer screen – the "NowClinic" concept. Patients connect with physicians through web chat or video conferencing, the same way they would from a "NowClinic" exam room at the Rite Aid pharmacy. There are no charges for virtual consultations with a nurse, who can advise if a doctor visit is warranted. There is a charge for speaking with a physician. *This movement is inevitable, especially due to access to care concerns; however, there should be limits for diagnosing within this type of setting.*	Approved at the Executive Board meeting held on 9/13/12. Report to Council at October 20, 2012 Annual Meeting was adopted.	
GOVERNANCE			
County Medical Societies Dissolution and Use of Funds	County members agreed and voted to distribute corporate assets remaining from each society to MSD to be used for the same purposes and uses originally designated for such funds. Monies now held by MSD in three separate restricted cash line items to be disbursed upon formal request (request from MSD, geographic group, practice type group) pursuant to the intended use of the funds (promote the interest of medical education and activities related to the practice and advancement of the medical profession. Funds may be applied to the expense of administrative support (ex., arranging the activity) and to the reasonable expense of the activity (room rental, reasonable food/beverage expense, speaker honorarium, applicable CME fees).	Adopted by Executive Board 6/14/12. The Executive Board in its adopted motion provided "opportunity for future revisions as necessary and that the guidelines will be reconsidered at a later date. (Board did not specify time certain)	

Ribbon Use at Annual Meeting	The use of the wealth of ribbons to identify the physician's affiliations will be discontinued. Council members will be identified, as well as DELPAC members. MSD staff will determine the best and most cost effective way to accomplish this.	Adopted at the July 12, 2012 meeting of the Executive Board.	
HEALTH CARE REFORM			
Coalition of State Medical & National Specialty Societies	MSD joined as a charter member of the Coalition – Coalition was formed after the Medical Association of Georgia presented a resolution to AMA House of Delegates on the right to privately contract. Those state societies who signed on to the resolution continued to be part of this group. The Coalition's purpose is to essentially reform the AMA to the ideologies of the AMA House of Delegates on health care reform. The Society's membership in the Coalition is not binding and MSD has the option to terminate its membership in the Coalition.	February 2010 Executive Committee recommendation to join. 3/11/2010 Board of Trustees approved membership.	Annual Membership
Coalition of State Medical & National Specialty Societies Health Care Reform (please also refer to MSD's Principles of Health Care Reform approved June 12, 2008)	**HEALTH CARE REFORM COALITION SUPPORT** A motion was approved to support Coalition of State Medical & National Specialty Societies' opposition to the House of Representatives Tri-Committee proposal (HR 3200), but with an understanding that the MSD supports an individual mandate because MSD does not believe that health system reform can work without an individual mandate, and that MSD supports Comparative Effectiveness Research (CER) with substantial practicing physician leadership directing the recommendations of the CER guidelines. An amendment was approved indicating support of patient choice and to accomplish patient choice, an individual mandate is necessary.	Approved at 7/9/09 Executive Cmte/Holding Co Joint meeting.	
Health Care Reform Principles	At the 2006 House of Delegates meeting, Resolution 06-2, "Universal Health Insurance" was introduced. This resolution passed the House. A Task Force was formed and developed a set of principles during its meetings held in 2007-2008. These principles are to be used as a mechanism by which to evaluate universal health care plan proposals at the federal and/or state levels. These principles encompass the core ideologies believed by the Task Force and the members of the Medical Society of Delaware as necessary to have in any universal health care reform plan. Town meetings held for the counties for discussion and feedback (4/30/08 for New Castle County and 5/21/08 for both Kent and Sussex Counties). The principles were then provided to the Board of Trustees for its final approval. To view the MSD Principles of Health Care Reform adopted in 2008, go to: http://www.medicalsocietyofdelaware.org/Portals/1/About%20Us/HCR%20Principles%206-12-08.pdf	Adopted by Board of Trustees June 12, 2008	

Health Courts	The Medical Society endorses the need for comprehensive litigation reform and supports the components of health courts as alternatives to the current system, worthy of further research and demonstration projects.	Adopted by Board of Trustees 3/9/06	
A Learning Health Care System	The Committee on Ethics agreed that a "learning health care system" is a health care system in which knowledge generation is so embedded into the core of the practice of medicine that it is a natural outgrowth and product of the health care delivery process and leads to continual improvement in care. This system would ensure that learning activities carried out are conducted ethically and that it is acceptable and essential to integrate research and practice. There are seven obligations in this system that are necessary: 1) Respect patients - obtain informed consents, soliciting and accepting advance directive, protecting confidentiality of health information, and evaluating the effectiveness of health care in terms of outcomes that matter to patients. 2) Respect clinician judgment – how best to care for a patient in light of multiple considerations and influence, which includes professional experience, experience of colleagues, scientific evidence, and the clinician's understanding of the patient's values and priorities. 3) Provide optimal care to each patient – moral responsibility of professionals to advance the interests of each patient by providing the patient with optimal care aimed at securing the best possible clinical outcome. 4) Avoid imposing nonclinical risks and burdens – clinical care and information can be used in ways that affect patients' interests in financial well-being, social standing and reputation, employment and insurance opportunities, dignity, privacy, and the joy of spending time with family and loved ones. 5) Address unjust inequalities – subject selection should be fair and distribution of research benefits and burdens should be just to avoid concerns about abuse of disadvantaged or vulnerable subjects in research. 6) Conduct continuous learning activities that improve the quality of clinical and health care systems – augment the obligation to stay current in knowledge and skills with an affirmative responsibility to contribute to that knowledge base – contribution to learning is morally obligatory and extends its reach beyond health care professionals to institutions, payers, and purchasers of health care. 7) Patients contribute to the common purpose of improving the quality and value of clinical care and the health care system – just as health professionals and organizations have an obligation to learn, patients have an obligation to contribute to, participate in, and otherwise facilitate learning, through research means. There is value in standardizing an approach to care by utilizing checklists, reminders, etc. to help practice better medicine. Physicians are voicing difficulty in finding time to listen to	Adopted by the Executive Board at its meeting on July 11, 2013.	

	patients to better understand their concerns and that EMRs do not necessarily help determine non-routine issues because the software is very standardized. *The committee agreed that, practicing physicians have the obligation to participate in performance and quality improvement in system learning activities and should drive the process.* At its July 11, 2013 meeting, the Executive Board approved the recommendation that, *practicing physicians have the obligation to participate in performance and quality improvement in system learning activities and should drive the process.*		
Patient-Centered Medical Home	The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth, and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Personal physician – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care. Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. Quality and safety are hallmarks of the medical home: • Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.	The Joint Principles of the Patient-Centered Medical Home were developed by the American Academy of Family Physicians in cooperation with the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association. The Society's Board of Trustees formally adopted these principles as policy at its meeting on September 13, 2007. 2011 – MSD	

	• Evidence-based medicine and clinical decision-support tools guide decision making. • Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. • Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met. • Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication. • Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model. • Patients and families participate in quality improvement activities at the practice level. Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff. Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: • It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit. • It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. • It should support adoption and use of health information technology for quality improvement. • It should support provision of enhanced communication access such as secure e-mail and telephone consultation. • It should recognize the value of physician work associate with remote monitoring of clinical data using technology. • It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits.) • It should recognize case mix differences in the patient population being treated within the practice.	embarked on creating a Pilot Program for a PCMH model.	

	• It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting. • It should allow for additional payments for achieving measurable and continuous quality improvements.		
PCMH recognition and accreditation guidelines	Because of the multiple entities developing and offering medical home recognition or accreditation programs, the AAFP, AAP, ACP, and the AOA are offering "Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs." The MSD Executive Board was in agreement with these guidelines, which provide an agreed upon pathway incorporating 13 criteria to fulfill the program requirements. All Patient-Centered Medical Home Recognition or Accreditation Programs should: 1) **Incorporate the Joint Principles of the Patient-Centered Medical Home**. These principles are intended to describe the characteristics of a PCMH, including: a personal physician in a physician-directed, team-based medical practice; whole person orientation; coordinated and/or integrated care; quality and safety; enhanced access; and payment. 2) **Address the Complete Scope of Primary Care Services**. The Institute of Medicine (IOM) has developed a commonly accepted definition of primary care which is: "Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community" (IOM, 1996). The term "integrated" in the IOM definition encompasses "the provision of comprehensive, coordinated, and continuous services that provide a seamless process of care." The PCMH model facilitates ideal primary care and therefore recognition and accreditation programs should attempt to assess all of the primary care domains outlined by the IOM – comprehensiveness, coordination, continuity, accessibility, and patient engagement and experience. This will further ensure that every recognized or accredited entity provides care consistent with the Joint Principles, including, but not limited to, having a whole person orientation which means taking responsibility for coordinating each patient's full array of health care services using a team-based approach (i.e., delivering care for all stages and ages of life, acute care, chronic care, behavioral and mental health care, preventive services, and end of life care) and coordinating and/or integrating care for services not provided by the PCMH across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). 3) **Ensure the Incorporation of Patient and Family-Centered Care Emphasizing Engagement of Patients, their Families, and their Caregivers**. A commonly accepted definition of "patient-centered care" also is provided by the IOM: Patient-centered care is "health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care" (IOM, 2001). Therefore, recognition and accreditation programs for the patient-centered medical home should attempt to incorporate elements that assess a practice's or organization's ability to implement patient- and family-centered care based on the needs and preferences of their patients, family, and caregivers; incorporate shared-decision making; encourage and support self-management and self-care	Adopted by Executive Board May 9, 2013	

techniques; facilitate complete and accurate information sharing and effective communication; encourage active collaboration of patients/families in the design and implementation of delivery of care; ensure cultural and linguistic competency among its clinicians and staff; and collect and act upon patient, family, and caregiver experience and satisfaction data. There should also be special considerations to align program standards, elements, characteristics, and/or measures with populations that have specific needs such as the pediatric and geriatric populations.

4) **Engage Multiple Stakeholders in the Development and Implementation of the Program**. The development, implementation, and evaluation of a PCMH recognition or accreditation program should be a transparent process, open to input (e.g., through a public comment period) from all relevant stakeholders, such as clinicians, practice staff, patients and families, professional societies, private and public payers, employers/purchasers, health care-oriented community organizations including patient and family advocacy groups, and representatives from quality improvement programs.

5) **Align Standards, Elements, Characteristics, and/or Measures with Meaningful Use Requirements**. Recognition and accreditation programs related to the PCMH should actively work to align their standards, elements, characteristics, and/or measures with the meaningful use criteria outlined by CMS and the Office of the National Coordinator for health Information Technology (ONC). In the short term, these programs should clearly identify which of their standards, elements, characteristics, and/or measures are related to the meaningful use criteria. Then over time, those items should evolve to align sufficiently with the meaningful use criteria such that CMS and ONC might allow recognized or accredited entities to receive "credit" based on achievement of PCMH status.

6) **Identify Essential Standards, Elements, and Characteristics**. Recognition and accreditation programs for the PCMH should clearly identify a set of standards, elements, and/or characteristics that are considered essential (i.e., core to being a medical home practice). These should include but not be limited to: 1) advanced access principles (e.g., same day appointments, extended hours, group and e-visits, and patient portals); 2) comprehensive practice-based services (e.g., acute and chronic care, prevention screening and ancillary therapeutic, support, or diagnostic service); 3) effective care management (e.g., demonstrated capacity to execute population management); 4) care coordination (e.g., between providers and other practices, subspecialty care, hospitals, home health agencies, nursing homes, and/or community-based care resources); 5) practice-based team care; and 6) guarantees of quality and safety (e.g., incorporation of evidence-based best practices, clinical outcomes analysis, regulatory compliance, risk management, and medication management). These items should be based on the best available evidence, which can be determined via literature review; ongoing evaluation of the individual standards, elements, and/or characteristics and the program as a whole; evaluation of implementation tools and resources; evaluations of projects, organizations, and practices that are utilizing the program; and expert stakeholder, patient, and family input. Flexibility for practices in satisfying these essential elements should be applicable to different sizes of practices from a small solo practice to a large multispecialty group and also be implementable in different geographic settings from rural areas to large metropolitan cities.

7) **Address the Core Concept of Continuous Improvement that is Central to the PCMH Model**. Transforming to a PCMH is a process requiring a culture of continuous quality improvement that will be different for each practice. Therefore, PCMH recognition and accreditation programs should foster practice transformation and acknowledge progress towards the medical home ideal by providing increasingly complex goals for practices to meet. These progressive goals could be

	reflected through different levels of recognition or accreditation, as well as through the use of practice-level outcomes measurement and time-limited recognition or accreditation that would require the need to periodically reapply. Additionally, recognition and accreditation programs should include goals that are more advanced or aspirational in nature for practices to pursue. For example, calling for the practice to seek feedback from its patients and families on key aspects of its operations and to document practice changes in response to that information. These goals could be presented as potential future standards, elements, policy changes, or characteristics that some practices or organizations might want to achieve sooner. Inclusion of these objectives would provide an opportunity for recognized or accredited medical homes to consider steps beyond the essential standards, elements, characteristics, and existing levels of the recognition or accreditation process. This approach also would allow recognizing and accrediting bodies to learn about the challenges, relevance, and implications of these more advanced elements. 8) **Allow for Innovative Ideas**. Patient-centered medical home recognition and accreditation programs should encourage applicants to submit innovative approaches (e.g., best practices) for providing patient/family-centered care, particularly in a team-based environment. This approach can also provide a data set from which the certifying, recognizing, or accrediting body, and possibly others, can learn about innovative ideas (e.g., best practices). 9) **Care Coordination within the Medical Neighborhood.** According to the Joint Principles, a medical home is characterized by every patient/family having a personal physician who provides first contact care, understands the health care needs of the patient/family, facilitates planned co-management across the lifespan, and has the resources and capacity to meet the patient/family needs. Recognition and accreditation programs for the patient-centered medical home should acknowledge the care coordination role of the PCMH practice or organization within the larger medical neighborhood and community that shares the care for its patients and families, including transitions across practices and settings (e.g., pediatric/adolescent care transitioning to adult care), interactions with the specialist and subspecialist practices, hospitalists, and care facilities such as hospitals and nursing homes and their connections to home and community based support services. 10) **Clearly Identify PCMH Recognition or Accreditation Requirements for Training Programs.** Recognition and accreditation programs for the patient-centered medical home should address the unique nature of health professional training programs (e.g., residency programs) by providing clarifications and/or additional explanations where necessary to permit such training site practices to be considered by recognition and accreditation programs. Additionally, patient-centered medical home recognition and accreditation programs should consider the "Joint Principles for the Medical Education of Physicians as Preparation for Practice in the Patient Centered Medical Home," released by AAFP, AAP, ACP, and AOA, when developing and/or revising their programs (AAFP, AAP, ACP, and AOA, 2010). 11) **Ensure Transparency in Program Structure and Scoring.** Programs for the recognition or accreditation of patient-centered medical homes should clearly identify which standards, elements, and/or characteristics relate to each other so that practices and organizations can tackle the prerequisite items first before moving on to others that rely on the responses and documentation for the previous items. Provision of a "roadmap" such as this will result in the recognition or accreditation process being more user friendly in terms of how the applicants can approach the requirements and move along the continuum toward medical home transformation, while still allowing for variation. Similarly, those programs that involve scoring, rating, or ranking of practices and organizations against their established standards, elements, and/or characteristics should		

	ensure that their scoring processes are informed by evidence, and are as transparent, consistent, and objective as possible. The scoring processes for these programs should include the provision of specific feedback to applicants regarding the calculation of their scores, highlight areas of strengths and weaknesses relative to the program's requirements, and acknowledge incremental improvements that have been or can be achieved. 12) **Apply Reasonable Documentation/Data Collection Requirements.** It may be necessary for a patient-centered medical home recognition or accreditation program to require provision of documentation by practices and organizations in order to verify that they are indeed implementing the standards, elements, and/or characteristics of the program. This documentation may be prospective "proof" of processes and structures that indicate the submitting practice or organization is capable of providing preventive, acute, and chronic care consistent with the patient-centered medical home model and/or process and outcome measure data that meet certain performance or improvement thresholds (e.g., chronic care management, provision of preventive services, patient experience). For any documentation approach that is taken, the requirements should be transparent, consistent, and regularly reviewed for their relevance and reliability. Documentation requirements found not to be relevant or reliable should be removed from the requirements when identified. Further, programs should be prepared to provide characteristics. This could eventually allow applicants to submit the required documentation directly from their health IT solutions. Recognizing and accrediting bodies should also consider consulting with public health agencies to ascertain those data elements that could effectively measure and enhance knowledge of health and healthcare disparities in a community. 13) **Conduct Evaluations of the Program's Effectiveness and Implement Improvements Over Time**. Entities involved in the development and implementation of patient-centered medical home recognition or accreditation programs should exhibit a commitment to comprehensively evaluate and improve their programs over time, informed by evidence, field testing, the experience of the stakeholders utilizing their programs including patients and families, public comment, and the changing health care environment. The evaluation should include qualitative measures that address quality of care (preventive, acute, and chronic) across all ages and cultural backgrounds; patient, family, and health care professional satisfaction; and the effectiveness of the recognition/accreditation program's technical assistance and guidance to applicants; as well as quantitative measures that address health outcomes, utilization and program costs, and the changing health care environment. Results of these evaluations should be published in the professional literature. Additionally, in order to ensure that the participating practices are fulfilling the program requirements, recognizing and accrediting entities should conduct random site visits and/or audits of a percentage of those practices. The participating practices should in turn have a transparent and easy-to-use mechanism for providing direct feedback to the recognizing or accrediting entities, and receive assurance of a timely response when a response is appropriate or requested.		
State Innovation Model (SIM)	In 2013, Delaware was awarded $2.5 million in grant money to create a State Innovation Model (SIM) of reform plan. The initiative is to create a health plan over a six month time frame to reform Delaware's health system. MSD members participated in the six different workstreams. An established governance structure is part of the model. A position statement in response to the SIM project was developed in 2013 in 2014 expressing inclusion of physician-led reform and physician-led care teams, as well as	Adopted by Executive Board July 11, 2013 The Executive Board reaffirmed its position at the	

	defining a position on a governance structure. The Executive Board reaffirmed its position that this effort must be physician-led.	May 8, 2014 meeting that having a physician-led team was imperative.	
MEMBERSHIP			
Former Members Membership Renewal Process	From time to time former members who have been dropped (non-payment of dues) or have resigned from MSD membership make a decision to rejoin the MSD. The following outlines the procedures for the two relevant scenarios. **<u>Membership termination within past membership year</u>** Should the physician have been dropped, resigned, or otherwise not continued membership within the past membership year, the member can rejoin without requirement of the application process. This assumes the physician continues to meet all requirements of membership (appropriate licensure as applicable, of good morale character, etc.). All dues must be paid to date to continue as a member without interruption. Staff will verify the physician's information in the database to ensure up-to-date information is maintained and the physician will automatically be reinstated. **<u>Membership termination longer than one membership year</u>** Should the physician have been dropped, resigned, or otherwise not continued membership for a period longer than one membership year, the member must go through the regular application process by completing an application and have the appropriate review to approve membership. Should the physician have a concern regarding his/her life membership status, the physician has the opportunity to pay all prior delinquent past year(s) dues and bring his/her dues payment status current and uninterrupted. This would be reflected as a continuous membership in the Society and apply to the requirements of life membership status. The physician would still be required, however, to go through the normal application process as if applying for membership for the first time. The physician is not required to pay all past dues, but the membership qualification for life status would be interrupted and begin accumulating the year of rejoining, once membership in the Society has been approved.	Approved by Committee on Membership at its meeting 6/4/07. BOT approved policy at its meeting 6/14/07 with a referral to the Bylaws Committee to consider inclusion in Bylaws. The October 20, 2007 House of Delegates changed the proposed Bylaws wording slightly to reflect the following, which was adopted by the House: "*The procedures for reinstatement for membership under varying circumstances are part of the Medical Society of Delaware Board of Trustees-approved guidelines.*"	
Part-Time Dues Status Submission Request Deadline	Board of Trustees adoption of policy establishing a mid-February annual deadline for receipt of the dues reduction request for part-time practicing physicians (does not pertain to hardship or other types of requests).	March 12, 2009 Meeting of the Board of Trustees	

	The rationale behind a deadline for these types of requests is that, annual dues bills are mailed out to the membership no later than the beginning of November for the following year's dues payment. Physicians will know in a reasonable period of time after receipt of the dues bill whether they will be practicing on a part-time status for the following year. Should a part-time practicing request not be received in time for the review and recommendation at the later March Executive Board meeting, the next review by the Board would be at its May meeting with the member essentially on hold for payment of dues for seven months since the first dues notice is mailed. It has been the Society's practice that should a physician pay dues and then retire mid-year, the dues are not refunded. This would hold true for any physician who pays a full year's dues and then changes their practicing status later in the year (unless they were then to apply for a financial hardship). It was confirmed that this deadline is not unreasonable, given the fact that physicians will receive a dues billing notice approximately three and ½ months prior to the deadline for submission. Any part-time status dues reduction requests received after this deadline would not be honored for that year.		
MISCELLANEOUS MSD			
Providing Exhibitors at MSD Meetings with Attendee Contact Information	MSD has received requests in the past and most recently regarding the 2011 Spring CME Symposium from exhibitors wanting a list of names and contact information of the attendees. MSD has not provided this information in the past, but felt it would be appropriate to revisit this issue and develop a formal policy. Motion adopted to provide the physician's office address and phone number to the exhibitors unless the physician opts out. A check box on the registration form would be utilized for those who do not wish their name provided to exhibitors.	6/9/11 by Board of Trustees	
Going Green	As part of the fiduciary responsibility outlined above, the Executive Committee has acted on the 2009 budget, recommending that committees convert meeting materials to paperless by posting to the MSD website. This decreases/eliminates copying and postage expenses and also provides convenience to the committee members by allowing access to the materials sooner and at any time committee members have access to the internet. The MSD website has been a useful vehicle to provide meeting materials electronically and positive feedback from the successful trial runs that have been implemented has been received.	By Executive Committee at its meeting on January 15, 2009	
Travel Reimbursement	Travel reimbursement policy for MSD representatives attending AMA meetings. Information from other state medical societies was taken into consideration in developing	Adopted by Board of Trustees	

	the new travel policy: 1) the actual cost of airline transportation will be reimbursed up to a maximum of the amount available through the AMA discounted rate. 2) Lodging costs will be reimbursed at the hotel convention rate. When multiple room options are available, the Society will reimburse for the lowest rate accommodations, single occupancy. 3) Meals and other incidentals, such as ground transportation (exclusive of any costs for spouses or guests), will be reimbursed on a cost reimbursement basis up to a maximum of $75 per day. 4) Receipts and reimbursement form are needed for all major expenses. 5) All reimbursement requests must be submitted within 21 days after return from travel.	September 21, 1991 Revised 2/9/95 Revised 5/8/97 Revised 2004	
PUBLIC HEALTH			
Cancer Reporting	MSD Environmental and Public Health Committee (EPH) approved the following recommendation at its March 25, 2008 meeting: *The MSD encourages regular reporting by the Delaware Division of Public Health regarding the status of cancer in the state and encourages the Division of Public Health to make its position on reporting known to the public in an understandable fashion.*	6/12/2008 - Board of Trustees adopted recommendation made by EPH	
Childhood Obesity Prevention and Treatment	A national Expert Committee established recommendations for all aspects of child and adolescent obesity care based on scientific evidence and clinical experience (some recommendations represent a consensus based on the best available information). The Expert Committee provided recommendations on prevention, assessment, and treatment. MSD Board of Trustees approved to support the national recommendation, promote the recommendations within the membership and in the fight against childhood obesity in Delaware, and also signed on to the "Commitment," which tracks organizations that support this initiative.	Board of Trustees adopted at its meeting on September 11, 2008.	
Chronic Disease Partnership	Environmental and Public Health Committee recommended that MSD work with the Partnership to Fight Chronic Disease (PFCD) to continue their efforts to build upon their current partnerships focusing on the issue of chronic disease through their new chapter in Delaware.	9/10/09 Board of Trustees approved to support MSD partnering with PFCD.	
Gun Control Policy	The physician-patient relationship is one of the first and best avenues of ensuring the health and safety of Delawareans. This relationship is vital and relies heavily on trust to ensure the betterment of public health. If in the course of diagnosis and treatment the physician believes the patient may be a danger to self or others, action should be taken within a system designed to support healthy outcomes and safety for the patient, their family, and the community. Physicians need flexibility to be able to discuss with their patients all aspects of leading a healthy life – including firearm safety. These health care professionals must be given the opportunity to exercise their judgment in how to conduct frank	Adopted by Executive Board at its meeting held on May 9, 2013	

	discussions with patients about firearm safety issues and the risks associated with the possession and use of firearms. Compelling physicians to act as the first line of law enforcement, as opposed to safeguarding the public's health, is not the answer. Physicians cannot and should not take that role. However, if and when possible dangers are discovered, they are and should be addressed to the fullest extent possible by notifying law enforcement when clinically warranted. Physicians see first-hand the devastating consequences of gun violence. Our nation and our state must strengthen its commitment and resources to comprehensive access to timely and appropriate mental health services for all citizens. Dangers presented by a patient are complex in their origin and may or may not be related to the mental health status of the patient. Mental health is but one factor among many that physicians examine when determining whether a patient represents a danger to society. Violent tendencies expressed by the patient represent a more apt measure of potential safety concerns and evidence-based interventions to this end must be more fully explored and implemented. In addition, we must: • Provide more safety education programs to promote responsible use and storage of firearms. • Strongly advocate the need for more funding for increased research on violence prevention and epidemiology of gun-related injuries and death. • Enable more research so that evidence-based interventions can be implemented. Integrating these research findings with a re-investment in our health system and improved education for health care professionals and the public will bring us closer to solving the problem. As physicians, we realize that this is a multi-faceted problem that requires a multi-faceted solution. We must have a comprehensive approach for the health and safety of all Delawareans and all stakeholders must be involved in addressing the solution.		
MOST ~~MOLST~~ (Medical Orders for Life Sustaining Treatment)	Originally referred to as "POLST" (Physician Orders for Life-Sustaining Treatment). POLST then referred to as "MOLST" – MOLST is a <u>medical</u> order to carry out advance directives. At its meeting on March 12, 2009, the Board of Trustees approved supporting the <u>concept</u> of a MOLST program being established in the State of Delaware. 2013 - The medical order form utilized in the MOLST process is for those with advanced serious illness to designate medical care in the final phase of life. The program is now referred to as "MOST." The procedure began in Delaware under the MOLST initiative, but was not supported by appropriate legal statute, which then created confusion among those required to abide by the care designated on the form, specifically with emergency responders. A multi-stakeholder group will introduce the appropriate legislation needed to ensure appropriate legal language.	Board of Trustees supported the concept of MOLST program at its meeting on March 12, 2009. Reaffirmed support of MOST on 5/9/13 at Executive Board meeting.	
Needle Exchange Program	MSD prepared a White paper, through the recommendations provided by the MSD Ad Hoc Committee on Needle Exchange Programs, and provided to the Honorable Margaret Rose Henry on May 29, 1998. The MSD supports the proposed needle exchange program for Wilmington for the following reasons: 1) Needle exchange programs help prevent the spread of HIV/AIDS among drug users and innocent bystanders. 2) Needle exchange programs can provide a venue for interacting with the drug-using population to provide medical services and access to rehabilitation and support		Needle Exchange Program signed in to law 7/17/06. ("Sterile Needle & Syringe Exchange Pilot Program")

	services. 3) An extensive review of the literature demonstrates that needle exchange programs do not increase the use of drugs. 4) Needle exchange programs will help prevent the spread of HIV/AIDS among unknowing sexual contacts and newborns.		
Oxycodone Limitation Status Change by Medicaid (unless prior authorization is granted). To be effective March 1, 2012.	"The Medical Society of Delaware recognizes that prescription drug abuse represents an urgent concern in our state and we commend the Delaware Division of Medicaid & Medical Assistance for its efforts to more tightly regulate opioid use and improve the care of Medicaid patients in need of pain management. Accordingly, we support the intent of the new oxycodone prescription policy for Medicaid providers effective March 1. While we support the intent of the policy, we do have clinical and ethical concerns about what is in the best interest of patients who are in need of appropriate prescription medication. Specifically, we are concerned about placing limitations on the number of pills to be prescribed, as this does not take into account the unique needs of the patient and their changing medical needs over the course of treatment. In addition, ethically, it is difficult to draw a distinction between patients with cancer and non-cancer patients without clinically reviewing the patient's long term pain management requirements. As there are various conditions that generate valid chronic pain, covering the scope of both cancer and non-cancer diagnoses, and the usage of medications for these conditions should be reviewed clinically. Also, the Medical Society sees benefit in the proposal to evaluate long acting opiods in certain situations, as opposed to using large quantities of the higher dose oxycodone. However, mandating prior authorizations for acute pain treatment can increase barriers to entry and limit patient access to medically necessary drug treatment. The Medical Society, the Markell Administration, and law enforcement are actively working together on this multifaceted problem. We consider this prescription policy to be part of a much larger and comprehensive solution." Statement attributed to Randeep S. Kahlon, MD, President Medical Society of Delaware	January 18, 2012	
Patient Safety Reporting	The MSD supports the General Principles on Patient Safety as outlined by the AMA. 1) Creating an environment for Safety – there should be a nonpunitive culture for reporting healthcare errors that focuses on preventing and correcting systems failures and not on individual or organization culpability	Adopted July 2000	MSD created Ad Hoc Task Force on Patient Safety in 2005

	2) Data analysis – Information submitted to reporting systems must be comprehensively analyzed to identify action that would minimize the risk that reported events recur. 3) Confidentiality- Confidentiality protections for patients, healthcare professionals, and healthcare organizations are essential to the ability of any reporting system to learn about errors and effect their reduction 4) Information sharing – Reporting systems should facilitate the sharing of patient safety information among healthcare organizations and foster confidential collaboration with other healthcare reporting systems. 5) Legal status of reporting system information – The absence of federal protection for information submitted to patient safety reporting systems discourages the use of such systems, which reduces the opportunity to identify trends and implement corrective measures. Information developed in connection with reporting systems should be privileged for purposes of federal and state judicial proceedings in civil matters, and for purposes of federal and state administrative proceedings, including with respect to discovery, subpoenas, testimony, or any other form of disclosure.		
Retail Health Clinics ("Minute Clinics")	The Committee on Ethics was hesitant to support the concept of retail health clinics due to concern with safety and quality issues. There was an inherent realization by the Committee on Ethics members that clinics will continue to be established due to consumer driven health-care and availability and convenience to the patient of the clinic set up, and decreased cost to patient. The Committee on Ethics thought it was best to put forth a set of guidelines in these circumstances so that clinics can be established along accepted guidelines. The Committee on Ethics supported recommendation of the attributes that the AAFP has developed for retail clinics, although it did not support the concept of retail health clinic establishment. Those attributes presented by the AAFP, recommended by the MSD Committee on Ethics, and adopted by the MSD Board of Trustees are: 1) Retail health clinics must have a well-defined and limited scope of clinic services. 2) Clinical services and treatment provided must be evidence-based and quality improvement-oriented. 3) The clinic should have formal connections with physician practices in the local community, preferably with family physicians, in order to provide continuity of care. Allied health professionals (i.e., nurse practitioners) should only operate in accordance with the state and local regulations. Ideally, other health professionals should be part of a "team-based" approach, with physician supervision.	Recommendation by the Committee on Ethics (at its meeting on February 15, 2006) and adopted by the Board of Trustees at its meeting on March 9, 2006.	

	4) There must be a referral system to physician practices or other facilities appropriate to the patient's symptoms beyond the clinic's scope of work. Patients should be encouraged to have a "medical home." 5) The clinic should have a sufficient electronic health records system for communication with the patient's primary care physician. The AAFP supports a system that would be compatible with the Continuity of Care Record.		
Surgical Access Programs In Delaware Support	Resolved, that the Medical Society of Delaware support the concept of the current VASAP and similar programs around the State; and be it further Resolved, that the feasibility of other VASAP-like programs in Delaware be determined in cooperation with organizations that can provide surgical facilities for outpatient surgical care for the uninsured and underinsured population in Delaware and also help promote medical volunteerism in Delaware.	Resolution 08-1, Adopted by HOD 10/11/08.	
Tobacco Sales	Resolved, that the Medical Society of Delaware supports the AMA's current policy on tobacco sales which, (a) publicly commends pharmacies and pharmacy owners who have chosen not to sell tobacco products and asks it members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; and (c) encourages development of lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members.	Resolution 07-5, Adopted with changes by HOD 10/20/07.	
Underage Alcohol Consumption	Resolved, that the MSD actively opposes underage drinking by working toward a comprehensive community-based environmental approach that includes local and state policies and medical services; and be it further Resolved, that the MSD support public health/environmental policies to curtail underage and high-risk drinking, including banning underage young people from entry into bars, increasing alcohol excise taxes, reducing or eliminating drink specials, reducing/controlling alcohol outlet density and requiring keg registration, mandating server and seller training and enforcement; and be it further Resolved, that the MSD designate a member(s) to participate on the AMA Action Team on Alcohol and Health.	Adopted by Board of Trustees July 14, 2004	
Vaccines - Seasonal and H1N1	Committee on Ethics (September 2009 meeting) recommended support of the use of vaccines for seasonal and H1N1 flu in light of the fact that health care professionals are resisting obtaining these vaccines for themselves.	12/10/2009 Board of Trustees approved recommendation made by Committee on Ethics.	

TESTIMONY AND STATEMENTS TO THE MEDIA AND GENERAL ASSEMBLY			
Contacts from the Media – Executive Board Members	Issues in health care are in the news on a daily basis. It may be likely that MSD leadership will be contacted directly by the media. A more formal process has been established when addressing inquiries from the media. Prior to granting an interview, physicians should contact MSD External Affairs as a resource to insure that MSD's various policies and positions are communicated in an accurate and consistent way.	Approved by Executive Board February 2012	
Statements by MSD Members to Media, etc.	BACKGROUND: From time to time, members of the Medical Society of Delaware may be requested by outside sources (such as insurers, reporters, and other news media, etc.) to provide statements or information on medically-related or other issues. It is a physician's right to speak to such outside sources and to express his or her opinion freely. It is important, however, that the physician make no reference to the Medical Society of Delaware or his or her affiliation with the Society, if the position being stated is a personal opinion and not that of the Society. It is requested that, should the physician wish to use their credential with the Medical Society, that the Medical Society pre-approve the position being articulated and any reference to MSD. The following is the policy statement adopted by the BOT: *Members of the Medical Society, when making public comment and mentioning as part of their statement an affiliation with MSD, must either clearly state that the position articulated is personal and does not represent the position or policies of the Medical Society of Delaware or have pre-authorization by the President or the Executive Committee prior to referencing a Society policy or position*.	Adopted by the Board of Trustees at its meeting on March 13, 2008. Published for member information in the online and print editions of MSDNews.	
Testimony/ Statements by MSD Members to General Assembly	In regard to members of the MSD who may testify before the General Assembly as individuals, the Society is to approve whenever a member chooses to testify and use the Society as a credential. Physicians testifying must make a specific disclosure if they are not representing the Society. 1) members of the Society, when making public statements and mentioning as part of their testimony a personal affiliation with MSD, must disclose whether they are speaking on behalf of MSD; and 2) MSD members are not permitted to testify on behalf of the Society unless so authorized by the President or the Executive Committee.	6/14/07 – Adopted by Board of Trustees	

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