

**AMA-YPS Handbook Review: HOD Reference Committee J (advocacy on medical service, medical practice, insurance and related topics) Full text at <http://www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/2009-interim-meeting/i09-reports-resolutions/business-hod.shtml>. Recommended AMA-YPS positions should be considered preliminary until ratified by the AMA-YPS Assembly on Nov. 6, 2009.**

Recommended AMA-YPS Positions: Support, Active Support, Oppose, Active Oppose, Monitor

HOD resolution or report (sponsor)	Action requested	YPS position	HOD final action
<p><b>BOT 4:</b> Hospital Systems' Practices of Reclassification of Place of Service, Opting Not to Bill Medicare for Hospital and Aggressive Denial of Hospital Days in Reaction to Recovery Audits</p>	<p>RECOMMENDATION</p> <p>The Board of Trustees recommends that the following be adopted in lieu of Resolution 217 (A-09) and the remainder of this report be filed:</p> <p>That our American Medical Association work with the Centers for Medicare &amp; Medicaid Services, the Government Accountability Office, and other stakeholders to ensure that: (i) when hospitals make reclassifications based on screening criteria in proprietary databases, both the admitting physicians and the patient is immediately notified; (ii) Recovery Audit Contractors, are precluded from making recoupments associated with "inappropriate admissions" and/or discrepancies between the hospital and physician's site of service; (iii) physicians are intimately involved in the development of the data being used by proprietary databases; (iv) a process is put in place whereby physicians can substitute their medical judgment for that of the software program's, and carriers and auditors will ensure that that judgment is considered and evaluated by physicians in the same state and specialty; and (v) the evidence underlying data programs and the processes being employed are completely transparent. (Directive to Take Action)</p> <p>Fiscal Note: Estimated Staff Cost \$4,580</p>	<p>Support</p>	<p>Adopted as amended. See <a href="http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf">http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf</a> for exact language.</p>
<p><b>BOT 9:</b> Clarification of the Title "Doctor" in the Hospital Environment</p>	<p>RECOMMENDATIONS</p> <p>The Board of Trustees recommends that the following be adopted and that the remainder of this report be filed:</p> <ol style="list-style-type: none"> <li>1. That the American Medical Association continue to support, as appropriate, the Scope of Practice Partnership in the Truth in Advertising campaign (Directive to Take Action).</li> <li>2. That the AMA reaffirm Policy H-275.925, which states that the AMA: (1) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and (2) supports state legislation that would make it a felony to misrepresent oneself as a physician (MD/DO). (Reaffirm HOD Policy)</li> <li>3. That section 4 of Policy D-405.991 be rescinded as it has been accomplished.</li> <li>4. Our AMA will study the feasibility and benefits of a Public Education campaign to include: 1) education of the public on the use of the terms "Doctor" and "Physician" as related to various health care providers within the Health Care setting; 2) the promotion of public awareness of the term "Physician" by developing an "Is your Doctor a Physician" program; and 3) the availability of quality name tags, available to AMA member physicians only for a reasonable fee, containing</li> </ol>	<p>Support</p>	<p>Adopted as amended. See <a href="http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf">http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf</a> for exact language.</p>

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	<p><del>the AMA Logo (as part of the overall physician advocacy/branding campaign), the member physician's name and degree (M.D., D.O.), photo and the highlighted subtitle "Physician", and report their findings and recommendations to the House of Delegates at or before the 2009 Interim Meeting.</del></p> <p>(Modify HOD Policy)</p> <p>Fiscal Note: \$5,000 for staff time.</p>		
<p><b>BOT 10:</b> Joint Commission Credentialing of Low Volume Physicians</p>	<p>RECOMMENDATIONS</p> <p>The Board of Trustees recommends that the following be adopted and the remainder of the report be filed:</p> <ol style="list-style-type: none"> <li>1. That our American Medical Association reaffirm Policy H-230.954, "Privileging Physicians with Low Volume Hospital Activity." (Reaffirm HOD Policy)</li> <li>2. That the AMA House of Delegates rescind D-230.987, "Joint Commission Credentialing of Low Volume Physicians." (Rescind HOD Directive)</li> </ol> <p>Fiscal Note: Less than \$500 to update policy.</p>	Support	Adopted
<p><b>CMS 1:</b> Emergency Room Contracts and Hospital Privileges</p>	<p>RECOMMENDATIONS</p> <p>The Council on Medical Service recommends that the following be adopted in lieu of Resolution 806 (I-08), and that the remainder of this report be filed:</p> <ol style="list-style-type: none"> <li>1. That our American Medical Association strongly encourage physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage. (New HOD Policy)</li> <li>2. That our AMA monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association. (Directive to Take Action)</li> <li>3. That our AMA reaffirm Policy H-130.948, which contains a series of principles to assist physicians and hospitals in addressing emergency room call coverage requirements. (Reaffirm HOD Policy)</li> <li>4. That our AMA reaffirm Policy H-160.927, which urges individual physicians or physician groups that believe they are being coerced into specific employment arrangements to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel. (Reaffirm HOD Policy)</li> </ol> <p>Fiscal Note: Staff cost estimated to be less than \$2,000 to implement.</p>	Support	Adopted

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<p><b>CMS 2:</b> Geographic Variation in Health Care Cost and Utilization</p>	<p>RECOMMENDATIONS                      The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:                      1. That our American Medical Association encourage further study into the possible causes of geographic variation in health care delivery and spending, with particular attention to risk adjustment methodologies and demographic factors that affect demand for health care services. (New HOD Policy)                      2. That our AMA encourage the development of a national claims database in order to facilitate research into health care utilization patterns across all segments of the health care delivery system. (New HOD Policy)                      3. That our AMA support efforts to reduce variation in health care utilization that are based on ensuring appropriate levels of care are provided within the context of specific clinical parameters, rather than on aggregated benchmarks. (New HOD Policy)                      Fiscal Note: Staff cost estimated to be less than \$500 to implement.</p>	<p>Support</p>	<p>Adopted as amended. See <a href="http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf">http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf</a> for exact language.</p>
<p><b>CMS 3:</b> Health Insurance Exchange Authority and Operation</p>	<p>RECOMMENDATIONS                      The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:                      1. That our American Medical Association (AMA) adopt the following principles for the operation of health insurance exchanges:                       a) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.                      b) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians.                      c) Physician and patient decisions should drive the treatment of individual patients.                      d) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.                      e) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. (New HOD Policy)</p>	<p>Support</p>	<p>Adopted as amended. See <a href="http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf">http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf</a> for exact language.</p>

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	<p>2. That our AMA reaffirm Policy H-373.998[2], which supports patient choice and empowering patients with incentives and understandable information about fees and prices. (Reaffirm HOD Policy)</p> <p>3. That our AMA reaffirm Policy H-165.846[4], which supports transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services. (Reaffirm HOD Policy)</p> <p>4. That our AMA reaffirm Policy H-185.975 addressing health plan transparency and publication of their payment policies, rules, and fee schedules for physicians. (Reaffirm HOD Policy)</p> <p>5. That our AMA reaffirm Policy H-385.926, which supports physician freedom of practice. (Reaffirm HOD Policy)</p> <p>Fiscal Note: Staff cost estimated to be less than \$500 to implement.</p>		
<p><b>CMS 5:</b> Radiology Benefits Managers</p>	<p>RECOMMENDATIONS</p> <p>The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:</p> <p>1. That our American Medical Association strongly encourage radiology benefits managers (RBMs) to adhere to uniform physician-developed best practice guidelines. (New HOD Policy)</p> <p>2. That our AMA support the use of appropriate use criteria developed by physicians with relevant expertise working in a collaborative process involving all national medical specialty societies that provide and/or order the service in question. (New HOD Policy)</p> <p>3. That our AMA support an independent study assessing the magnitude of the cost and administrative burden of imaging utilization strategies on ordering physician offices, imaging providers, and patients and the impact these strategies have on patient safety and outcomes. (New HOD Policy)</p> <p>4. That our AMA oppose the practice of forced test substitution and denial of requested imaging services by RBMs contracted by third-party payers that meet appropriate use criteria, and that RBMs be held accountable for harm caused by substitution or delay of requested studies. (New HOD Policy)</p> <p>5. That our AMA encourage the Physician Consortium for Performance Improvement® to continue to develop patient-centered measures, including those that address the appropriate use of imaging. (New HOD Policy)</p> <p>Fiscal Note: Staff cost estimated to be less than \$500 to implement.</p>	<p>Support</p>	<p>Adopted as amended. See <a href="http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf">http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf</a> for exact language.</p>

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<b>Resolution 801:</b> Regulation of Personal Health Records (MI)	RESOLVED, That our American Medical Association formulate guidelines for personal health records (Directive to Take Action); and be it further RESOLVED, That our AMA use these guidelines to lobby Congress to enact legislation for fair usage of personal health records. (Directive to Take Action)  Fiscal Note: Implement accordingly at estimated cost of \$23,000 which includes staff time, travel and meetings, lobbying, pursuit of legislation and formulation of "guidelines."	Monitor/Support for Referral	Referred
<b>Resolution 802:</b> Price Transparency in Health Care (MI)	RESOLVED, That our American Medical Association support legislation that requires insurance providers to provide an online resource for patients and physicians to calculate charges and out-of-pocket expenses associated with investigations and therapies in an effort to better educate patients and physicians about health care costs, equip patients to recognize value in health care, empower patients to participate in the spending of their health care dollars, and promote one-time and long-term patient savings in an effort to reduce economic strains on health care systems. (New HOD Policy) Fiscal Note: Implement accordingly at estimated staff cost of \$1,900.	Monitor	Reaffirmed
<b>Resolution 803:</b> Physician Compensation for Case Management Services (FL)	RESOLVED, That our American Medical Association develop a plan to allow compensation for time spent educating case managers and similar hospital personnel as to specific patient treatment plans. (Directive to Take Action)  Fiscal Note: Implement accordingly at estimated staff cost of \$3,056.	Monitor	Reaffirmed
<b>Resolution 804:</b> Refugee Health Care (AMA-MSS)	RESOLVED, That our American Medical Association recognize the unique health needs of refugees (New HOD Policy); and be it further RESOLVED, That our AMA encourage the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees (Directive to Take Action); and be it further RESOLVED, That our AMA support extending beyond eight months the period during which new refugees are eligible for Medicaid coverage under the Refugee Medical Assistance program. (New HOD Policy) Fiscal note: Implement accordingly at estimated staff cost of \$1,144.	Monitor	Adopted as amended. See <a href="http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf">http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf</a> for exact language.
<b>Resolution 805:</b> Emergency Department Readiness to Care for Children (AAP)	RESOLVED, That our American Medical Association affirm the importance that all emergency departments stand ready to care for children of all ages (New HOD Policy); and be it further RESOLVED, That our AMA advocate for hospital administrators, emergency department medical directors and emergency department nurse managers to be aware of and compliant with the Guidelines for Care of Children in the Emergency Department (New HOD Policy); and be it further	Support	Adopted with original language.

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	<p>RESOLVED, That our AMA advocate for the inclusion of the Guidelines for Care of Children in the Emergency Department for care of children in standards for hospital accreditation and as part of the required conditions of participation for state and federal funding. (New HOD Policy)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,900.</p>		
<p><b>Resolution 806:</b> Principles for Developing a Sustainable and Successful Hospitalist Program (AMA-OMSS)</p>	<p>RESOLVED, That the following 15 principles be endorsed by the American Medical Association House of Delegates:</p> <p>PRINCIPLES FOR A SUSTAINABLE AND SUCCESSFUL HOSPITALIST PROGRAM</p> <p>Vision</p> <p>1. Seek to involve and address the needs of all key stakeholders in designing and implementing a hospitalist program. These stakeholders include patients, the medical staff, other clinical professionals, hospital administration, and the hospitalists.</p> <ul style="list-style-type: none"> <li>• Patients: A hospitalist program introduces a new “player” into the healthcare system. Patients expect to have their primary care physician (PCP) treating them when they are admitted to the hospital. As such, it is important that all parties (the PCP, the hospital, and the hospitalist) develop communication programs that explain the hospitalist model. Brochures and newsletters are tools that can be used to improve communications. Also, it is important to measure patient satisfaction. When evaluating patient satisfaction with hospitalists, recognize that there are factors that can negatively impact these ratings – specifically, the likelihood that the patients have been admitted through the emergency department and they are expecting care from their PCPs.</li> <li>• Medical Staff: Hospitalist programs can provide a significant service to other physicians at the hospital. Specifically, 1) PCPs may not want to do emergency call at the hospital; 2) PCPs may decide that doing inpatient care is not cost effective and/or it disrupts their office-based practice; 3) surgeons and specialists may seek hospitalist support in handling more routine inpatient care and/or in co-managing their patients; and 4) emergency physicians and hospitalists have to work together to treat and admit patients. As such, it can be helpful to involve the medical staff in the design, implementation, and review of the hospitalist program. A “Hospitalist Advisory Committee” may be a useful vehicle for addressing these issues. A hospitalist program may want to implement satisfaction surveys, to determine how the hospitalists are perceived by other members of the medical staff. Also, hospitalists should be involved in medical staff activities and in its leadership.</li> </ul>	<p>Monitor/Refer</p>	<p>Substitute Resolution 806 adopted in lieu of Resolution 806. See <a href="http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf">http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf</a> for exact language.</p>

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	<p>• Other Clinical Professionals: The care and treatment of medical inpatients requires coordination among all of the clinical professionals in the hospital – nurses, case managers, social workers, physical therapists, etc. These professionals also can play a role in the development and implementation of a hospitalist program. If nurse turnover is an issue at the hospital, hospitalists may play a role in addressing nurse satisfaction.</p> <p>• Hospital Administration: Hospital administrators often define the goals and provide the financial support for hospitalist programs. By definition, they will play a key role in designing and monitoring the hospitalist program.</p> <p>• Hospitalists: Hospitalists need to be treated as professional colleagues and as equal, legitimate members of the medical staff, not as contractors hired to do the work that other physicians do not want to do. A successful hospitalist program will acknowledge the importance of physician satisfaction and the risks and dangers to the program of the potential burnout of hospitalists.</p> <p>NOTE: In developing and implementing the goals of the hospitalist program, a balance must be sought among the interests of the various stakeholders. Issues may arise if it appears that the interests of one group of stakeholders (i.e., the hospital administrators, the medical staff, other clinical staff, the hospitalists) is over-emphasized.</p> <p>2. Promote a hospitalist model that focuses on team-based inpatient care. The delivery of inpatient medical care often suffers from coordination problems. During the hospital stay, patients and their family members may have to sort through information, diagnoses, and treatments from an attending physician, consulting specialists, nurses, residents, therapists, social workers, case managers and others. Effective inpatient care is a “team sport”. Since hospitalists spend virtually all of their time in the hospital, there is a unique opportunity for hospitalists and other clinical professionals to develop shared goals, mutual respect, and improved communication. A team-based model of inpatient care can result in superior coordination of care and patient outcomes.</p> <p>3. Recognize the potential of hospitalists to help address vital strategic issues for the hospital. These concerns include financial pressures; staffing shortages and dissatisfaction; quality and patient safety; new technologies; employer and consumer demands for performance metrics; capacity constraints; and increased competition. Many physicians are no longer able or willing to serve on hospital committees or play a leadership role for the medical staff. Hospitalists have the potential to step in and help address these key issues for the following reasons:</p>		

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	<ul style="list-style-type: none"> <li>• Hospitalists spend the majority of their time in the inpatient environment, making them familiar with hospital systems, policies, services, departments, and staff.</li> <li>• Hospitalists are inpatient experts who possess clinical credibility when addressing key issues regarding the inpatient environment.</li> <li>• Many hospitalists are hospital employees who can understand the tradeoffs involved in balancing the needs of the institution with those of the medical staff, the referral sources, and the patients. Even hospitalists who are not employed by the hospital have an intimate knowledge of the issues that the hospital is facing and are invested in finding solutions to these problems.</li> </ul> <p>4. Anticipate the ongoing evolution in the scope of hospitalist practice. As hospitalist programs mature within their organizations, often the hospital leadership and medical staff seek to expand the role and responsibilities of hospitalists. All hospitalists should be prepared for an evolving set of responsibilities that may expand beyond the traditional scope of their training background. If hospitalists agree to assume broader responsibilities, they may need to acquire additional skills and expertise. That being said, the hospital leadership and medical staff should be careful not to overburden the hospitalists or mandate new responsibilities for the hospitalists. A balance must be sought that addresses a reasonable workload, the skills of the hospitalists, and the needs of the institution.</p> <p>Organization/Structure</p> <p>5. Choose a hospitalist leader with the right skills and experience. Selecting the right leader is fundamental to a successful hospitalist practice. These individuals are hard to find. They must be excellent clinically and have superb communications skills. Although they need to be assertive, they must also be good listeners. Political skills are essential to navigate medical staff, departmental, and administrative issues. An understanding of and appreciation for practice economics will help to ensure that revenue is optimized and benefits to the financial supporters of the program are tracked.</p> <p>6. Build structure and incentives with the goal of creating an “ownership” mentality for hospitalists in the practice. Hospitalists need to think of themselves as owners of their practice, even if they are employees or contractors of a hospital or multispecialty clinic. An employee or “shift” mentality may lead to hospitalists unwilling to step in to help out other physicians (both hospitalists and non-hospitalists) or to stay until the work is done. They</p>		

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	<p>may feel like it is someone else's problem to address the financial status of the hospitalist program. There are many ways that a hospitalist program can create this sense of ownership, but perhaps the most effective is to implement a compensation system that rewards performance, including productivity and clinical quality. The goal of the compensation model and incentives should be to connect physician incomes with the economic health and/or clinical quality of the practice. Ongoing training and education with regular audits for proper documentation, billing, and coding are essential to maximizing reimbursement for the work that has been done and to maintaining fiscal viability of any program. Physicians who are in a hospital employee or "guaranteed salary" practice model may be particularly vulnerable to neglecting proper billing and coding since this might not affect their individual income, but this has tremendous impact on the financial health of both the program and the hospital.</p> <p>7. Assure that the hospitalist practice has the necessary tools and support to achieve their objectives: Like any physician practice, a hospitalist program needs adequate administrative support to help with billing, performance reporting, tracking patient census and volumes, information exchange with PCPs, etc. The practice may want to consider purchasing one of the hospitalist software products available in the marketplace. Also, hospital administration should assure that the hospitalists have access to other hospital departments such as information systems, finance, and utilization reporting. Finally, the medical director of the hospitalist program needs sufficient non-clinical time to address administrative and leadership issues.</p> <p>Relationships/Communications</p> <p>8. Use of hospitalist program should be optional for referring physicians and should never be mandated, especially not by hospital administration or by third party payers. Success of a hospitalist program requires the support and "buy-in" of all of the stakeholders involved in its use, particularly the referring physicians and the patients. Under no circumstances should a PCP be required to refer patients to a hospitalist program in lieu of caring for that patient him/herself. Likewise, no third-party payors should require patients be followed by a hospitalist rather than their PCPs they have chosen, unless the PCP is not contracted with the payor or the facility. PCPs may choose to forgo rounding on their own hospitalized patients and this, in turn, may require those patients to see a different physician, but those patients could usually then choose a different physician that still makes rounds if this is their preference.</p>		

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	<p>9. Develop a process for identifying, addressing, and resolving issues between hospitalists and the medical staff. Whenever a hospitalist program is introduced at a hospital, a range of new “practice” issues arise with the medical staff. Examples include: 1) the roles of the hospitalist and the emergency physician; 2) the role of the hospitalist in providing emergency department call; 3) the responsibilities of the hospitalist and the surgeon when co-managing a patient; 4) the responsibilities of the hospitalist and the medical specialist when co-managing a patient; 5) the availability of specialists for consultations; 6) the hospitalist’s choice of consultants; and 7) the timeliness of hospitalist communications to PCPs; etc. Physician leadership at the hospital (e.g., a Chief Medical Officer or Vice President – Medical Affairs) can play a vital role in identifying and resolving these issues. Some hospitals have used a “Hospitalist Advisory Committee” to address the issues.</p> <p>10. Assure hospitalists and community physicians share accountability for the patient and the exchange of patient information in a timely manner. Community physicians (typically PCPs) refer their patients to hospitalists for inpatient care. This creates a discontinuity of care and both parties must assume a level of accountability. At admission, the PCP must be sure that the hospitalist receives all information need to treat the patient. At discharge, the hospitalist must dictate discharge notes which should be transcribed and transmitted to the referring doctor on a “stat” basis. It is at these “transitions of care” that there are risks to the patient. Both parties must be diligent to assure that key information (medications, test results, follow up requirements, etc.) is transmitted and acted upon in a clear and timely fashion. During the hospitalization, the hospitalist needs to communicate to the PCP if there are significant changes in the patient’s condition; the PCP should be accessible if any new issues arise that may require further input or information.</p> <p>11. Establish regular communication and dialog between the hospital leadership and the hospitalist program. Hospital leadership needs to review the performance of the hospitalist program to assure that the objectives are being met. The hospitalists need access to hospital administrators and medical staff leaders to address obstacles or barriers to their performance. In successful hospitalist programs, there are periodic meetings between the two parties at which these topics are discussed and action plans are developed for moving forward.</p>		

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	<p>Operations/Management</p> <p>12. Design a flexible schedule for the hospitalists that recognizes competing priorities and demands. A hospitalist's schedule should take into account the following variables:</p> <ul style="list-style-type: none"> <li>• Patient-hospitalist continuity over the course of the hospital stay. Ideally, a patient should see the same hospitalist throughout his or her hospital stay. This is likely to improve patient satisfaction, reduce errors, and increase hospitalist efficiency.</li> <li>• The bimodal distribution in work over the course of the day. A typical day for a hospitalist practice follows this pattern: 1) it is very busy with rounds on existing patients from early in the morning until sometime in the early afternoon; 2) then it is relatively quiet in the early afternoon; 3) finally it gets busy again with admissions from late afternoon until about 10 p.m. to midnight.</li> <li>• Sustainable physician lifestyle. Is the group's schedule one that a doctor could work for many years? Or do problems arise such as regular night work leading to sleep deprivation or working too few days annually so that each worked day requires a very high patient load? Does the schedule protect extended "block time off" but trade this for working too many days consecutively so that physicians are exhausted by the end of the "long stretch?"</li> <li>• Reasonable provision for night work. Once a hospitalist group is admitting six to eight patients per day, the program should consider a separate night shift staffed by a doctor who has no daytime responsibility the day before or after. Ideally, the practice should have one or more dedicated "nocturnists" who work only at night, while the remaining doctors in the group work only during the daytime.</li> <li>• Adaptability and scalability. Every group should think about how their schedule might change if/when patient volume grows and one or more doctors are added. Growth will often require changing the schedule significantly, rather than just adding new doctors into the existing scheduling rotation.</li> </ul> <p>13. Staff the hospitalist program in a way that recognizes the potential for growth, the daily variations in patient volume, and the hospitalists' responsibilities: A significant problem encountered by many hospitalist programs is patient volume growth that occurs more quickly than anticipated. Recruiting lead times for hospitalists are long and physician turnover is common. A frequent cause of hospitalist practice crisis or failure is an overwhelmed hospitalist team. A hospitalist program should staff in a way that appropriately anticipates growth in patient volume.</p>		

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	<p>From day-to-day, there are significant variations in the volume of patients demanding care from hospitalists. Hospitalist staffing needs to recognize this variation. A cap on patient volume for individual hospitalists in the practice can be a useful tactic. Specifically, when one doctor reaches the cap in patients, other hospitalists help out.</p> <p>Finally, as previously described, hospitalists often have broad non-patient care responsibilities within the hospital – leading projects, staffing committees, etc. The hospitalist staffing model must provide sufficient “protected time” for these activities.</p> <p>14. Track and report hospitalist performance measures against goals: In conjunction with the hospital and the medical staff, the hospitalist practice should establish performance goals and metrics. By tracking performance against these measures, variations can be picked up earlier in the process and corrective actions introduced. The program should generate periodic performance reports on parameters such as clinical quality, resource utilization, practice economics, physician productivity, and satisfaction (of patients, referring physicians, nurses, and hospitalists). These performance reports should be shared with the hospitalists in the practice and other stakeholders (e.g. hospital quality program) as appropriate.</p> <p>15. Focus on effective revenue cycle management for the hospitalist program through systems, training, and reporting. (New HOD Policy): Unless patient encounters are coded properly, billed accurately and promptly, and collected fully, the hospitalist practice will experience significant deficits and/or require excessive levels of subsidization. Hospital billing departments may not be familiar with the role of hospitalists. In those situations, seek out a vendor that has experience in the hospitalist field and check its references. Make sure it has integrated a compliance program into the coding and billing process and has the ability to provide complete activity and trend reports.</p> <p>Poor coding, especially under-coding, is a common problem among hospitalist programs. This is especially true for programs that have not implemented production-based incentives. Educating the doctors in coding and undertaking regular audits of their performance is worth the effort and expense. It can lead to significant additional revenue to the hospitalist practice, potentially reducing the amount of financial support required from the hospital or medical group. (New HOD Policy)</p> <p>Fiscal Note: Implement accordingly at estimated cost of \$3,000.</p>		

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<p><b>Resolution 807:</b> Medicare's Proposal to Eliminate Payments for Consultation Service Codes (11 specialty societies)</p>	<p>RESOLVED, That our American Medical Association oppose all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA work with Centers for Medicare &amp; Medicaid Services (CMS) and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$4,580.</p>	Monitor/Support	<p>Adopted as amended. See <a href="http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf">http://www.ama-assn.org/assets/meeting/mm/i-09-ref-comm-j-annotated.pdf</a> for exact language.</p>
<p><b>Resolution 808:</b> Readability of Medical Notices of Privacy Practices (AMA-MSS)</p>	<p>RESOLVED, That our American Medical Association continue to support physician efforts to provide Notices of Privacy Practices at an appropriate reading level and in a language appropriate to the patient population served (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA make available on its Web site a link to the US Department of Health and Human Services Health Resources and Services Administration document, Plain Language Principles and Thesaurus for Making HIPAA Privacy Notices More Readable. (Directive to Take Action)</p> <p>Fiscal note: Staff cost estimated at less than \$500 to implement.</p>	Support	Adopted
<p><b>Resolution 809:</b> Reimbursement for Professional Services (FL)</p>	<p>RESOLVED, That our American Medical Association pursue legislation requiring physician reimbursement for time spent providing professional services through the use of such modalities as telephone, email and other electronic communication methods, regardless of the treating physician's physical proximity to the patient at the time those services are rendered. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,859.</p> <p><b>This topic is currently under study by the Council on Medical Service.</b></p>	Monitor/Support	Referred
<p><b>Resolution 810:</b> Transition to ICD-10 Code Sets (CT, ME, MA, NH, RI, VT)</p>	<p>RESOLVED, That our American Medical Association develop systems to help physicians transition to the ICD-10 coding system. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated cost of \$100,000.</p>	Support	Adopted

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<p><b>Resolution 811:</b> Guaranteeing Due Process for Employed Physicians (CT, ME, MA, NH, RI, VT)</p>	<p>RESOLVED, That our American Medical Association study the unique employment arrangements of physicians employed or contracted by health care organizations (Directive to Take Action); and be it further RESOLVED, That our AMA seek legal advice for producing model language for inclusion in employment contracts and medical staff bylaws that would provide the greatest possible protection for physicians against denial of due process by health care organizations (Directive to Take Action); and be it further RESOLVED, That our AMA design, produce, and make available to all members, an educational package that helps physicians negotiate contracts and formulate staff bylaws that provide the greatest possible protection from denial of due process following termination of employment or premature termination of contracts by health care organizations. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$9,294.</p>	Support	Adopted
<p><b>Resolution 812:</b> Non-Payment for Never Events (Utah)</p>	<p>RESOLVED, That our American Medical Association advocate that the Centers for Medicare &amp; Medicaid Services (CMS) modify its Hospital Acquired Condition – Present on Admission (HAC-POA) rule to evaluate any non-payment events on a case-by-case basis, rather than by category, to determine whether they were preventable (Directive to Take Action); and be it further RESOLVED, That our AMA modify its billing codes to enable physicians and surgeons to indicate, in billing for a particular service, whether the need for the service was reasonably preventable as iatrogenic or nosocomial (Directive to Take Action); and be it further RESOLVED, That our AMA modify its billing codes to facilitate the ability of physicians to bill for consultation and treatment services of a patient's condition that may otherwise (e.g., under the CMS HAC-POA rule) be deemed non-payable services. (Directive to Take Action). Fiscal Note: Implement accordingly at estimated staff cost of \$1,859.</p>	Support	Referred