Society for Participatory Medicine
Board of Directors
Agenda

January 31, 2011

Call to Order	Alan
Brief recap - looking back & looking forward (2 minutes)	Dave

"We've been together as a board for just over 6 months, our broader membership is starting to get activated, vibrant quick teams is the structure for harnessing this energy to propel PM forward"

Approval of Minutes	
Treasurer's Report / membership report (5 minutes)	John
Public policy update (5 minutes)	Danny
Journal update (5 minutes)	Charlie, Carol, Alan
Member services / volunteers (5 minutes)	Deb, Cheryl
Social media team and e-patients.net report (5 m)	Dave, Susannah
Corporate recruitment report/discussion (10 minutes)	Danny, Paul, David, John
Proposed By-laws changes (10 minutes)	John
Guidelines report (5 minutes)	Alan, Indu, Carol
2011 Goals (5 minutes)	Danny
Communications/Adjourn	Alan

M E M O R A N D U M

TO: Board of Directors, Society for Participatory Medicine

FR: David Harlow, Chair, Public Policy Committee

RE: Report from Public Policy Committee

DT: January 26, 2011

The Public Policy Committee has been in existence for just over two months. It is very much a work in progress, and one of the items on my agenda for the Committee is to devote some time to developing a charter and standardizing some operating procedures and principles.

In the interim, until we have the opportunity to do that foundational work, we have been engaging in the policymaking processes swirling about us these days, and offering commentary on pending regulations and the like from the perspective of the Society.

To date, we have filed two formal comment letters, and offered additional comments in two additional contexts, as follows:

1. ACO Standards – Request for Information from CMS – Comment letter submitted November 22, 2010 (copy attached; posted on home page of http://participatorymedicine.org).

   This letter provided recommendations for definitions of patient engagement and patient-centeredness to be included in the regulations that will define Accountable Care Organizations (ACOs) in response to an RFI from CMS. The substance of the letter was drawn from working documents curated by Alan Greene, and was vetted by Danny Sands and the Executive Committee. The draft regulations should be issued in the near future, at which time we will have a second bite at the apple, should the draft not be fully reflective of our initial recommendation.

2. ACO Standards – Request for comments from NCQA on its draft ACO certification standards – Responses submitted via web form, late November

   These comments offered a highly abbreviated version of the CMS comment letter (there was a strict character limit on comments).

3. Meaningful Use – HIT Policy Committee Meaningful Use Workgroup – Request for suggestions of measures to use in assessing achievement of Meaningful Use – Suggestions submitted via web form, late December

We suggested the use of certain metrics for the "patient and family engagement" category of measure concepts: specifically, HCAHPS scores and a questionnaire developed to measure "patient activation" (Hibbard et al., Health Serv. Res. Aug. 2004, available at: http://j.mp/i4fxH3). We also recommended that a care plan must be fully accessible to a patient's family/caregiver. I received input on this matter from Dave DeBronkart.

4. PCAST Report – Comment letter submitted January 19, 2011 (copy attached; posted on home page of http://participatorymedicine.org).

   I convened a working group including Fred Trotter and Adrian Gropper, and we worked up our comment letter via email, conference calls and Google Docs over about a two-week period, and then incorporated comments from Danny Sands and the Executive Committee. This letter makes a strong statement that the patient must be an equal node on the network – on par with the providers using a patient's EHR. It also notes that the technical solution proposed by PCAST will not be implementable for a long time – certainly not in time to enable achieving Meaningful Use Stage 2, and that therefore other approaches, available now, should be used. We identified the Direct Project as an example of a system that is almost ready for prime time, but stopped short of a specific endorsement.

I have convened a working group to develop the Society's comments on Meaningful Use Stage 2 criteria. We will be using the same tools as the PCAST working group: private Google Docs, conference calls, and email. I solicited membership via the listserv and several members have volunteered to be involved in this endeavor: Susan Woods, Norma-Jeanne Hennis, Fred Trotter, Adrian Gropper, Mike Scott, and, once again, Dave and Danny. Some members have already begun to comment on the proposals via the Google Docs. Comments are due March 4.

Ted Eytan and a couple of the folks involved in the workgroups described above have expressed an interest in taking part in development of the committee's charter and operating guidelines. As time permits, I will turn my attention to that undertaking, and present the output of that process to the Board for approval.

I would like to develop a more consistent approach to communicating our work to the Society as a whole and to the world at large. One channel will be a Public Policy tab on the PM.org website. I wrote an inaugural blog post on e-patients.net, and it was syndicated by THCB and BetterHealth; I reposted it on my own blog as well. I've tweeted links to the comment letters and they've been retweeted. I believe that we should have a regular press release or social media release program (e.g., though http://pitchengine.com). This could allow for broader exposure, beyond "the usual suspects," and the social media echo chamber, which should be good for the organization and the cause. Many organizations that regularly file comments on proposed regulations put the word out in a manner that allows for other news outlets to pick up their

message, so that the message may be amplified. Thus far, the only blog post about our comments that I am aware of is on the blog of the medical transcriptionists association.

I try to keep track of regulatory activity and calls for comments that are relevant to the Society, but I certainly welcome input from members of the Board should an opportunity for comment or other engagement come to your attention.

Thank you for helping to get this operation under way, and please do not hesitate to be in touch with me to discuss any aspect of this report or committee activities. My contact information:

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David Harlow

Chair, Policy Committee

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November 22, 2010

Donald M. Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Room 445–G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: [CMS–1345–NC] Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Saving Program

Dear Dr. Berwick:

On behalf of the Society of Participatory Medicine, we are writing to provide input, solicited at the Accountable Care Organization (ACO) Workshop on October 5, 2010, on key elements of the ACO definition that are of greatest concern to the Society:

- The ACO shall define processes . . . to promote patient engagement
- The ACO shall demonstrate . . . that it meets patient-centeredness criteria specified by the Secretary [of Health and Human Services]

Patient Protection and Affordable Care Act (ACA), s. 3022(b)(2)(G) and (H).

The Request for Information (RFI) published in the Federal Register on November 17, 2010 specifically solicited input on the definition of patient-centeredness as well.

The Society of Participatory Medicine has individual and institutional members nationwide. It was founded to study and promote participatory medicine, which we see as being centered around networked patients shifting from being mere passengers to responsible drivers of their health, and providers who encourage and value them as full partners. For further background on the Society and its tenets, we invite you to peruse the Society's website (http://participatorymedicine.org), its online journal, The Journal of Participatory Medicine (http://jopm.org) and its blog, e-patients.net (http://e-patients.net).

We applaud the government's efforts to date in developing a high-performance health care system that can improve its processes and outcomes as a result of being more highly attuned to patients, and we are pleased to offer a series of specific recommendations regarding definitions of patient engagement and patient-centeredness in order to promote these positive outcomes. We propose that the regulations provide:

Patient Engagement. Each ACO shall define processes to promote patient engagement. Such processes shall include:

1. Working with patients to identify and minimize barriers to timely and effective action by patients.
2. Involving patients with central, meaningful roles in practice improvement efforts, such as quality improvement teams. This may include involving patients in developing patient materials and evaluating practice design, staff, and workflow.
3. Creating a patient advisory council with adequate resources and meaningful access to ACO leadership.
4. Mechanisms for regular assessment (at least annually) and improvement of patient engagement standards and processes.

Patient-Centeredness. In order to be eligible to participate in an ACO, a health care provider shall, and each ACO shall ensure that a health care provider that participates in such ACO shall:

1. Collaborate with patients to ensure that they have the knowledge, skills and support to make informed decisions about their care as providers and patients work together to achieve the patients' aims.
2. Maintain and enforce policies that ensure the provision of clear explanations and availability of individuals' information about their health and health care while guarding the privacy of this data.
    a. Comply with all legal requirements related to timely patient access to complete patient records, including without limitation HIPAA, and provide access to electronic health records, e.g. through the "Blue Button" system.
    b. Comply with all Meaningful Use requirements established by CMS.
    c. Maintain an on-line patient portal.
    d. Provide visit and discharge summaries to patients.
    e. Provide continuity of care communications to other providers engaged in a patient's care.
3. Maintain and enforce policies that facilitate and encourage individuals' full engagement and participation in their care, but do not require it. Such polices shall include, without limitation, the following:
    a. Offer open scheduling and extended office hours.
    b. Create reminders for patients and providers, delivered by means selected by the individual.
    c. Provide direct patient access to health data (e.g., lab results, growth carts, immunization records).
    d. Otherwise use technology as appropriate to facilitate meaningful patient and family (and/or other patient designees') participation in care.
    e. Provide transparent information about services, their cost, insurance coverage and

4. Serve as a knowledgeable resource about the tools, communities, and databases patients can use to support participation in their care.
5. Communicate with patients using approaches that minimize barriers to timely and effective action by patients.
6. Accommodate diversity in literacy, culture, ability and level of functioning and support the ability of all to participate in their care.
7. Collaborate with patients in order to
    a. Identify and monitor treatment and self-care goals.
    b. Understand what matters to the patient throughout the course of care, and implement changes to provider operations to accommodate patient needs and preferences (e.g., ask patient permission to include a student or trainee in a patient visit, provide patient chairs in addition to examination tables in examination rooms, provide pen and paper available for patients or designees to use in taking notes during appointments).
    b. Listen to patients with respect and cultural sensitivity.
    c. Respect patients' time.
8. Train staff on policies relating to patient-centeredness.
9. Adopt mechanisms for regular assessment (at least annually) and improvement of patient–centeredness standards and processes.

Given the broad vision behind the legislative language calling for these regulatory enactments, and the lofty goals of the "Triple Aim" which you described at the ACO Workshop, we urge you to be bold at this critical juncture, and include the strong framework for ensuring patient engagement and patient-centeredness that we offer today for your consideration. We believe that our recommendations are congruent with earlier work on patient engagement and patient-centered care at the Institute for Healthcare Improvement. We also wish to emphasize that final regulatory language should be broad enough to accommodate not only Stage 1 Meaningful Use criteria, but also the Stage 2 and Stage 3 Meaningful Use criteria now being developed as recommendations by the HIT Policy Committee's workgroups.

We are available to discuss these recommendations with you and your staff.

Thank you for the opportunity to provide these comments.

Sincerely,

Danny Z. Sands, MD
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David C. Harlow

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January 19, 2011

Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Attention: Steven Posnack
Hubert H. Humphrey Building, Suite 729D
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Posnack:

On behalf of the Society for Participatory Medicine, I am writing to provide our reactions to the *Report to the President Realizing the Full Potential of Health Information Technology to Improve Healthcare for Americans: The Path Forward*, submitted by the President's Council of Advisors on Science and Technology (PCAST) in December 2010, in response to the December 10, 2010 Federal Register Request for Information calling for comments on the PCAST Report.

The Society for Participatory Medicine has individual and institutional members nationwide comprising patients, non-professional caregivers, and clinicians. It was founded to study and promote participatory medicine, which is centered around networked patients shifting from being mere passengers to responsible drivers of their health, and providers who encourage and value them as full partners. For further background on the Society and its tenets, we invite you to peruse the Society's website (http://participatorymedicine.org), its online journal, The Journal of Participatory Medicine (http://jopm.org) and its blog, e-patients.net (http://e-patients.net).

We applaud PCAST's goal of developing a harmonized structure for the national exchange of health information, and we are pleased to offer a series of specific recommendations which we believe are critical to ensure that the information may flow as freely as needed, and to ensure that all patients have the opportunity for meaningful input to the design of this new system, for access to their health data, and for input into the ways in which data that pertains to them is used.

As empowered, engaged patients we want clinical aggregation of our health care data to be done with us, not to us. The best way to do that is to give us the opportunity to aggregate our own health data first. Specifically, the Society's position is that each and every patient must have full rights to his or her health information, as peers on

any health information network. We recognize that this goal may not be immediately achievable in its entirety, but elements of this goal may be achieved over time. (These elements are set forth below in order of difficulty, beginning with the easiest to achieve.) In the long run, each patient should have the right, and the easily exercised ability, to

1. Access all of their own health data. (The right to receive data)
2. Share information in the record with other individuals or organizations, privately or publicly, as the patient sees fit. (The right to send freely)
3. Aggregate data in a meaningful way from multiple sources (e.g., multiple physicians, clinical labs, imaging centers), before anyone else does, or at least as soon as anyone else does. (The right to aggregate)
4. Flag errors and add comments, and have comments acknowledged even if not "accepted", in an automated and trackable fashion. (The right to correct data)

The Society is technology agnostic. For purposes of this discussion, our key comment, and our goal for the national HIT infrastructure, is that **every patient must be a full peer on the health information network**. Based on the technology that is currently available and in development, this goal is achievable **now**. We do not see PCAST as embracing this goal in its report, and we believe that failure to do so represents at best a lost opportunity, and at worst a trampling of patients' rights. The vision of the future as articulated by PCAST retains a view of the patient as the subject of care, not as a participant in his or her own care. While there is certainly a place for medical experts and expert systems, the central role of the patient in directing his or her care, in shared medical decision making, must be formalized in our national health information exchange strategy.

We offer some technology-specific comments only because we believe that some technologies are more likely to lead to the realization of our goals sooner, more effectively and efficiently than others. These goals, however, are independent of, and primary to, any particular technology.

We are very concerned by PCAST's exclusive emphasis on a new XML standard, just as we are by the legacy systems that focus on data access and interchange through the IHE. XML is a powerful standard, which is capable of representing any given set of information in countless different ways. A national technology strategy that centrally relies on a command-and-control approach to having all users everywhere implementing XML-based standards identically is a non-starter. IHE has taken years of consensus building, yet adoption is limited at best. IHE is still years away from consistent broad-based adoption. It is almost entirely moot to discuss the tagged XML PCAST model as an improvement over IHE. Like IHE, a PCAST XML interchange strategy will take years or decades to build strong adoption. We need the power and intelligence of full semantic interoperability using XML as a basis, but we should not simply wait for it to happen.

Tools such as those under development through the Direct Project may allow patients to assume their role as full peers on the network sooner rather than later. The Direct Project represents one alternative approach to solving this problem. It is currently in beta testing at multiple sites, and will reportedly be ready for broader deployment within the next six to twelve months. "The Direct Project specifies a simple, secure, scalable, standards-based way for participants to send encrypted health information directly to known, trusted recipients over the Internet." (See http://directproject.org; accessed January 13, 2011.) The Direct Project currently aims to be compatible with IHE XML standards, and can reportedly support PCAST-inspired XML standards as well. The

Society appreciates the design of approaches like the Direct Project, which can enable patients to participate as full peers on the network, unlike IHE and the PCAST models.

A rich XML-based 'smart' HIE architecture, like IHE or something based on the PCAST recommendations, can and perhaps should be developed and rolled out over time, but there is a crying need to address the lack of patient access and patient parity with respect to health information as soon as possible.

Rolling out an alternative or interim system now, instead of waiting for implementation of IHE or the PCAST XML standard, will effectively put patient data in the hands of every patient now, rather than years or decades from now. In a similar vein, we applaud the VA's Blue Button Project, which has taken the first step of giving every VA patient access to his or her patient data, now, rather than something more polished later.

How will patients use this data? While we at the Society have many ideas about what we would like to try, no one really knows how engaged patients will innovate to improve their own care, once they have access to improved data. But that information -- what patients want to with their own data -- is critical to the long-term success of any health information exchange effort.

To the degree that a national strategy chooses to invest in complex XML-based health information exchanges like PCAST-XML or IHE, funding should be provided to create freely accessible provider portal software. This provider portal software should be specifically designed to give patients direct access to their data encoded in their choice of simple formats as well as advanced XML formats. The portal should enable patients to send their data to individuals, organizations and HIE services that they trust as well as allow patients to download the data directly, so that they can do whatever they want with it. It is not enough to prevent the data silos that have dominated Health IT for so many years. These silos should be opened to the patient first and health care providers should be asked to use the same portals as patients with careful, evidence-based scrutiny of special privileges for role-based access.

An aspirational goal for health information exchange should be to make it more broadly bi-directional. To the extent that provider portals become able to accept incoming messages in human-readable, XML-based and innovative formats, patient understanding and access to what is being said about them will be critical to building the trust we all depend on.

Again, **empowered, engaged patients want the aggregation of their health data to be done with them, not to them.** It is not possible for anyone to truly understand what might be possible with fully integrated health records. By giving patients access to the privilege of aggregation first, they will be able to inform the information exchange process as a whole. They will know just what kind of privacy privileges they want. By allowing patients into the big tent early on, the feedback to be garnered from patients will improve the next steps of the process – data standardization and data authentication – by demonstrating the ways in which patients want to access, modify, react to and share the data in their health records.

Ultimately, patients need to have a better window into the privacy and security of their health information – beyond the protections afforded under HIPAA – so as to be able to understand how their data is being shared and used for "health care operations" and ensure that it is being shared, used and aggregated only in a manner that respects the limits imposed by law and by patient agreement.

We suggest that health information exchange should learn to navigate health information with and through patients, rather than presume to navigate around them.

We are available to discuss these recommendations with you and your staff.

Sincerely,

Danny Z. Sands, MD
President
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David Harlow, JD MPH
Chair, Public Policy Committee
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Membership Quick Team – Deb Linton, Cheryl Greene, Jon Lebkowsky, e-paitient Dave

Volunteering Update

- To date 20 people have inquire about volunteering
- They report that they've heard about the Society from
    - e-patient Dave – 5 Jon Lebkowsky – 1 Dr. Pauline Chen – 1
      DrGreene.com – 1 John Lester – 1 Unreported – 11
- Our most active volunteer placement is with the Social Media Quick Team and JoPM
- We are recruiting for three open positions:
    - Corporate Membership Team Lead
    - Corporate Membership Team Member
    - Curator of the "Speaking Events" page on the Participatory Medicine site

Speaking Events Page

- Successfully added to SPM.org
- Should we keep this?
    - If so, how can we make this resource more valuable?

Member Networking Receptions

- Successful East Coast Reception timed around the CCH Symposium
- West Coast Reception planned to happen around Health 2.0 Conference

List serve launched and archived

- Only members can mail the list but the archive is open to the public
- Extreme praise for Jon Grohol
- We need your help monitoring conversation for new ideas and promoting dialog

Newsletter

- Updates from the Board (excerpts from meeting minutes – Society activity)
- Community Updates (featured member content - tips on how to jump into member listserv discussion topics – Latest on Networking Receptions)
- Journal Highlights (links to articles we'd like to feature (old if not new articles)
- e-Patients.net Highlights (links to select posts and/or provocative comments)
- Additions from last time (member-identified content that we may have missed)

February retrospective on e-patients.net

by e-Patient Dave on January 30, 2011

Researching recently I wound up looking at where we were two years ago - February 2009, just as the Society for Participatory Medicine (SPM) was forming. Fascinating to see what topics were live then and are still relevant today – this community has focused on some great discussion, whose relevance has panned out well.

"Patients" vs. "Health Care Consumers"? Both, If You Ask AmyT

Healthcare's going through social change, and in times like that, language can disturb people. This was our first post on what's become an ongoing subject: do we call ourselves "patients" (a term that some find diminishing) or "consumers" (which some also find diminishing) or what?

This post covered the view of Amy Tenderich of DiabetesMine, who's on the editorial board of our Journal of Participatory Medicine. Our most recent post on it is December's A lot of shackling lives in language, which links to a good post by SPM member Fred Trotter.

Twitter, Facebook, and e-patients

From the Pew Internet Project's first report on Twitter: "Twitter users engage with news and own technology at the same rates as other internet users, but the ways in which they use the technology—to communicate, gather and share information—reveals their affinity for mobile, untethered and social opportunities for interaction. …"

Welcome VisibleBody.com

This post led to a line in a talk I gave in September, "Why not Google Earth for my body?" The idea was to "mash up" VisibleBody with my own digital CT scan data so I (or you) can visualize our actual innards. Then in late 2010 Google announced the Google Body "body browser."

Visible Body is miles ahead of Google Body, but hey, we're in this to create the future, right? I hope Visible Body will connect itself to many data sources, including digital scan data.

Why? Because I've heard repeatedly that people change behavior better when they're looking at their own situation, vs generic advice. And in healthcare, outcomes don't change if behavior doesn't change.

A thousand points of pain

A business-oriented discussion of why any attempt to change the *business* of healthcare was going to meet terrific resistance, because if you cut costs 10% in a trillion dollar industry ($100 billion), it means *somebody* is going to lose $100 billion of income. And that won't happen easily. It became apparent that we consumer/patients must be responsible for our own improvements.

Medpedia: Who gets to say what info is reliable?

Discussion (with 68 comments) of the newly announced "medical wikipedia," based on the skewy view that any info vetted by health professionals is trustworthy, and anything that's not is not. In particular see our John Grohol's excellent discussion in a Feb 24 comment on how wrong their article on depression was – despite being vetted by a certified professional.

It's important for e-patients *and providers* to understand this: the info professionals have can be seriously out of date, and people need to be open to other sources.

Why Technology is No Longer Optional in Public Health

A short link to a post by @MindofAndre on mobile tech's potential. He was right: two years later mobile health / mHealth is hot, with annual conferences and a whole Pew Internet report; our most recent post is "it's not just phones and browsers," and see Susannah Fox's talk at Mayo Transform conference. If you want to anticipate the future, keep tabs on Andre.

Participatory medicine might have reduced this tragedy

A terrible story where blind trust led to disaster at a famous medical center; being an engaged patient and family may have made all the difference. "For me this story triple-underscores the importance of every patient, caregiver and provider embracing the principles of participatory medicine. Medicine is too complex today for any one group to bear all the responsibility – even great doctors. And we as patients need to understand that our lives are on the line, AND we can make a difference."

MedPage: Negative Data on Seroquel Suppressed by Drug's Maker

Our first post on what's been a distressingly steady subject: corruption in marketing of medications. To this day I don't understand why people in an industry that makes miraculous medications (which saved my life) sometimes feel compelled to lie, knowingly or callously unknowingly causing people harm. It's simply essential that informed, engaged patients know about this when they participate in decisions about their treatments.

In this case the drug maker reported to the FDA that they'd run several trials with the drug, and knowingly hid the fact that most of the trials didn't work out well, and in fact caused harm.

——

February 2009 was also when Congress passed the Federal stimulus bill (ARRA), including the HITECH provision to encourage healthcare to modernize through the "meaningful use" of health IT. By February 2010 intense discussions were underway in Washington to define that. Members of the Society for Participatory Medicine submitted testimony at several meetings. A few highlights from that month:

- Participatory Medicine in Time magazine: Cancer community ACOR was highlighted, along with numerous other e-patients and resources.
- Meaningful use testimony – requests for your input What to do about "the cream of the crap"? ONC's Adoption/Certification Workgroup meeting and results Testimony submitted to the Adoption/Certification Workgroup for its Feb 25 meeting
- Health IT executive Denny Porter also proposed that we create bridges between all the various Federal health records systems: Proposal for a health data system to support urgent cancer patients and wounded warriors

Finally, every February 28 is Rare Disease Day - "Alone we are rare. Together we are strong." Rare Disease Day 2/28/10:

"One profound shift in healthcare enabled by the internet is the Web's ability to be a common platform for huge numbers of low-volume diseases. This is the "long tail" effect that makes Amazon and eBay a success, selling vast numbers of items you never would have seen before the Web.

The difference, of course, it that this isn't about obscure books; in this case lives are at stake."

We hope to keep using this blog to host discussions about the present and the future that will help advance the cause of participatory medicine. Thanks for reading and thanks for your many great comments.

——-

Are you a member of the Society for Participatory Medicine? Our two content-related projects – this blog, and the Journal of Participatory Medicine – are free and open-access. For funding we rely on philanthropy and unrestricted corporate memberships (see ourmembership page), and almost all our work is done by volunteers (volunteer here) and individual members (just $30 a year). Participate – help create the future of participatory medicine!

SPM Fundraising / Corporate Membership QuickTeam
Meeting Minutes

1/19/11
Present: John Grohol, David Lansky, Danny Sands, Paul Wallace
Next meeting: TBD

I. Announcements

Has been too long since we last convened, and our deadlines have slipped; minutes reviewed
Treasurer:

We have 20 corporate members, 16 Innovators @250, 3 Bronze @5000, 0 Silver @10k, 1 Gold @20k
Mitchell Fund providing $50k per year
Fund balance $105k, and we had earmarked funds for corporate member recruitment

II. Discussion

Recognition that committee is small and members are too busy in our professional lives so need some help executing on our goals, so we need to expand our committee to members outside the Board. Might find a member with a marketing background to chair the committee

Need to spend $$ on recruitment and retention of members

Still missing statement of value proposition, which may vary by type of company and may be at the micro, meso, or macro level

We can triangulate to arrive at a value proposition, by using three techniques:

1. Propose value propositions through reflection about our own experiences and our own organizations
2. Survey existing corporate members
3. Interview target corporate members

SPM Salon Event:

Committee agrees to work on salon event, inviting 15-20 target corporate members (maybe with some existing members) to a nice dinner, with a speaker. We will not be targeting "Innovator" companies, because even if they join they don't generate sufficient revenue. Some of the event would be structured discussion to determine their careabouts and to share what the Society has been doing. May provide them with a public policy briefing, as well. We are targeting first salon for late February/Early March in Bay Area. May coordinate with PBGH board meeting 3/17 if we have overlapping invitees.

We also envisioned the development of materials targeted to specific constituencies (e.g., Why is PM Important to Employers?)

Potential speakers at salon include:

- Roni Zeiger (Google)
- Ted Eytan (Kaiser)
- Anna-Lisa Silvestri (Kaiser)
- Paul Tang (Palo Alto Medical Group)
- Kate Christensen (Kaiser)
- Others?

III. Actions

Action	Owner
Recruit members to join/lead this QuickTeam via listserv	Danny
Begin development of candidate list of corporate value proposition	Paul
Develop planning of salon (invitees, speakers, etc.)	David
Develop/delegate development of public policy briefing	Danny (done)
Develop corporate member survey	Not assigned (awaiting new QuickTeam members)

DZS 11/19/2011

BYLAWS

OF

THE SOCIETY FOR PARTICIPATORY MEDICINE, INC.

ARTICLE I

PURPOSE

The Society For Participatory Medicine, Inc. (the "Corporation") shall exist to promote the concept of participatory medicine by and among patients, caregivers and their medical teams and to promote clinical transparency among patients and their physicians through the exchange of information on a website of the Corporation, via conferences, as well through the distribution of correspondence and other written materials; to advance the understanding of physicians and other professionals in the importance of well-informed, empowered and engaged patients making informed decisions about their care and treatment; to foster communication among medical, communication, patient advocacy and public health subspecialties and the exchange of a wide range of ideas related to participatory medicine; to support informational and other research programs of the highest quality in participatory medicine; to proactively minimize the effect of the digital divide in the development of participatory medicine in minorities and disenfranchised populations by providing information to patients through the distribution of informational materials and correspondence ; to conduct any and all lawful activities that may be necessary, useful or desirable for the furtherance, accomplishment or attainment of the foregoing purposes, which activities would not endanger its not-for-profit status; to conduct any and all other charitable activities as shall from time to time be found appropriate in connection with the foregoing as are lawful for not-for-profit corporations, within the meaning of Section 501(c)(3) of the Code; and to conduct any and all lawful activities that may be necessary, useful or desirable for the furtherance,

accomplishment or attainment of the foregoing purposes, which activities would not endanger its not-for-profit status; and to conduct any and all other activities as shall from time to time be found appropriate in connection with the foregoing and as are lawful for not-for-profit corporations, within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended; and, in furtherance thereof, to exercise any and all powers which it may now or hereafter be lawful for the Corporation to exercise under and pursuant to the Corporation's Certificate of Incorporation and the laws of the State of New York (the "Purpose").

ARTICLE II

OFFICES

SECTION 1. Principal Office. The principal office of the Corporation shall be in the city, incorporated village or town and county within the State of New York as is designated in the Corporation's Certificate of Incorporation.

SECTION 2. Additional Offices. The Corporation may also have offices and places of business at such other places, within or without the State of New York, as the Board of Directors of the Corporation (the "Board of Directors" or the "Board") may from time to time determine or the business of the Corporation may require.

ARTICLE III

MEMBERS

The Corporation shall have no members.

ARTICLE IV

BOARD OF DIRECTORS

SECTION 1. Powers, Number and Qualifications. The Board shall be responsible for the overall policy and direction of the Corporation, and may delegate responsibilities for day-to-day operations to the Corporation's Executive Director and committees.

A Director shall perform his or her duties as a Director, including such Director's duties as a member of any committee of the Board upon which such Director may serve, in good faith, in a manner such Director reasonably believes to be in the best interests of the Corporation, and with such care as an ordinarily prudent person in a like position would use under similar circumstances. In performing such Director's duties, a Director shall be entitled to rely on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by:

(a) one (1) or more officers or employees of the Corporation whom the Director reasonably believes to be reliable and competent in the matters presented;

(b) counsel, public accountants or other person as to matters that the Director reasonably believes to be within such person's professional or expert competence; or

(c) a committee of the Board upon which such Director does not serve, duly designated in accordance with a provision of these Bylaws, as to matters within its designated authority, which committee the Director reasonably believes to merit confidence;

but such Director shall not be considered to be acting in good faith if such Director has knowledge concerning the matter in question that would cause such reliance to be unwarranted. A person who performs such duties shall have no liability by reason of being or having been a Director of the Corporation.

The number of directors constituting the entire Board of Directors shall be as many as thirteen (13); however the number of directors may be increased or decreased by amendment of these Bylaws, but no decrease shall shorten the term of any incumbent director and in no event shall the Board consist of less than three (3) directors. A majority of the Board of Directors shall be persons who have demonstrated their support for the

Purpose as evidenced by their accomplishments, formal education or training or their history of volunteer or other contributory service to medical or healthcare organizations. Each director shall be at least eighteen (18) years of age.

Presumption of Assent. A Director of the Corporation who is present at a meeting of its Board of Directors at which any action on any corporate matter is taken shall be presumed to have assented to the action unless such Director's dissent shall be entered in the minutes of the meeting or unless such Director shall file such Director's written dissent to such action with the Secretary of the meeting before the adjournment thereof or shall forward such dissent in writing to the Secretary of the Corporation within three (3) days after the adjournment of the meeting. Such right to dissent shall not apply to a Director who voted in favor of such action.

SECTION 2. Election and Term of Office. The names and addresses of the members of the first Board of Directors have been stated in the Articles. Such persons shall hold office until the organizational meeting of Board of Directors and/or until their successors shall have been elected and qualified. Each Director shall hold office until the due election and qualification of their successor(s) or until their earlier death, resignation or removal.

SECTION 3. Removal. Any director may be removed, for cause or without cause, by a vote of a majority of the directors then in office, at any special meeting of the Board called for that purpose.

SECTION 4. Resignation. Any director may resign from office at any time by delivering a resignation in writing to the Secretary, and the acceptance of the resignation, unless required by its terms, shall not be necessary to make the resignation effective.

SECTION 5. Vacancies and Newly Created Directorships. Any newly created directorships and any vacancies on the Board of Directors arising at any time and from any cause may be filled at any meeting of the Board of Directors by a majority of the directors then in office, and the directors so elected shall serve until his or her successor is duly elected and qualified or until their earlier death, resignation or removal.

SECTION 6. Place of Meetings. Subject to the provisions of Section 11 of this Article IV, the Board of Directors may hold meetings, both regular and special, either within or

without the State of New York as may be determined by the Board. Any one or more members of the Board or any committee thereof may participate in a meeting of the Board or such committee by conference telephone or similar communications equipment allowing all persons participating in the meeting to hear each other at the same time. Participation by such means shall constitute presence at a meeting.

SECTION 7. Regular Meetings. Regular meetings of the Board shall be held at such time and at such place as shall from time to time be determined by the Board by resolution at a duly called meeting. Personal notice of regular Board meetings is not required to be given to directors.

SECTION 8. Special Meetings. Special meetings of the Board may be called by the President or chair on two (2) days prior notice to each director, either personally or by regular mail, electronic mail or by facsimile. Special meetings shall be called by the President or Secretary in like manner and on like notice on the written request of any one director.

SECTION 9. Quorum and Voting. At all meetings of the Board of Directors, a majority of the entire Board shall be necessary to constitute a quorum for the transaction of business, and the vote of a majority of the directors present at the time of the vote if a quorum is present shall constitute the act of the Board of Directors, except as may be otherwise specifically provided by law. If a quorum shall not be present at any meeting of the Board of Directors, the directors present thereat may adjourn the meeting from time to time until a quorum shall be present. Notice of any such adjournment shall be given to any directors who were not present and, unless announced at the meeting, to the other directors.

SECTION 10. Written Consents. Any action required or permitted to be taken by the Board or by any committee thereof may be taken without a meeting if all members of the Board or the committee consent in writing or e-mail to the adoption of a resolution authorizing the action. The resolution and the written consents shall be inserted in the minute book of the Corporation with the minutes of the proceedings of the Board or committee.

SECTION 11. Compensation. The Board of Directors, as such, shall not receive any stated salary for their services, but, by resolution of the Board of Directors, a fixed fee and expenses of attendance, if any, may be allowed for attendance at each regular or special meeting of the Board; provided, however, that nothing herein contained shall be

construed to preclude any director from serving the Corporation in any other capacity and receiving compensation therefor. The Corporation shall not lend money to or use its credit to assist its Directors or officers.

SECTION 12. Director Conflict of Interest Any Director who has an interest in a contract or other transaction presented to the Board or a committee thereof for authorization, approval, or ratification shall make a prompt and full disclosure of their interest to the Board or committee prior to its acting on such contract or transaction. Such disclosure shall include any relevant and material facts known to such a person about the contract or transaction that might reasonably be construed to be potentially adverse to the Corporation's interest.

No Director shall cast a vote on any matter which has a direct bearing on services to be provided by that Director, or any organization which such Director represents or which such Director has an ownership interest or is otherwise interested or affiliated, which would directly or indirectly financially benefit such Director. All such services will be fully disclosed or known to the Board members present at the meeting at which such contract shall be authorized.

ARTICLE V

NOTICES

SECTION 1. Form and Delivery. Notices to directors shall be in writing and may be delivered personally or by regular mail, electronic mail or by facsimile. Notice delivered personally shall be deemed to be given on the day when such notice is received by the recipient. Notice by mail shall be deemed to be given five (5) days after the time when deposited in the post office or a letter box, in a pre-paid sealed wrapper, and addressed to directors at their addresses appearing on the records of the Corporation. Notice by electronic mail or facsimile shall be deemed to have been given three (3) days after transmission to the director's electronic mail address or facsimile number listed in the records of the Corporation, provided that the sender produces evidence of the date and time of transmission of such notice by machine log.

SECTION 2. Waiver. Whenever a notice is required to be given by any statute, the Corporation's Certificate of Incorporation or these Bylaws, a waiver thereof in writing, signed by the person or persons entitled to such notice, or by electronic mail from the address of the person giving the waiver, whether before or after the time stated therein, shall be deemed equivalent to such notice. In addition, any director attending a meeting of the Board of Directors without protesting prior to the meeting or at its commencement such lack of notice shall be conclusively deemed to have waived notice of such meeting.

ARTICLE VI

OFFICERS

SECTION 1. Officers. The Board may elect officers of the Corporation as it deems in the best interests of the Corporation. The Board shall have the authority to supervise, control, hire, terminate, and set the compensation of any and all officers and employees that they in their discretion may determine to be necessary for the conduct of the business of the Corporation, pursuant to Purpose.

Until the next annual meeting of the Board of Directors, the initial officers of the Corporation shall be as follows:

Board Chairpersons	Daniel Z. Sands, MD and Dave deBronkart
President	Alan Greene, MD
Vice President	Gilles Frydman
Treasurer	John M. Grohol, Psy.D.
Secretary	Theresa Graedon, Ph.D.

SECTION 2. Authority and Duties. All officers, as between themselves and the Corporation, shall have such authority and perform such duties in the management of the Corporation as may be provided in these Bylaws, or, to the extent not so provided, by the Board of Directors.

Chairpersons. Whenever possible one patient or patient advocate and one healthcare professional shall serve together as Chairpersons of the Board of Directors. The two Chairpersons shall be members of the Board of Directors and preside over all meetings of the Board unless otherwise provided for in the Chairpersons' absence.

President. The President shall be the principal executive officer of the Corporation and, subject to the control of the Board of Directors, shall in general supervise and control the business of the Corporation. The President shall serve as chairperson of the Executive Committee. The President may sign, with the Secretary or any other proper officer of the Corporation thereunto authorized by the Board of Directors, any promissory notes, deeds, mortgages, leases, contracts, or other instruments that the Board of Directors has authorized to be executed, except in the cases where the signing and execution thereof shall be expressly delegated by the Board of Directors or by these Bylaws to some other officer or agent of the Corporation, or shall be required by law to be otherwise signed or executed. The President shall perform all duties incident to the office of President and such other duties as may be prescribed by the Board of Directors from time to time. In the absense of the Chairpersons of the Corporation, the President shall, when present, preside at all meetings of the members of the Board of Directors when such meeting is duly called and the Chairpersons are unable to attend such meeting.

Vice President. In the absence of the President or in the event of the President's death, inability or refusal to act, the Vice President shall perform the duties of the President and, when so acting, shall have all the powers of and be subject to all the restrictions upon the President. The Vice President shall also represent the Corporation in such capacity, and shall perform such other duties, as from time to time may be assigned to the Vice President by the President or by the Board of Directors.

Secretary. The Secretary shall attend all meetings of the Board of Directors and shall prepare and maintain proper minutes of those meetings. The Secretary shall be the custodian of the official seal of the Corporation, if any, and shall affix that seal on all documents executed on behalf of the Corporation, pursuant to due authorization by the Board of Directors. The Secretary shall have the custody of and properly protect all executed deeds, leases, agreements and other legal documents and records to which the Corporation is a party or by which it is legally affected. The Secretary shall in general perform all duties incident to the office of Secretary and such other duties as from time to time may be assigned to the Secretary by the President or the Board of Directors.

Treasurer. The Treasurer shall be the principal financial officer of the Corporation and shall have charge and custody of and be responsible for all funds of the Corporation. The Treasurer shall sign all checks and promissory notes of the Corporation and shall receive and give receipts for moneys due and payable to the Corporation from any source whatsoever and deposit all such moneys in the name of the Corporation in such banks, trust companies or other depositories as shall be selected in accordance with the provisions of Article 6 of these Bylaws. The Treasurer shall keep or cause to be kept, adequate and correct accounts of the Corporation, including accounts of its assets,

liabilities, receipts and disbursements. The Treasurer shall submit to the Board of Directors and the President, when required, statements of the financial affairs of the Corporation. The Treasurer shall in general perform all of the financial duties incident to the office of Treasurer and such other duties as from time to time may be assigned to the Treasurer by the President or the Board of Directors. If required by the Board of Directors, the Treasurer shall give a bond for the faithful discharge of the Treasurer's duties in such sum and with such surety or sureties as the Board of Directors shall determine.

SECTION 3. Appointment, Term of Office and Removal. The Board shall have the sole authority to appoint officers of the Corporation. Officers shall be elected from among the members of the Board. Officers shall continue in office until his or her successor shall have been duly appointed and qualified, or until his or her death, resignation or removal. Any officer of the Corporation may be removed, with or without cause, by a vote of a majority of the entire Board.

SECTION 4. Officer Conflict of Interest. Any officer who has an interest in a contract or other transaction presented to the Board or a committee thereof for authorization, approval, or ratification shall make a prompt and full disclosure of their interest to the Board or committee prior to its acting on such contract or transaction. Such disclosure shall include any relevant and material facts known to such person about the contract or transaction that might reasonably be construed to be potentially adverse to the Corporation's interest.

SECTION 5. Compensation. The compensation of all officers and agents of the Corporation, if any, shall be fixed by the Board of Directors in its reasonable discretion.

SECTION 6. Vacancies. If an office becomes vacant for any reason, the Board of Directors shall fill the vacancy. Any officer so appointed by the Board of Directors shall serve until his or her successor shall have been duly appointed and qualified, or until his or her death, resignation or removal.

SECTION 7. Bonds. In the event that the Board of Directors so requires, any officer or agent of the Corporation shall deliver to the Corporation a bond for such term, in such sum and with such surety or sureties as shall be satisfactory to the Board of Directors for the faithful performance of the duties of his or her office and for the restoration to the Corporation, in case of his or her death, resignation, retirement or removal from office, of all books, papers, vouchers, money and other property of whatever kind in his or her possession or under his or her control belonging to the Corporation.

ARTICLE VII

COMMITTEES

SECTION 1. Committees of the Board. The Board of Directors, by resolution adopted by a majority of the Directors then in office, may designate and appoint one or more Director committees, each of which shall consist of two or more Directors, as well as the name the chairperson for such committees. These may include, but not be limited to a Journal Committee, a Blog Committee, and the Standing Board Committees.

Board committees, to the extent provided in the resolution establishing the committee, shall have and exercise the authority of the Board of Directors in the management of the Corporation; provided, however, that no Board committee shall have the authority of the Board of Directors in reference to (i) authorize distributions, (ii) approve dissolution, merger or the sale, pledge or transfer of all or substantially all of the Corporation's assets, (iii) elect, appoint or remove directors or fill vacancies on the Board of Directors or on any of its committees, or (iv) adopt, amend or repeal the Articles or these Bylaws. The designation and appointment of any such Director committee and the delegation of authority to a Board committee shall not operate to relieve the Board of Directors, or any individual Director, of any responsibility imposed upon the Board of Directors, or any individual Director.

Standing Board Committees.

a. Executive Committee. The Executive Committee comprises the President, Co-chairs, Vice President and additional members as determined by the Board of Directors , with the total being no more than nine. The Board of Directors delegates to the Executive Committee issues within the Board's jurisdiction that are considered ordinary in nature and not otherwise reserved by the Articles of Incorporation, these Bylaws, or required by law to be conducted only by the Board of Directors.

b. Audit & Finance Committee. The Audit & Finance Committee has accountability to the Board of Directors for the accurate accounting of the Corporation's revenue and expenses. This assignment includes serving as the Audit Committee and working with the Corporation's auditors. In addition, it is responsible for recommending an annual budget to the Board and for long-term financial planning for the Corporation.

c. Governance Committee. The Nominating & Governance Committee is responsible for making recommendations to the Board of Directors regarding: the addition of new Board members; the replacement of Board members when terms have expired or as otherwise necessary; and the nomination of Officers of the Board. In addition, the committee is responsible for periodic review of the Corporation's governance structure and for recommending alterations to that structure as they deem appropriate.

Tenure. Each member of a committee shall continue as such until the next annual meeting of the Board of Directors of the Corporation and until a successor is appointed unless (i) the committee is sooner terminated, (ii) such member is removed from the committee, or (iii) such member ceases to qualify as a member of the committee.

Chairperson. One member of each committee shall be appointed chairperson by the Board of Directors.

Vacancies. Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of the original appointments.

Resignation. Any committee member may resign at any time by giving written notice to the Board of Directors, the President, or the Secretary of the Corporation. Unless otherwise specified in the notice of resignation, the resignation shall take effect upon receipt. Acceptance of the resignation shall not be necessary to make the resignation effective.

Removal. Any committee member may be removed by the person or persons authorized to appoint such member with or without cause.

Quorum. Unless otherwise provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

ARTICLE VIII

CONTRACTS, CHECKS, BANK ACCOUNTS AND INVESTMENTS

SECTION 1. Checks, Notes and Contracts. The Board is authorized to select the banks, brokerages or depositories it deems proper for the funds of the Corporation. The Board shall determine who shall be authorized from time to time on the Corporation's behalf to sign checks, drafts or other orders for the payment of money, acceptances, notes or other

evidences of indebtedness. The Board shall determine who shall be authorized from time to time on the Corporation's behalf to enter into contracts or to execute and deliver other documents and instruments.

SECTION 2. Investments. The funds of the Corporation may be retained in whole or in part in cash or be invested and reinvested from time to time in such property, real, personal or otherwise, including stocks, bonds or other securities, as the Board may deem desirable.

ARTICLE IX

FISCAL YEAR

The fiscal year of the Corporation shall be determined by the Board of Directors.

ARTICLE X

AMENDMENTS

These Bylaws may be amended at any meeting of the Board of Directors by a vote of the majority of the entire Board of Directors, except that (i) any amendment which increases the quorum requirement or the proportion of votes necessary for the transaction of business or of any specified item of business, and (ii) any increase or decrease in the size of the Board of Directors must be authorized by a vote of two-thirds of the entire Board.

ARTICLE XI

INDEMNIFICATION

(a) Except as otherwise provided by law, no director or officer of the Corporation shall be liable to any person other than the Corporation based solely on such director's or officer's conduct in the execution of such office unless such conduct constituted gross negligence or was intended to cause the resulting harm.

(b) The Corporation shall indemnify to the maximum extent permitted by law, except as provided in paragraph (c) of this Article XI, any person made, or threatened to be made, a party to any action or proceeding, whether criminal or civil, including an action by or in

the right of the Corporation to procure a judgment in its favor, by reason of the fact that such person, or such person's testator or intestate, is or was a director or officer of the Corporation including also an action by or in the right of any corporation, partnership, joint venture, trust, employee benefit plan or other enterprise in which such director or officer served in any capacity at the request of the Corporation, against judgments, fines, amounts paid in settlement and reasonable expenses, including attorneys' fees actually and necessarily incurred as a result of such action or proceeding, or any appeal thereon, and to the extent permitted by law shall advance monies in respect thereof, and including attorneys' fees and costs actually and necessarily incurred by a director or officer in seeking to enforce his or her indemnification rights hereunder.

(c) The Corporation shall not indemnify any director or officer if a judgment or other adjudication adverse to the director or officer establishes that his or her acts were committed in bad faith or were the result of active and deliberate dishonesty and were material to the cause of action so adjudicated, or that he or she personally gained in fact a financial profit or other advantage to which he or she was not legally entitled.

(d) The Corporation shall have the power, to the full extent permitted by law, to purchase and maintain insurance to indemnify its directors or officers, and to indemnify the Corporation for any obligation which it incurs as a result of indemnification of directors or officers.

CERTIFICATION

The undersigned does hereby certify that there is attached hereto a complete and accurate copy of the Bylaws of **THE SOCIETY FOR PARTICIPATORY MEDICINE, INC.**, a New York Not-for-Profit Corporation, adopted by the Board of Directors and it has been compared with and is identical to the original.

IN WITNESS WHEREOF, the undersigned has set his hand this [___] day of January, 2009.

_____

Gilles Frydman

Director

Proposed Changes to the Society for Participatory Medicine (SPM) Bylaws

Submitted by John M. Grohol, Treasurer, Society for Participatory Medicine
Revision: January 28, 2011

(This document is numbered for your convenience in discussing changes; the numbers do not correspond to anything within the current Bylaws.)

General

1. Paragraph numbers to be added to all sections.

Proposed Changes to Article VI: Officers

2. Replace Chairpersons text and description with:

Chairperson. A Chairperson shall be appointed by the Board of Directors from amongst the members of the Board of Directors. When possible, one patient or patient advocate and one healthcare professional may also serve together as Chairpersons of the Board of Directors. The Chairperson(s) shall be members of the Board of Directors and preside over all meetings of the Board unless otherwise provided for in the Chairperson(s)' absence. The term of the Chairperson(s) shall be for a minimum of one (1) year, but may continue for up to three (3) years by annual consent of the Board of Directors.

3. President-Elect: The President-Elect shall assume the duties of the President in the absence of of the latter. In addition, the President-Elect shall have such additional duties as may be designated by the President or Board of Directors.

4. Past President: The immediate Past President shall serve as Chairperson of the Nominations Committee and shall assume the duties of the President in the absence of the President and President-Elect.

5. Vice President position is removed and all language throughout the bylaws referring to the Vice President shall be changed to "President-Elect."

6. Members-at-Large: There shall be two (2) Members-at-Large, each serving a one-year term. Members-at-Large come from members of the Organization and are members of the Executive Committee. The Members-at-Large are expected to chair or cochair at least one committee, task force, or quickteam.

7. The term for the offices of President, President-Elect and Past President shall be for one (1) year each, with the President-Elect succeeding to the President and Past President with no additional election needed, unless for any reason that person is unable to fulfill this three year succession.

8. The term of the Secretary shall be two (2) years.

9. The term of the Treasurer shall be three (3) years.

10. Section 3 shall be changed to:

SECTION 3. Appointment and Removal of Officers. The Board shall have the sole authority to elect and appoint officers. Officers shall be elected from among the members of the Board or from the general membership of the Corporation. Any officer of the Corporation may be removed, with or without cause, by a vote of a majority of the entire Board.

Proposed Changes to Article VII: Committees

11. Section 1. All references to "Board Committees" and "Committees of the Board" will be changed to "Committees."

12. Section 1. Introduction shall be changed to:

Committees. The Executive Committee may designate and appoint one or more Committees, each of which shall consist of two or more members from the Organization, as well as to name the chairperson for such committees. These may include, but not be limited to a Journal Committee, a Blog Committee, and the Standing Board Committees.

13. Section 1, d. Nominations Committee. The Nominations Committee shall be responsible for all nominations and elections. The Committee shall consist of the Past President who shall serve as Chair. Any Committee member who is an active candidate for any office within the Corporation must disqualify him/herself from service on the Committee in the year of that individual's candidacy. The Chair is responsible for issuing a call for nominations so that it reaches the Corporation's members in a timely fashion. The Nominations Committee will strive to recruit members from diverse groups to stand for election. The Nominations Committee is responsible for determining any additional qualifications for office; however, such qualifications must be approved by the Executive Committee before becoming active.