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MEMORANDUM

MEDICAL SOCIETY OF THE STATE OF NEW YORK
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February 18, 2020

TO: **MSSNY COUNCIL**

FROM: **JOSHUA COHEN, MD**
JANINE FOGARTY, MD
JOHN MAESE, CHAIR, MSSNY TASK FORCE ON END OF LIFE

SUBJECT: **2019 HOUSE OF DELEGATES RESOLUTIONS 273 AND 274**

The MSSNY End of Life Task Force presented two resolutions to the 2019 MSSNY House of Delegates entitled: Resolution 273 Hospice Recertification for Non-Cancer Diagnosis (i.e. dementia) and Resolution 274 End of Life Care Payment. These resolutions were sent to the Division of Soci-Medical Economics Reference Committee at the house. Due to conflicting testimony about these resolutions, the recommendation from the reference committee was these resolutions be referred them to MSSNY Council. MSSNY Council in turn, sent them back to the task force for further study and review. The original resolutions are as follows:

Resolution 273 Hospice Recertification for Non-Cancer Diagnosis (i.e. dementia)

> **RESOLVED, That the Medical Society of the State of New York seek the passage of state regulation and/or legislation that allows automatic reinstatement for hospice if a patient survives for more than 6 months with a non-cancer diagnosis and prognosis remains terminal; and be it further**
>
> **RESOLVED, That the Medical Society of the State of New York send a resolution to request that the American Medical Association petition CMS for regulation and/or legislation that allows automatic reinstatement for hospice if a patient survives for more than 6 months with a non-cancer diagnosis and prognosis remains terminal.**

Resolution 274 End of Life Care Payment

> **RESOLVED, that Medical Society of the State of New York send a resolution to the American Medical Association (AMA) requesting that the AMA petition CMS to allow patients in a hospice to cover the cost of housing ("room and board") a patient in a nursing home or assisted living facility ("room and board") and/ or allow the use their skilled nursing home benefit while 16 receiving hospice services.**

Resolution 273 was discussed at length with the task force members with input from Regina McNally, VP of MSSNY Soci-Medical Economics Division and with Carla Braveman, Director of the NYS Hospice and Palliative Care Association. Ms Braveman did indicate that to the members that it is sometime difficult for non-cancer patients to be reinstated to the hospice system if they survive more than six months. There was concerns that the title of the resolution and the use of (i.e. dementia) really did not apply here and that the focus should not be on dementia. The task force members

agreed that the resolution should be amended editorially for better clarity and that the title be changed to delete dementia.

The following amended resolution is now before the MSSNY Council as follows:

RECOMMENDATION A:

RESOLVED, That the Medical Society of the State of New York ~~seek the~~ support the passage of state regulation and/or legislation that allows automatic reinstatement for hospice if a patient survives for more than 6 months with a non-cancer diagnosis and prognosis remains terminal; and be it further

RESOLVED, That the Medical Society of the State of New York send a resolution to ~~request that~~ the American Medical Association requesting that ~~petition~~ CMS ~~for regulation and/or legislation that~~ allows automatic reinstatement for hospice if a patient survives for more than 6 months with a non-cancer diagnosis and that prognosis remains terminal.

RECOMMENDATION B:

Title Change:

Hospice Recertification for Non-Cancer Diagnosis ~~(i.e. dementia)~~

(FOR MSSNY COUNCIL ACTION)

Resolution 274 was also discussed at length by the task force members and following the presentation and discussion with Carla Braveman. The task force recommended that there be an amended resolution submitted to the MSSNY Council and that some of the wording be revised and that the resolution be split into two resolved for transmittal to the AMA be revised.

The following amended resolution is now before the MSSNY Council as follows:

RESOLVED, That Medical Society of the State of New York send a resolution to the American Medical Association (AMA) requesting that the AMA petition CMS to allow hospice patients~~, in a hospice~~ to cover the cost of housing ("room and board") as a patient in a nursing home or assisted living facility ~~("room and board")~~, and be further

RESOLVED, That the AMA advocate for patients be allowed to ~~and/ or allow the~~ use their skilled nursing home benefit while receiving hospice services.

(FOR MSSNY COUNCIL ACTION)

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February 20, 2020

TO: **MSSNY COUNCIL**

FROM: **JOSHUA COHEN, MD**
JANINE FOGARTY, MD

SUBJECT: 2019 RESOLUTION 111 -- MSSNY Support for Impairment Research

Resolution 111 entitled "MSSNY Support for Impairment Research" came before the MSSNY 2019 House of Delegates and the original resolution was as follows:

> **RESOLVED, that the Medical Society of the State of New York submit to the American Medical Association House of Delegates a resolution to commit all necessary resources and efforts needed to researching and developing a robust body of evidence for reliable and reproducible methods of assessing impairment of drivers and other appropriate and applicable operators of mechanized vehicles.**

This resolution came before the Governmental Affairs B Reference Committee and the testimony submitted was in support and in opposition to the resolution. There was some agreement at the reference committee that while fatigue was a cause for vehicular accidents it was not the number one reason for vehicular accidents and that it is difficult to assess by law enforcement. Due to the limited information, the reference committee did refer this resolution to the MSSNY Council which in turn send it to the MSSNY Committee on Preventive Medicine and Family Health for further discussion and recommendation.

On February 6, 2020, Larry Melniker, MD, Vice President of the Medical Society County of Kings to speak about the resolution. Dr. Melniker also provided to the committee members various articles that pertain to fatigue and vehicle accidents. Dr. Melniker wanted the resolution to go to the AMA and to call upon the AMA to commit resources to study the issue of driver impairment. Dr. Melniker indicated that in the last several years the neurological impairment research has become more robust. He indicated that his resolution could be the first step to reducing accidents due to impairment of drivers, by assessing level of impairment. Dr. Melniker indicated that there is no objective test that has been developed and that is why he is asking the AMA to develop assessment levels. Dr. Melniker indicated that he was new to the resolution process and that he was willing to work on the resolution to improve it.

Following discussion with Dr. Melniker, the committee members indicated that the resolution needed further development of the whereas (building the clinical evidence for the resolved),

the resolved and even the title as it does not speak specifically about what type of impairment research. A member indicated that the AMA would not do research, but would make recommendations to the various councils to review There were concerns that this will have a large fiscal note attached to this since the resolution is asking for the AMA to study methods of assessing impairments. There were also comments that there are other entities that the AMA would advocate for another group to do the research. Members of the committee indicated a willingness to work with Dr. Melniker to submit an enhanced resolution to the 2020 House of Delegates that better articulates why fatigue and vehicular accidents needs further study and why assessment of driver impairment needs to be address.

Therefore, the MSSNY Committee on Preventive Medicine and Family Health recommends that the resolution not be adopted, with the recommendation to the writer of the resolution be revised and resubmitted to the 2020 House of Delegates.

(FOR MSSNY COUNCIL ACTION)

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February 21, 2020

TO: **MSSNY COUNCIL**

FROM: **JOSHUSA COHEN, MD**
JANINE FOGARTY, MD
BONNIE LITVACK, MD

SUBJECT: **MSSNY POLICY 125.996**

The Medical Society of the State of New York's Heart, Lung, Cancer Committee has been revising MSSNY Policy 125.996. MSSNY Policy 125.996 came before the MSSNY Council last year with revisions and it was requested that input from the various specialty societies be included. Outreach was facilitated repeatedly to the various specialties and some of the responded and each of the comments were incorporated below. The policy has been updated to reflect the changes in methodology.

125.996 MSSNY Policy 125.996: Screening Programs And Interventions Most Beneficial In Improving The Overall Public Health

MSSNY has long advocated for the rights of patients to have access to various screening services and interventions most beneficial in improving the overall health of the public. Obviously access to these important health care service recommendations is dependent upon the acceptance, agreement and availability of them by relevant private and public insurance entities, which is why MSSNY continues to support and advocate for insurance coverage for all of these screening programs. MSSNY Policy 125.996 was developed and put forward to the MSSNY Council in 2010 and was also reaffirmed by the MSSNY Council in 2011. These revisions pertained to various updates from medical specialties or organizations throughout the last ten years and represent only recommendation, but not practice guidelines, for physicians.

MSSNY supports and advocates for insurance coverage for all of these screening programs:

Essential Behavioral Changes

1) ***Tobacco Cessation Counseling*** – Tobacco cessation counseling on a regular basis is recommended for all persons who use tobacco products. Providers are advised to use the 5-A approach (Ask, Advise, Assess, Assist, Arrange). Information on how to access free support services should be provided, and nicotine replacement, nicotine receptor partial agonist (varenicline) or bupropion therapy should be offered. Pregnant women and parents with children living at home also should be counseled on the potentially harmful effects of smoking on fetal and child health. (US Preventive Services Task Force) http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.html

2) ***Healthy Diet and Nutritional Intervention Counseling*** – Dietary counseling is recommended for adults and parents of children over the age of 2, to emphasize fiber-rich produce (i.e., fruits and vegetables) and minimally-processed grains, limiting the dietary intake of refined sugar and saturated fats and encouraging intake of mono-unsaturated fats.

(http://www.cochrane.org/CD009825/VASC_mediterranean-diet-for-the-prevention-of-cardiovascular-disease;
http://www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/in-depth/mediterranean-diet/art-20047801;
http://www.nhlbi.nih.gov/health/health-topics/topics/dash/)

3) ***Exercise Promotion***--Counseling patients to incorporate regular physical activity into their daily routines is recommended to prevent coronary heart disease, hypertension, obesity, and diabetes. General recommendations for adults are to do 150 minutes (more is advisable) of aerobic physical activity a week, preferably at moderate-to-vigorous intensity but at light-to-moderate intensity for persons with chronic conditions who are unable to do moderate intensity activity; strength training of all large muscle groups is recommended for two days a week. These recommandations are based on the proven benefits of regular physical activity (Department of Health and Human Services, Centers for Disease Control and Prevention, American College of Sports Medicine, National Physical Activity Plan, National Center for Education in Maternal and Child Health, American Academy of Family Physicians, American Academy of Pediatrics, The American Heart Association, and The American College of Obstetricians and Gynecologists).

Essential Preventive Screening

1) ***Hypertension Screening and Treatment***--Screening for hypertension in adults in adults aged 18 and older should occur.

Blood pressure categories are:

- Normal: Less than 120/80 mm Hg;
- Elevated: Systolic between 120-129 *and* diastolic less than 80;
- Stage 1: Systolic between 130-139 *or* diastolic between 80-89;
- Stage 2: Systolic at least 140 *or* diastolic at least 90 mm Hg;

Hypertensive crisis: Systolic over 180 and/or diastolic over 120, with patients needing prompt changes in medication if there are no other indications of problems, or immediate hospitalization if there are signs of organ damage.

(2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: Executive Summary Paul K. Whelton, Robert M. Carey, Wilbert S. Aronow, Donald E. Casey, Karen J. Collins, Cheryl Dennison Himmelfarb, Sondra M. DePalma, Samuel Gidding, Kenneth A. Jamerson, Daniel W. Jones, Eric J. MacLaughlin, Paul Muntner, Bruce Ovbiagele, Sidney C. Smith, Crystal C. Spencer, Randall S. Stafford, Sandra J. Taler, Randal J. Thomas, Kim A. Williams, Jeff D. Williamson and Jackson T. Wright Hypertension. 2017;HYP.0000000000000066, originally published November 13, 2017)

2) ***Diabetes Screening and Treatment*** – The US Preventive Services Task Force recommends screening for abnormal blood glucose as part of the cardiovascular risk assessment in adults 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet or physical activity. (USPSTF Recommendation: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/screening-for-abnormal-blood-glucose-and-type-2-diabetes?ds=1&s=diabetes

3) ***Primary Prevention of CVD in Adult*** – *Frequency of Screening* In general, a comprehensive assessment of risk factors should be performed at least every 5 years starting at 18 years of age, and a global risk score should be calculated at least every 5 years starting at the age of 35 years for men and 45 years for women. Those with increased cardiovascular risk, for example, those with diabetes, cigarette smokers, or those with obesity, should have their risk factors and cardiovascular risk assessed more frequently. (J Am Coll Cardiol, 2009; 54:1364-1405, doi:10.1016/j.jacc.2009.08.005 © 2009 by the American College of Cardiology Foundation). Journal of the American College of Cardiology March 2018 DOI: 10.1016/j.jacc.2018.01.004 2018 ACC/AHA Clinical Performance and Quality Measures for Cardiac Rehabilitation; A Report of the American College of Cardiology/American Heart Association Task Force on Performance Measures Writing Committee Members, Randal J. Thomas, Gary Balady, Gaurav Banka, Theresa M. Beckie, Jensen Chiu, Sana Gokak, P. Michael Ho, Steven J. Keteyian, Marjorie King, Karen Lui, Quinn Pack, Bonnie K. Sanderson and Tracy Y. Wang)

4) ***Primary Prevention of Stroke*** – Guidelines include well-known prevention measures such as controlling high blood pressure, not smoking, avoiding exposure to secondhand smoke, being physically active and treating disorders that increase the risk of stroke such as atrial fibrillation (a type of irregular heartbeat),

carotid artery disease and heart failure. The guidelines suggest physicians consider using a risk assessment tool such as the Framingham Stroke Profile to assess patients' risk. (American Heart Association/American Stroke Association; US National Institute of Neurological Disorders and Stroke).

5) ***Breast Cancer Screening Mammography and Appropriate Treatment***—All women should be evaluated for breast cancer risk no later than age 30. For women at average risk for developing breast cancer, annual mammography should begin at age 40. Mammographic screening should continue as long as a woman is in good health. Regular mammographic screening results in substantial reduction of breast cancer mortality across multiple studies. Women should be familiar with the known benefits, limitations, and risks of breast cancer screening. Women should also know how their breasts normally look and feel and report any breast changes to a health care provider right away. Breast ultrasound may be used for supplemental screening in addition to mammography in women with mammographically dense breasts. Some women – because of their family history, a genetic tendency, or certain other factors – should be screened with MRIs along with mammograms and may benefit from beginning to screen earlier than age 40. Women should consult with a health care provider about their risk for breast cancer and the best screening plan for them. (ACR, ACOG, NCCN, SBI, ASBrS)

6***) Colon Cancer Screening and Appropriate Treatment***--Colon and rectal cancer Screening--Starting at age 45, both men and women should follow one of these testing plans: Tests that find polyps and cancer. A colonoscopy every 10 years, or CT colonography (virtual colonoscopy) every five years, or flexible sigmoidoscopy every five years, or double-contrast barium enema every five years. Tests that mostly find cancer include yearly fecal immunochemical test (FIT), or yearly guaiac-based fecal occult blood test (gFOBT), or Stool DNA test (sDNA) every three years. If the test is positive, a colonoscopy should be done. The multiple stool take-home test should be used. One test done in the office is not enough. A colonoscopy should be done if the test is positive. The tests that can find both early cancer and polyps should be the first choice if these tests are available and patients are willing. The most important thing is to get tested, no matter which test is chosen. Patients should talk to a health care provider about which tests might be right for them. If individuals are at high risk for colon cancer based on family history or other factors, they may need to be screened using a different schedule. Patients should talk with a health care provider about their history and the testing plan that's best for them. (ACS Recommendation)

7) ***Cervical Cancer Screening and Appropriate Treatment***--Cervical cancer testing should start at age 21. Women under age 21 should not be tested. Women between the ages of 21 and 29 should have a Pap test done every 3 years. HPV testing should not be used in this age group unless it's needed after an abnormal Pap test result. Women between the ages of 30 and 65 should have a Pap test plus an HPV test (called "co-testing") done every five years. It is acceptable to have a Pap test alone every three years. Women over age 65 who have had regular cervical cancer testing in the past 10 years with normal results should no longer be tested for cervical cancer. Once testing is stopped, it should not be started again. Women with a history of a serious cervical pre-cancer should continue to be tested for at least 20 years after that diagnosis, even if testing goes past age 65. A woman who has had her uterus and cervix removed (a total hysterectomy) for reasons not related to cervical cancer and who has no history of cervical cancer or serious pre-cancer should not be tested. All women who have been vaccinated against HPV should still follow the screening recommendations for their age groups. Some women – because of their health history (HIV infection, organ transplant, DES exposure, etc.) – may need a different screening schedule for cervical cancer and should talk to a health care provider about their history. (ACS Recommendation) Additionally, for transgender or non-binary persons, such screening and testing should be conducted on patients according to their anatomy to ensure that that these individuals are receiving proper screening, until more specific guidelines are available.

8) **Prostate Cancer Screening and Treatment** – Physicians should have an informative discussion about the risk of prostate cancer with their male patients at age 40 and identify those patients who are at higher than average risk based on family history, race, ethnicity, lifestyle factors and other

chronic illnesses. Physicians should offer male patients, at age 45 who are at higher risk and age 50 or average or low risk, yearly testing, including but not limited to, serum PSA and the digital rectal exam. Patients should be referred to a specialist if findings suggest the possibility of prostate cancer. (ACS Recommendation 2010-present) Additionally, for transgender or non-binary persons, such screening and testing should be conducted on patients according to their anatomy to ensure that that these individuals are receiving proper screening, until more specific guidelines are available.

9) ***Immunizations***--The best way to reduce vaccine preventable diseases is to have a highly immune population. Appropriate vaccinations should be available for all adults including the following: Influenza, tetanus, diphtheria, acellular pertussis, measles, mumps, rubella, varicella, zoster, HPV male and female, pneumococcal, hepatitis A and B, meningococcal, and *Haemophilus Influenzae* type B immunizations. (CDC Recommended Immunization Schedule for Adults Aged 19 Years or Older, United States, 2018)

10) ***Genetic Testing***-- All cancer patients deemed at risk for having inherited a recognized cancer predisposition mutation should be seen pre- and post-test by a board-certified genetic counselor or board-certified MD geneticist appropriately trained in cancer genetics. Risk Assessment should include at minimum:

- Full three generation pedigree
- Evaluation of hereditary cancer syndromes and which test is appropriate/indicated
- Discussion/education of risks, benefits and limitations of genetic testing
- Coordination of optimal individualized specific genetic testing if and when appropriate
- Discussion of genetic test results and all other cancer related implications for patient and at-risk family members

Breast:

Version 1.2019 Screening Guidelines, 05/17/19 NCCN

MRI is also indicated for patients with prior history of breast cancer, Gail risk >1.7%, 20% risk defined by personal history of LCIS or ADH/ALH, untested for familial TP53 mutation, untested for familial PTEN mutation. MRI is also a consideration for mutation carriers in the ATM, CDH1, CHEK2, NBN, NF1, and PALB2 genes.

Prostate:

To identify men at high risk for prostate cancer: according to NCCN Guidelines Version 1.2018, BRCA1/2 testing is indicated for those with personal history of metastatic prostate cancer or with hi-grade prostate cancer (Gleason score> or= 7) who have a close (1^{st},2^{nd}, or third degree) relative with ovarian cancer, or breast cancer <50, or with 2 relatives with breast, pancreatic, or prostate cancer at any age. Also by NCCN Guidelines V.2018 Prostate Cancer Early Detection Guidelines screening for those with family or personal history of high-risk germline mutations.

Further, MSSNY recommends that physicians concentrate on these interventions for all of their patients and that New York State policy makers devote its limited public resources to these screening and treatment interventions on behalf of those adults unable to afford health care. Also, for each intervention, physician and patient should discuss the positive and negative aspects. **(Council 3/8/10; Reaffirmed by Council 1/20/11 in lieu of 2010-163)**

(FOR MSSNY COUNCIL ACTION)