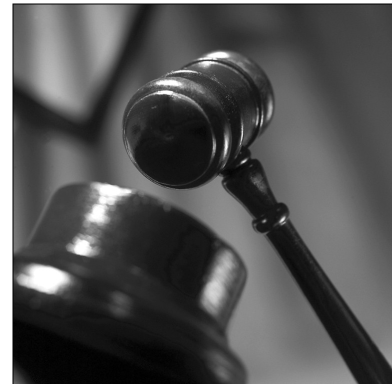

A Healthy Commonwealth 2012

Progress Made….Challenges Ahead

■ **Senator Richard T. Moore, Senate Chair**
Joint Committee on Health Care Financing

January 2009

Massachusetts is not only a state, but is established as a "Commonwealth." Our first Governor of the Province of Massachusetts Bay, John Winthrop, defined what that meant in his famous "City on a Hill" sermon in 1630. In that founding document, Governor Winthrop declared it to be our duty to care for one another, to share our good fortune to meet the needs of those among us who are less fortunate, and work together to build a stronger, healthier community.

Beginning with the 2005-2006 Session, the Legislature laid the foundation for a Healthy Commonwealth with the passage of our landmark health care reform law – Chapter 58 of the Acts of 2006. In addition to expanding access to affordable health insurance, the reforms included development of a statewide infection control program, the creation of the Health Care Quality and Cost Council to set quality improvement and cost containment goals, initiation of a first-in-the-nation pediatric palliative care program, and enhancement of the state's prevention agenda. Several other important steps such as the purchase of hypodermic needles without prescription also contributed to improving the health of the people of the Commonwealth.

By 2008, Massachusetts achieved nearly universal health coverage with an estimated 97% of her citizens with health insurance. These reforms have received much attention and praise both here at home and across the nation. Significantly, the Massachusetts example and reform principles are among the building blocks for national health reform being discussed at the federal level. However, the changes enacted in Health Reform I were just the first steps toward creating a world-class health care system for everyone in our Commonwealth.

During the 2007-2008 Session, the Legislature took another major step toward that system. Recognizing that to sustain, and move beyond the dramatic gains being realized with the passage of Health Reform I, key quality, safety, and cost control measures were needed. The signature bill of the most recent session is Chapter 305 of the Acts of 2008 - An Act to promote cost containment, transparency and efficiency in the delivery of quality health care.

This comprehensive measure established the statutory foundation for greater transparency in health quality and cost for consumers and providers, set realistic goals of moving health care into the 21st century with dramatic expansion of e-health initiatives and health information technology, provided mechanisms for real cost containment, established programs for expanding the availability of primary care providers, and established goals and benchmarks for measuring progress toward improved quality and cost containment.

The legislation also set in motion the opportunity for dramatic reform of health care through a review of health care payment which could trigger fundamental change in how health care is delivered in Massachusetts. While some providers may simply hope for more money, the goal of payment reform needs to address a more effective use of existing resources and funds as well as compensation for a different delivery model along the lines of "medical home" care delivery especially for managing those with chronic disease.

Complete text and summary information for all health care related bills being filed by Senator Moore for the 2009-2010 Session are available at **www.senatormoore.com/health**

Some examples of other pieces of legislation that lay the groundwork for different delivery models, successfully passed by the legislature this past session, are Public Health Regionalization and Collaborative Drug Therapy Management. The regionalization bill strengthens the Massachusetts public health system by pooling the resources of multiple towns to provide state and local municipalities with the means to deliver public health services more efficiently and effectively. Additionally the collaborative drug therapy bill pools resources and improves pharmaceutical care for patients by combining the skill and expertise of physicians and pharmacists and enabling them to collaborate their practices, which has been shown to increase patient safety while also reducing medication errors as well as health care costs.

This document, "A Healthy Commonwealth 2012 – Progress Made… Challenges Ahead" is Senator Richard T. Moore's health care legislative agenda for the 2009-2010 legislative session. It is the Second Edition of "A Healthy Commonwealth 2012," which was originally released by Senator Moore in January 2007. It builds off the foundation established by the landmark health care reform achieved in Chapter 58 of the Acts of 2006 – inspired by then-Senate President Robert E. Travaglini, and the equally impressive Chapter 305 of the Acts of 2008 – crafted under the leadership of Senate President Therese Murray.

The bills that comprise "A Healthy Commonwealth 2012 – Progress Made…Challenges Ahead" collectively represent the third phase of the state's health reform agenda. While listed in no particular order, each of these initiatives will bring Massachusetts even closer to the goal of quality, affordable health care for all and will help to grow and stimulate the critical health care sector of our state's economy. The major features of "Health Reform III" include:

- Health Care Payment Reform
- Further Strengthening Health Care Reform
- Comprehensive Prevention and Wellness Strategy
- Stronger Leadership in Health Care Quality Improvement and Cost Containment
- Strengthening the DON Review Process and Protecting Community Hospitals
- Health Care Workforce and Workplace Improvement Initiatives
- Medical Malpractice Reform
- Further Regulating the Pharmaceutical Industry

— Health Care Payment Reform —

While some providers would define "payment reform" as increasing reimbursement from all payers – especially MassHealth (Medicaid) - such a simple change would not produce any reform and would only tend to make health care less sustainable. While the amount of reimbursement needs to be sufficient to deliver quality care and attract the best providers, the Commission on the Health Care Payment System provides an enormous opportunity for reform that would otherwise be lost by just raising the rates.

Health care payments in Massachusetts, and in much of the nation, are focused on treatment of illness or injury and the number of patients seen – fee for service – rather than on promoting the goals of improving health quality outcomes and promoting wellness. Currently, care delivered is reimbursed even when that care is not always evidence-based or produces the most appropriate outcome. Reimbursement levels, which tend to be greater for specialty care than for primary care, have also contributed greatly to diminishing availability and access to primary care.

Therefore, payment reform must focus on attaining the goals of promoting wellness and health care quality, managing chronic disease by treating the whole patient, enlisting the active participation of the patient and the patient's family, obtaining the best outcome that evidence-based practice can provide, and expanding access to primary care.

Chapter 305 of the Acts of 2008 established, in Section 44, the Special Commission on the Health Care Payment System, and charged it with making recommendations to the Legislature by April 1, 2009. Senator Moore will be serving on the commission as the Senate President's appointee, and is dedicated to creating a more equitable health care payment model for the Commonwealth. Unfortunately, as a result of the Governor's delay in making his appointments to the commission, the projected date for finalizing review and making recommendations has been pushed back to May. Fortunately, however, the co-chairs of the commission, Commissioner Iselin and Secretary Kirwan, are very committed to and focused on the goals of the commission, and it is anticipated that the recommendations will serve as a collaborative payment reform model for legislation that will encourage expedited legislative action.

— Further Strengthening Health Care Reform —

Health care reform does not end with Chapter 58 of the Acts of 2006 or with Chapter 305 of the Acts of 2008. We need to continue to build upon these monumental reforms and continue to make changes where changes are needed and push for further reform as we implement the reforms that we have already enacted into law. Much more needs to take place for implementation of health reform to be successful. We cannot be satisfied until our health care is the best in the nation.

▪ Senator Moore's Related Legislation for the 2009-2010 Session

An Act Strengthening Health Reform

In the past two and a half years, health reform has expanded health care access to over 440,000 people across Massachusetts. Despite this success, gaps in coverage still exist, affecting people's ability to access health care services. This bill seeks to address these gaps

by making care consistent throughout public health care programs – Commonwealth Care, MassHealth, and the Health Safety Net – to help individuals maintain the most appropriate coverage to maximize the individual's health benefits and the state's financial reimbursement. This bill (1) aligns the Commonwealth Care application and appeals process with MassHealth to ensure continuity of coverage; (2) prohibits lifetime caps in all Massachusetts health insurance plans; and (3) makes the health safety net retroactive coverage consistent for all eligible patients.

An Act Requiring the Public Reporting of Potentially Preventable Hospital Readmissions

This bill follows on the heels of a Potentially Preventable Readmission (PPR) Steering Committee, organized by the division of health care finance and policy, to evaluate a specific methodology for use in tracking the number and rate of potentially preventable readmissions in order to spur reduction in unnecessary readmissions and improve quality of care. It mandates the public reporting of PPRs with a link to the HCQCC website and establishes a task force within the division to study the drivers of PPRs and make recommendations by December of 2009.

An Act to Improve the Delivery of Health Care

This bill authorizes The Department of Public Health to promulgate regulations for the development and implementation of checklists of care that hospitals shall use to prevent medical errors and reduce healthcare-associated infection rates. A recent *Boston Globe* article noted that a study led by Harvard researchers showed that deaths and complications dropped by an astounding one-third when operating room doctors and nurses completed a simple safety checklist before, during and after surgery.

An Act Relative to the Qualifying Student Health Insurance Program

This bill essentially repeals the current QSHIP program established for higher education students attending school in the commonwealth, and replaces it with the requirement that students have health insurance coverage that meets the definition of 'creditable coverage'. While the Chapter 58 Health Reform expanded access to health care by offering more affordable and comprehensive products, the student population was excluded from benefitting from these reforms. The Division of Health Care Finance and Policy is currently working with an actuarial to review the QSHIP plans and compare them with other plans currently offered, such as the young adult plans. It is anticipated that their findings will offer some further guidance.

An Act Relative to the Modernization of Optometric Care

This bill adds Section 66C to Chapter 112 of the General Laws, which would enable duly certified and registered optometrists to issue written prescriptions and to treat eye conditions with oral therapeutic agents. Optometrists have this authority in 45 other state in the nation. Optometrists in the Commonwealth can currently treat eye conditions, excluding glaucoma, with topical therapeutic agents only. This bill requires the optometrists to exercise professional judgment to refer any patient to a licensed physician or other qualified health practitioner if the presenting problems of the patient are not within the scope of practice of the optometrist.

An Act Regarding Medical Record Retention Requirements

Chapter 305 of the Acts of 2008 reduced the number of years that hospitals are required to store medical records from 30 to 20 years. The original bill from the Senate proposed a reduction to 15 years, but as a result of negotiations with the House the final number agreed upon was 20. The problem with this number is that it falls too far behind national averages for record retention requirements. The national average among other state laws is 10 years; The Federal Medicare and Medicaid record retention law requires 5 years; and HIPAA provisions require 6 years of retention. Reducing this number even further has potential for further cost-savings and alleviating administrative burdens.

— Comprehensive Prevention and Wellness Strategy —

Heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes cause 7 of every 10 deaths in the United States each year. These chronic diseases account for more than 75 percent of the 1.4 trillion that we spend annually, as a nation, on medical care. However, while these chronic diseases are among the most prevalent and costly health conditions, they are also among the most preventable of all health problems. Expanding our efforts to prevent illness and to stay healthy is among the most effective means of containing costs of health care. Investment in primary prevention will enable us to continue to contain costs in the long-term.

Prevention and wellness policy initiatives have gained an increasing amount of attention in the nation and in the commonwealth as a means to cut and sustain health care costs. Cities and towns, schools and businesses across the state have implemented wellness and prevention programs. For example, the Department of Public Health just recently launched its Mass in Motion Program. This campaign encourages people to eat healthier and to get more exercise through initiatives such as school-based healthy meal programs, workforce wellness activities and menu labeling.

This session the focus needs to be on building upon existing prevention and wellness programs in the commonwealth and creating a more comprehensive strategy to managing and preventing chronic diseases. Some of the ways we can contribute to reducing the prevalence and costs of chronic diseases are by:

- Promoting health and wellness programs at schools, worksites, healthcare and community-based settings.
- Enacting policies that promote healthy choices and healthy environments.
- Ensuring access to a full range of quality health services.
- Supporting implementation of programs that focus on eliminating racial, ethnic, and socio-economic based health disparities.
- Supporting efforts to effectively educate the public about their health and prevention of chronic disease.

School health programs, workplace wellness activities, and elderly falls prevention are some areas where modest investments could return major dividends.

Senator Moore's Related Legislation for the 2009-2010 Session

An Act to Promote Healthy School Meals

This bill establishes a pilot program within the department of education to create an incentive for schools to improve the nutrition of and amount of local Massachusetts-grown food in meals served. It lays the foundation for school wellness policy improvement and both school incentives and accountability for wellness work, beginning with the nutrition of meals and a la carte offerings. The goal is to increase the nutritional standard of and proportion of fresh, locally grown food in meals served to public school students in schools participating in the National School Lunch Program and School Breakfast.

An Act to Improve Public Contracting with Massachusetts Farmers

This bill amends current state purchasing laws to increase opportunities for local farmers to sell to schools, and to state colleges and universities. It creates an incentive for large urban school districts to use products from Massachusetts farmers by increasing the maximum no-bid contract amount from $25,000 to $50,000, and it creates an incentive for state colleges and universities to use products from Massachusetts farmers by adding colleges and universities to the local agricultural preference statute.

An Act Providing Chapter 70 Accountability for Adequate Access to School Nursing

This legislation increases the transparency and accountability in Chapter 70 relative to adequate school nursing. It amends Chapter 70 by including a definition of school nurse professional staff, which is consistent with the mandate for access to registered school nurses found in Chapter 71, Section 53. Further, the foundation budget calculation included in a newly proposed definition for "foundation school nurse professional staff", would create an opportunity to account for access to school nurses for all student enrollees, and provide additional accounting for students in low income districts. School nursing is a specialized practice of professional nursing that advances the well being, academic success, and life-long achievement of students. To that end, school nurses facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self management, self advocacy, and learning.

An Act to Provide Coverage for Tobacco Use Cessation Under Commonwealth Care

Tobacco use is the leading preventable cause of disease, disability and death in the United States, according to the Centers of Disease Control and Prevention (CDC). Because socioeconomic status is the single greatest predictor of tobacco use, we want to make sure that our efforts to cut down tobacco use are focused accordingly. This bill requires any policy of health insurance coverage issued by the Commonwealth Care program to provide coverage for tobacco cessation treatment. By offering this type of coverage to individuals up to 300% of the federal poverty level we will be utilizing our resources in the most effective way possible.

An Act Establishing the Massachusetts Childhood Vaccines Program and the Massachusetts Immunization Registry

Massachusetts' nationally revered Childhood Immunization Program is currently in crisis. Significant increases in the number and cost of vaccines, and two rounds of the recent 9C cuts, which have resulted in a reduction of more than $6 million in the state vaccine account, have made our long history of "universal distribution" of all recommended vaccines for all children in the state impossible to sustain. Our immunization rates, which have historically led the country, have dropped, and we have had to suspend implementation of our State's Immunization Registry. The proposed legislation provides a creative and fiscally responsible solution to this crisis by creating a Vaccine Purchase Trust Fund. Money would be pooled from federal sources (VFC and 317), state appropriations, and contributions from insurance companies based on their covered lives (all children). This bill would also mandate adequate reimbursement for all routinely recommended vaccines not provided by the state and would also revive, and fund, the state's Immunization Registry which has been inactive for the past year due to lack of funding.

An Act Promoting Healthy Alternatives in the Commonwealth's Public Schools Food Programs
(Re-file of Senate 1262 from the 2007-08 session)

The purpose of this bill is to reduce obesity and improve the health of Massachusetts's children by establishing a five-year school nutrition demonstration project that implements stricter standards of nutrition in public schools by limiting the types of food and beverages offered in vending machines located on school property.

An Act to Improve Access to Child and Adolescent Mental Health Services
(Re-file of Senate 608 from the 2007-08 session)

Some students who have learning, behavioral or emotional problems in school could benefit from the after-school counseling services of a Licensed Educational Psychologist. However, many students are not able to do so because their parents cannot afford to pay for those expenses. Currently health insurers are required to reimburse certain licensed mental health professionals including psychotherapists licensed to practice medicine (psychiatrists), psychologists, licensed clinical social workers, clinical specialists in psychiatric and mental health nursing and mental health counselors for outpatient mental health services. Massachusetts law provides for licensure of educational psychologists, but does not require insurers to cover their services. This legislation would require health insurers to add licensed educational psychologists to the group of providers they are required to reimburse for outpatient mental health services.

An Act Relative to the Labeling of Certain Food Products
(Re-file of Senate 1290 from the 2007-08 session)

This bill requires restaurants with ten or more locations nationally to print nutritional information on their menus. Restaurants are increasingly becoming American's dining rooms of choice. The USDA estimates that Americans spend roughly half of their food dollars away from home, up from 26% in 1970. Unfortunately, many restaurant menu

options are higher in calories, sodium, and fat than the meals consumers would eat in their homes – characteristics that some studies suggest have contributed to America's climbing obesity rate. By requiring chain restaurants to print nutritional information on their menus, this bill would work to provide consumers the tools they need to better control their diets and perhaps curb America's obesity problem.

An Act to Prevent Falls Among Older Adults
(Re-file of Senate 422 from the 2007-08 session)

This bill creates a Falls Prevention Program in the Commonwealth. It would require the Secretary of Elder Affairs to: (1) oversee and support a statewide education campaign focusing on reducing falls among older adults, on preventing repeat falls, and on educating health professionals about falls risk, assessment, and prevention; and (2) award grants for local, regional and statewide education campaigns.

A Resolve Relative to the Prevention of Falls in the Elderly Community
(Re-file of Senate 421 from the 2007-08 session)

This bill would establish a commission on falls prevention to study and make recommendations on how to reduce the likelihood of seniors suffering from debilitating falls in the Commonwealth.

Falls are some of the most preventable injuries, but they routinely lead to the death of hundreds of elderly residents. In 2006 alone, 340 Massachusetts residents age 65 and older died after falls. Another 20,000 needed hospital stays, and 37,000 required emergency room visits. Hospital charges for fall-related visits in the state were almost $500 million in 2006. There are a few relatively simple steps that can help prevent falls, including getting regular eye exams, eating food rich in calcium and vitamin D, exercising to improve balance, and installing railings and grab bars where needed.

— Stronger Leadership in Health Care Quality Improvement and Cost Containment —

The Massachusetts Quality and Cost Council was established pursuant to Chapter 58 of the Acts of 2006 and further defined by Chapter 305 of the Acts of 2008, to provide leadership for improving health care quality and bend the curve of rising health care costs. Unfortunately, the Patrick Administration has never adequately funded the Council and, in the Fall of 2008, the funding for all staff, except a lower level coordinator, was eliminated. Although the Council was specifically placed, "within, but not subject to the control," of the Executive Office of Health and Human Services, EOHHS attempted to closely control the work of the Council.

The Quality and Cost Council was considered to be, by those who helped to create the Health Care Reform law, the essential ingredient to reforming the health care system. Acknowledging that universal coverage could only be sustained by simultaneously focusing on quality improvement and cost containment, the QCC was created to promote transparency in the system and to focus on making quality and cost information accessible to the residents of the Commonwealth. The intent

of the proposed legislation is to create a more independent entity that will be more equipped to withstand uncertainties within the administration and to strengthen, overall, the governance of health care at the state level.

■ Senator Moore's Related Legislation for the 2009-2010 Session

An Act Relative to the Health Care Quality and Cost Council

This bill recreates the Council as an independent entity not subject to the control of the Executive Office of Health and Human Services, and designates the members of the council to vote annually to elect a chair of the Council. The Secretary of Health and Human Services will remain as a member, but not necessarily chair, of the Council.

An Act Relative to Centers for Excellence

This bill creates a commission to study, coordinate and explore the feasibility of developing consolidated centers of excellence focused on technology, performance measurement and quality improvement. Currently the QCC, the Betsy Lehman Center and the MA Health Quality Partners are all recognized as centers for quality. Coordinating these entities to avoid duplication would allow greater effectiveness. The legislature has recently coordinated other entities with conflicting or duplicative duties to great effect.

An Act Reforming the Administration of Health Care
(Re-file of Senate 684 from the 2007-08 session)

This bill divides the Executive Office of Health and Human Services into an Executive Office of Human Services and an Executive Office of Health. The combination of Health with Human Services creates an agency that is too large to be effectively managed when both areas have constant demands for state attention and oversight. Health reform isn't completed with the passage of Chapter 58, it has really just begun. Continued high level leadership will be needed for some years to come. The new cabinet level agency would include the Department of Public Health, the Department of Mental Health, the Division of Health Care Finance and Quality, the Division of Medical Assistance and several smaller units.

— Strengthening the DoN Process and Protecting Community Hospitals —

Determination of need laws in Massachusetts were originally aimed at limiting health care facility costs and allowing coordinated planning of new services and construction. The basic assumption underlying DoN regulation is that excess capacity (in the form of facility overbuilding) directly results in health care price inflation. When a hospital cannot fill its beds, fixed costs must be met through higher charges for the beds that are used. Bigger institutions have bigger costs, so DoN supporters say it makes sense to limit facilities to building only enough capacity to meet actual needs. However, during the 1980s a new emphasis on market solutions for controlling health care costs led to a repeal of many of the federal provisions related to DoN, and by the late 1990s the DoN process had shifted to a focus on maintaining quality. Today, the Department of Public Health (DPH) describes its mission as the promotion of "availability and accessibility of cost effective quality health care," noting that the program was originally created to "encourage equitable geographic and socioeconomic access to health care services, help maintain standards of

quality, and constrain overall health care costs by eliminating duplication of expensive technologies. Community hospitals are suffering in large part because the DoN process is not functioning as it was originally intended to function. We need to put the "Need" back into "Determination of Need".

■ **Senator Moore's Related Legislation for the 2009-2010 Session**

An Act Relative to Strengthening the DON Program

The Determination of Need process should be strengthened to evaluate and compare the safety, efficacy and cost effectiveness of whether new facilities, expansions of existing facilities, or new technologies are necessary by requiring an enhanced planning process. This bill requires the Department of Public Health (DPH), as part of the DON process, to conduct a statewide planning initiative for the purposes of planning and coordinating the availability and delivery of health care services within the Commonwealth. The resulting plan will be utilized as part of the DON program to evaluate the need for individual proposed new facilities or expansion of services or beds. It also removes the exemption from DON requirements for ambulatory surgical centers, certified or seeking certification by Medicare, that are conducted by a hospital licensed under section 51, or by the federal government or the Commonwealth from having to comply with the DON process.

An Act to Support Primary Care Recruitment by Community Hospitals

This bill establishes a Primary Care Development Fund using an existing funding source – the surplus contained in the Commonwealth's Health Safety Net Fund. The new fund would provide grants to community hospitals to aid in physician recruitment and retention activities thereby helping to ensure primary care physician access in their communities. This initiative is crucial because of the documented shortage of primary care physicians – particularly with more individuals insured under universal health insurance. Moreover, the effort required to identify, recruit and retain such individuals is a significant drain on the already scarce community hospital resources.

An Act Financing Health Care through Moral Obligation Bonds
(Re-file of Senate 668 from the 2007-08 session)

The community hospital system is financially stressed, yet needs to significantly invest in capital improvements. Other states have utilized a system known as Moral Obligation Bonds that don't legally mandate repayment by the state, but utilize the state's credit rating. The financial market has recognized this mechanism and there have been no defaults. This bill utilizes the expertise of the Mass. Health and Educational Facilities Authority to establish such a system for capital investment in our fifty plus community hospitals.

An Act to Create a Commission to Determine the Capital Needs of Community Hospitals
(Re-file of Senate 692 from the 2007-08 session)

Community hospitals continue to move closer to a position where they will not be able to expand appropriately (to accommodate projected increases in the over 65 population, etc..) leaving all of the potential growth to the teaching hospitals. Currently, more than half of all hospital admissions are to teaching hospitals which is about 2 1/2 times the national average. Over the last several years the entire increase in hospital admissions has been to

teaching hospitals. The commission created by this bill focuses on identifying the capital needs of community hospitals, the ability of hospitals to meet those needs and the identification of potential actions that can be undertaken by public programs to better optimize the availability of capital.

— Health Care Workforce and Workplace Improvement Initiatives —

There are already several health care professions that have insufficient numbers of professionals entering the field. Chapter 305 of the Acts of 2008 established the Health Care Workforce Center and included provisions to encourage more primary care providers. However, the dramatic increase in older citizens that will occur in the next decade will increase the shortage of such professionals and create additional shortages among health care providers. In an effort to address these issues, legislation and funding are needed to provide an adequate supply of professionals and to improve the practice environment in which they work in order to maximize their skills and abilities.

▪ Senator Moore's Related Legislation for the 2009-2010 Session

An Act to Improve Nurse Safety

This legislation strives to improve the safety of both nurses and patients through increasing protections for health care professionals, establishing safe patient handling procedures in health care facilities and ensuring that nurses are trained in evidence-based strategies for the movement of patients. Doing so will reduce workplace risks and provide nurses with the tools they need to keep themselves and, in turn, patients safe.

An Act Relative to Home Health Aides

This bill seeks to refine the Commonwealth's Nurse Practice Act (NPA) to specify appropriate nurse delegation practices. To provide quality care to home health patients, other states like Oregon, Washington and New Hampshire have established successful state-based, nurse-directed medication administration models, which, depending on the state, clearly differentiate delegation of administration by setting and/or patients. This bill allows the administering of certain medication to a home health patient by a trained and certified home health aide and ensures accountability and responsibility by also requiring that home health agencies provide training and establish documentation protocols.

An Act Establishing a Health Care Electronic Prescribing Tax Credit

By proposing tax credits for providers who participate in e-prescribing programs this bill supports the effort to expand use of e-prescribing, which has been shown to reduce medical errors and lower costs.

An Act to Prohibit Mandatory Overtime for the Health Care Workforce

This bill prohibits health care facilities from enforcing mandatory overtime on any member of the health care workforce unless there is a facility-wide staffing emergency in effect. It also contains a provision to requires all members of the health care workforce to be given at

least 10 hours of off-duty time immediately after working more than 12 hours due to overtime.

An Act to Promote the Nursing Profession and Promote Safe Patient Care
(Re-file of Senate 1244 from the 2007-08 session)

This bill provides a process to bolster the supply of nurses and nurse faculty through incentives for students and matching grants for hospitals. It also creates a public accountability process for developing staffing patterns for patient care. The bill further provides a process to evaluate and report on measures to improve the quality of patient care through staffing patterns.

An Act Relative to Patient and Medical Intern and Resident-Physician Safety and Protection
(Re-file of Senate 1247 from the 2007-08 session)

This bill authorizes and directs the Department of Public Health to promulgate rules and regulations relative to limiting the number of hours medical interns and resident-physicians work in any given week. The bill establishes in the law that interns, resident physicians and fellows working in excess of the ACGME recommended 80 work week is prima facie evidence of mistreatment of patients. This puts some "teeth" in the professional standards. This is critical since studies have demonstrated that over 83% currently work in excess of the recommended hours over a year after the medical profession agreed to the 80 hours limits for safe care. The bill also sets up a commission within DPH to determine if the duty hour schedule should be reduced below the 80 hours.

An Act Adopting the Nurse Licensure Compact
(Re-file of Senate 1288 from the 2007-08 session)

This bill allows Massachusetts to join the growing ranks of states with interstate nursing compacts (NLC). Joining the NLC will decrease barriers to nursing care and will help ensure the availability of licensed nurses during a disaster or other time of great need for qualified nursing services. The NLC also provides for greater nurse mobility, of particular value in our New England region with close proximity to bordering states. Further the NLC will clarify the authority to practice for nurses currently engaged in tele-nursing, interstate practice, or other models of contemporary nursing practice. The Mass. Board of Registration in Nursing's role in patient safety and public protection will also be enhanced by earlier identification of nurses facing adverse actions in other states. Of additional note, the NLC enhances information sharing among states and facilitates an accurate understanding of the nursing population.

— Medical Malpractice Reform —

Medical errors remain one of the leading causes of death and injury in Massachusetts. Reducing such errors would improve the quality of health care and reduce the cost. One of the major problems in the effort to improve patient safety is that the current litigious nature of medical errors promotes a culture of secrecy which prevents sharing of information about medical errors that would reduce their repetition in other similar situations. Health care consumers, injured by the health care system, are often unable to obtain information about an error that occurred to them as patients; or to a loved one as family members. The current system fails miserably at making the

practice of medicine safer for the patient.

In addition to the counter-productive nature of the current system, the increasingly high costs of medical malpractice insurance are continuing to drive health care providers out of the state. A report recently released by the Division of Insurance entitled *Medical Malpractice Insurance in the Massachusetts Market* states that "Total Massachusetts medical malpractice premiums increased from $198 million in 2001 to $301 million in 2007; an increase of over 50% in six years. Risk Retention Groups account for 10% more of the market in 2007 than in 2001." At a time when the Chapter 58 Health Reform law is increasing the demand for physician services, we cannot afford to disincentive health care providers to keep their practices in the state through skyrocketing malpractice premiums.

Reform of the Commonwealth's Medical Malpractice system is essential to giving consumers a greater voice when they, or family members, are injured by a health care provider. The system must be re-designed so that health care providers can learn from the mistakes of others and so that those injured can receive appropriate compensation for their injury without the need, in most cases, for an adversarial process that undermines patient trust in their providers.

In addition to legislation, it is critical that error reduction efforts such as the Betsy Lehman Center for Patient Safety and the Massachusetts Infection Prevention Program be fully funded and encouraged by the Executive Branch.

■ Senator Moore's Related Legislation for the 2009-2010 Session

An Act to Establish an Adverse Event Disclosure and Compensation Grant Program

This bill establishes a grant program that provides funding to eligible hospitals in order to implement an adverse event disclosure and compensation program. This program is based on an arguably simple model of early disclosure to patients of medical errors, apologizing for these errors, and providing timely and fair compensation to patients outside the traditional tort system. This model was most notably put into successful practice by the University of Michigan in 2001, and was implemented in even more comprehensive fashion by the University of Illinois in 2006.

An Act Reforming the Medical Malpractice System
(Re-file of Senate 953 from the 2007-08 session)

This bill makes several fundamental changes to the medical malpractice system such as, stricter standards on expert witnesses, the elimination of joint and several liability, and Extension of the collateral source rule to future sources of compensation.

— Further Regulating the Pharmaceutical Industry —

Section 14 of Chapter 305 of the Acts of 2008 amended the General Laws by creating Chapter 111N which, in Section 2, directed the Massachusetts Department of Public Health to establish a marketing code for pharmaceutical and medical device manufacturers. The Department's first draft of the regulations did not adequately represent the intent of the legislature which was primarily to create more transparency within the industry for the residents and health care

consumers of the commonwealth, but we are hopeful that the second draft will more closely mirror the legislative intent. The pharmaceutical and medical device companies pour billions of dollars into marketing each year, and as the governing body of the people we have an obligation to make sure that this money is not causing undue influence in doctor's offices and in their prescription writing habits. The following bills attempt to give the consumer more peace of mind by creating more transparency within the industry and by prohibiting unethical sales and marketing tactics as well.

▪ Senator Moore's Related Legislation for the 2009-2010 Session

An Act Protecting Confidentiality of Patient Prescription Records
(Re-file of Senate 1275 from the 2007-08 session)

This bill prohibits prescriber information data to be sold to pharmaceutical companies. Patient specific and provider specific data relative to issuance of prescription medications is currently sold to pharmaceutical companies to market drugs to patients directly or to reward or punish physicians who prescribe a company's products. The marketing generated from the identification of such data increases the cost of health care by promoting high cost brand name drugs when generic drugs or lower cost brand drugs that are therapeutically equivalent would be just as effective. New Hampshire in 2006 enacted legislation to protect prescription data and this law was recently upheld as constitutional and not a violation of the First Amendment by the First Circuit U.S. Court of Appeals.

An Act Establishing a Massachusetts Comparative Cost Effectiveness Institute

This bill creates a Comparative Effectiveness Institute that would conduct comparative research on new and existing procedures, drugs, devices and biologics to validate their effectiveness. This would reign in cost and inefficiencies by identifying clinical waste thereby reducing inappropriate, ineffective or redundant care and offers a unique opportunity for Massachusetts to take the lead in this new and emerging field. This proposal builds on study of issue that was included in Chapter 305.