

REPORTS OF THE BOARD OF TRUSTEES

The following reports, 1–11, were presented by David O. Barbe, MD, MHA, Chair:

1. PHARMACIST ADMINISTRATION OF IMMUNIZATIONS (RESOLUTION 212-I-12)

Reference committee hearing: see report of [Reference Committee B](#).

HOUSE ACTION: REFERRED FOR REPORT AT A-14

At the American Medical Association (AMA) 2012 Interim Meeting, the House of Delegates (HOD) referred Resolution 212, “Pharmacist Administration of Vaccines” and requested a report back at the 2013 Interim Meeting. In Resolution 212, the Louisiana Delegation asked our AMA to:

1. Recognize the role of the pharmacist as an essential member of the medical home model health team and the potential role that pharmacists may play in increasing immunization rates in this country.
2. Reaffirm its commitment that such endeavors are physician-led and that pharmacists’ administration of immunizations is only proper when any of the following criteria are satisfied:
 - the pharmacist has an order from a physician licensed to practice medicine in the state where the immunization is to be administered;
 - the pharmacist has a collaborative agreement with a physician licensed to practice in the state where the immunization is to be administered; or
 - the state where the immunization is to be administered has designated a state of emergency which necessitates the rapid immunization of the population in order to respond to the public health state of emergency, during which time administration by pharmacists should be limited to the specific vaccine required to respond to the emergency and only for the duration of the emergency declaration.
3. Support that a state’s educational requirements of pharmacists who administer immunizations be developed from input by both the state’s boards of medicine and pharmacy.
4. Oppose any federal or state legislation allowing pharmacists to administer immunizations without a licensed physician’s order or collaborative agreement, or during a designated state of emergency.
5. Draft model legislation which supports a medical home model and requires a physician’s written or standing order, or a collaborative practice agreement between a physician and a pharmacist for the administration of immunizations, and to outline educational and safety requirements which must be satisfied in order for a pharmacist to administer immunizations, and to distribute this model legislation to state and specialty societies.

This report is written in response to the referral of Resolution 212.

PHARMACISTS’ ROLE IN THE MEDICAL HOME AND IN INCREASING IMMUNIZATION RATES

As members of the physician-led health care team, pharmacists may provide beneficial contributions directly related to safe, effective, and optimal medication use and access to immunizations. Pharmacists’ practice in these physician-led, collaborative settings ranges from immunizations, to medication therapy management, to disease management.¹ A growing body of research demonstrates the valuable role pharmacists can play in physician-led models of health care delivery, such as patient-centered medical homes (PCMH).² Systematic reviews of the evidence demonstrate the effects of physician-led, pharmacist-provided direct patient care on various health care outcomes.³ For example, pharmacists’ direct patient care interventions among therapeutic outcomes have demonstrated favorable outcomes such as decreased blood pressure, hemoglobin A1c, cholesterol, and risk factors for coronary heart disease.⁴

Similarly, institutions including the Institute of Medicine (IOM) also have recognized the critical role played by pharmacists in the areas of medication safety and management, as well as the value of physician-pharmacist

collaboration in patient care.⁵ Pharmacists who perform direct patient care services (also known as clinical pharmacists in many settings) are specially trained to monitor medication therapy with the goals of achieving desired therapeutic outcomes and reducing adverse health events.⁶ With regard to immunization, national medical specialty societies including the American Academy of Family Physicians and American College of Physicians have similarly recognized the valuable role of pharmacists in immunization practice in the United States (US), preferably in the PCMH model of care.⁷ It is reasonable to conclude that pharmacists are essential members of physician-led teams including the PCMH, with a potential role in increasing immunization rates in this country.

PHARMACIST IMMUNIZATION EDUCATIONAL REQUIREMENTS

The increased complexity of pharmaceutical applications is at least partially reflected in the pharmacy profession's decision to upgrade its educational standards. Until July 1, 2000, an individual who wished to become a pharmacist could enroll in a program of study that would lead to either a Bachelor of Science or a Doctor of Pharmacy (PharmD) degree. As of July 1, 2000, the PharmD is the only degree accredited by the American Council for Pharmaceutical Education. PharmD programs take six years to complete and typically involve two years of pre-professional coursework and four years of professional education. In addition, after graduating from pharmacy school, a new PharmD graduate may seek optional advanced training in pharmacy. Further, any pharmacist who wishes to immunize must undergo additional training and certification in immunization delivery. The majority of immunizing pharmacists in the US—approximately two-thirds—have gained certification to do so through completion of a 20-hour certificate course sponsored by the American Pharmacists Association (APhA).⁸

State law also varies regarding the educational requirements pharmacists must meet in order to be allowed to immunize. These laws are largely governed by state legislatures, but can also be the purview of state boards of medicine and pharmacy. Medicine has a clear interest in ensuring that state laws on the qualifications of those who administer vaccines are sufficient to protect the health and safety of patients. Therefore, the AMA believes that a state's educational requirements of pharmacists who administer vaccinations should be developed from input by both the state boards of medicine and pharmacy.

pharmacist administration of immunizations

According to the Centers for Disease Control and Prevention (CDC) Approved Immunization Schedule for Adults, most, but not all, states allow pharmacists to administer immunizations licensed by the US Food and Drug Administration that are recommended by the CDC Advisory Committee on Immunization Practices. However, some states set limitations on pharmacist-administered immunizations based on age. For example:

- 13 states place no age limitation on pharmacist administration of immunizations or are silent on the matter.
- 14 states allow pharmacists to administer immunizations only to those patients who are over the age of 18 or an adult.
- 23 states and the District of Columbia (DC) allow pharmacists to administer immunizations to patients under the age of 18. Specifically:
 - Three states allow pharmacists to administer immunizations to patients over 14 years of age.
 - One state allows pharmacists to administer immunizations to patients over 13 years of age.
 - Three states and DC allow pharmacists to administer immunizations to patients over 12 years of age.
 - Two states allow pharmacists to administer immunizations to patients over 11 years of age.
 - Two states allow pharmacists to administer immunizations to patients over 10 years of age.
 - Four states allow pharmacists to administer immunizations to patients over nine years of age.
 - Four states allow pharmacists to administer immunizations to patients over seven years of age.
 - Three states allow pharmacists to administer immunizations to patients over six years of age.
 - One state allows pharmacists to administer immunizations to patients over five years of age.

In addition, five states either reduce the required patient age or expand the types of authorized vaccines during public health states of emergency.

The types of immunizations that pharmacists are authorized to administer varies from state to state. For example:

- All 50 states and DC authorize pharmacists to administer the Influenza immunization.
- 46 states and DC authorize pharmacists to administer the Pneumococcal immunization.

- 44 states and DC authorize pharmacists to administer the Zoster immunization.
- 39 states and DC authorize pharmacists to administer the Td/Tdap immunization.
- 25 states and DC authorize pharmacists to administer any/all immunizations or immunizations as recommended by the CDC's Immunization Schedule for adults and/or children.

Most states require a prescription, protocol, standing order, consent of parent or guardian, or a combination of these factors prior to a pharmacist being authorized to administer immunizations.

States can also impose these requirements in conjunction with age and/or authorized type of immunization restrictions. For example:

- 31 states and D.C. require that a physician protocol be in place prior to pharmacist administration of immunizations.
- 18 states and D.C. require a prescription prior to pharmacist administration of immunizations.
- 13 states and D.C. require a standing order or physician authorization prior to pharmacist administration of immunizations.
- 7 states and D.C. require additional consent from a parent or legal guardian before a pharmacist may administer any immunization to a minor under 18 years of age.

The AMA state Advocacy Resource Center (ARC) maintains 50-state surveys that provide detailed information on the state laws and regulations that govern pharmacist immunization practice. These surveys are on file with the AMA ARC and are available upon request by contacting arc@ama-assn.org.

Taken together, state law on pharmacist administration of immunizations is instructive. The AMA, therefore, believes that pharmacist administration of immunizations is only proper when any of the following criteria are satisfied:

- The pharmacist has an order or prescription from a physician licensed to practice medicine in the state where the immunization is to be administered;
- The pharmacist has a protocol or collaborative agreement with a physician licensed to practice in the state where the immunization is to be administered; or
- The state where the immunization is to be administered has designated a state of emergency which necessitates the rapid immunization of the population in order to respond to the public health state of emergency, during which administration by pharmacists should be limited to the specific vaccine required to respond to the emergency, for the duration of the emergency declaration.

Accordingly, the AMA will oppose any state or federal legislation that allows pharmacists to administer immunizations without any of the above criteria, and will work with interested state and national medical specialty associations to ensure pharmacist immunization laws are consistent with the above criteria. The AMA will also continue to foster our collaboration with the APhA on areas in which physicians and pharmacists can work together in the interest of patient access to high-quality medical care.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 212-I-12 and that the remainder of the report be filed.

The Board recommends that AMA policy be that:

1. Pharmacists are essential members of physician-led teams, including the patient-centered medical home, with a potential role in increasing immunization rates in this country.
2. Pharmacist administration of immunizations is only proper when any of the following criteria are satisfied: (a) the pharmacist has an order or prescription from a physician licensed to practice medicine in the state where the immunization is to be administered; (b) the pharmacist has a protocol or collaborative agreement with a physician licensed to practice in the state where the immunization is to be administered; or (c) the state where the immunization is to be administered has designated a state of emergency which necessitates the rapid

immunization of the population in order to respond to the public health state of emergency, during which administration by pharmacists should be limited to the specific vaccine required to respond to the emergency, for the duration of the emergency declaration. The American Medical Association opposes any state or federal law that allows pharmacists to administer immunizations without any of the above requirements, and will work with interested state and national specialty medical associations to ensure pharmacist immunization laws are consistent with the above criteria. These criteria do not apply to administration of the influenza vaccine, if authorized by state law.

3. A state's educational requirements for pharmacists who administer immunizations should be developed from input by both the state boards of medicine and pharmacy.

REFERENCES

- ¹ Giberson S, Yoder S, Lee MP. Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. A Report to the US Surgeon General. Office of the Chief Pharmacist. US Public Health Service. Dec 2011.
- ² Bunting BA, Smith BH, et al. The Asheville Project: clinical and economic outcomes of a community-based long-term medication therapy management program for hypertension and dyslipidemia. Carter BL, Bergus GR, et al. A cluster randomized trial to evaluate physician/pharmacist collaboration to improve blood pressure control. *J Am Pharm Assoc.* 2008;48(1):23-31. Greenwich. *J Clin Hypertens.* 2008;10(4):260-71. Bluml BM, McKenney JM, et al. Pharmaceutical care services and results in project ImPACT: hyperlipidemia. *J Am Pharm Assoc.* 2000;40(2):157-65. Hawksworth GM, Corlett AJ, et al. Clinical pharmacy interventions by community pharmacists during the dispensing process. *Br J Clin Pharmacol.* 1999;47(6):695-700.
- ³ Chisholm-Burns MA, Lee JK, Spivey CA, et al. US Pharmacists' Effect as Team Members on Patient Care. *Med Care.* 2010;48: 923-933.
- ⁴ *Id.*
- ⁵ Kohn LT, Institute of Medicine. Academic Health Centers: Leading Change in the 21st Century. Washington, DC: National Academy Press; 2003.
- ⁶ Chisholm-Burns 2010.
- ⁷ "[T]he AAFP recommends that vaccine administration be provided in the medical home setting. When vaccines are administered elsewhere, the information should be transmitted back to the patient's primary care physician and their state registry when one exists so that there is a complete vaccination record." American Association of Family Physicians. Pharmacists (policy statement). (2002) (December 2011 Board) Available at www.aafp.org/about/policies/all/pharmacists.html. "Because of the extensive state legislation that already exists, allowing pharmacists and nurses to administer immunizations, the potential benefit of nonphysician immunization of patients is widely recognized. Pharmacists provide increased access to immunization through extended business hours and locations. Increased access to immunization by trained pharmacy professionals will help to decrease antibiotic resistance and increase adult immunization. Pharmacists and physicians should focus on delivering vaccines to those populations most at risk, in an attempt to decrease mortality rates from preventable diseases." American College of Physicians. Pharmacist Scope of Practice. *Ann Intern Med.* 2002;136(1):79-85.
- ⁸ The most common immunization delivery course is a certificate program created by APhA for pharmacists who wish to incorporate immunization into their practice. The APhA course, "Pharmacy-based immunization delivery," requires 12 hours of self-study, 8 hours of seminar and demonstration, and hands-on experience in intramuscular and subcutaneous vaccination techniques. In addition, participants must pass an exam, and obtain certification in cardiopulmonary resuscitation (CPR). The APhA reports that the certificate program has been recognized by the Centers for Disease Control (CDC) for its quality and content. The training framework encompasses guidelines for pharmacy-based immunizations adopted by the APhA (and reviewed against other professions' guidelines to meet or exceed existing guidelines), CDC recommendations, and guidelines adopted by other healthcare and government organizations. As of December 2012, more than 200,000 pharmacists have been trained through the program. APhA Pharmacy-Based Immunization Delivery Program Overview.

2. NON-PHYSICIAN PRACTITIONERS CERTIFYING MEDICARE PATIENTS' NEED FOR THERAPEUTIC SHOES AND INSERTS (RESOLUTION 213-I-12)

Reference committee hearing: see report of [Reference Committee B](#).

HOUSE ACTION: REFERRED FOR REPORT AT A-14

At the American Medical Association (AMA) 2012 Interim Meeting, the House of Delegates (HOD) referred Resolution 213, "Non-Physician Practitioners Certifying Medicare Patients' Need for Therapeutic Shoes and Inserts," and requested a report back at the 2013 Interim Meeting. In Resolution 213, the Idaho Delegation asked:

That our American Medical Association (AMA) support authorization of physician assistants and nurse practitioners under the supervision of an MD or DO to certify Medicare beneficiaries' need for therapeutic shoes and/or inserts; and

That our AMA advocate for the authorization of physician assistants and nurse practitioners under the supervision of an MD or DO to certify Medicare beneficiaries' need for therapeutic shoes and/or inserts to the Centers for Medicare and Medicaid Services and, if federal law must be amended, advocate to Congress.

The reference committee heard overwhelming testimony about the unintended consequences related to the recommendations of Resolution 213, and expressed its concern that, as worded, the recommendations of Resolution 213 could be interpreted to mean more than intended.

Consequently, the reference committee recommended referral of Resolution 213 for study and provision of possible guidance related to such terms as "supervision," "under the direction of," and "in collaboration with," in the context of current state statutes affecting the practice of medicine. The reference committee recommended that our AMA seek the assistance of the relevant councils and interested members of our AMA Scope of Practice Partnership in undertaking this study. A task force composed of representatives from the Board of Trustees, Council on Legislation, Council on Medical Service, Council on Medical Education, and Integrated Physician Practice Section was subsequently convened to accomplish this purpose. (See Appendix A.) In recommending referral, the reference committee also suggested that our AMA look at existing state-level policies and statutory language that have created unintended burdens and increased administrative hassles for physicians and whether organized medicine could address these issues without implicating scope of practice-related consequences.

DISCUSSION OF DEFINITIONS

The AMA defines "team-based health care" as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.¹ However, our AMA has yet to define what we mean by the terms including "physician-led," "supervision," and "collaboration."

Physician Leadership of Health Care Teams

The importance of effective teamwork in health care has long been recognized. More than 100 years ago, Mayo Clinic Founder William J. Mayo, MD wrote that,

The sum total of medical knowledge is now so great and wide-spreading that it would be futile for any one man... to assume that he has even a working knowledge of any part of the whole... It has become necessary to develop medicine as a cooperative science; the clinician, the specialist, and the laboratory workers uniting for the good of the patient, each assisting in elucidation of the problem at hand, and each dependent upon the other for support.²

As noted extensively in AMA communications and advocacy initiatives, the AMA strongly supports physician-led, team-based care as the optimal model of health care delivery. The unwavering principle that clinical care teams ought to be physician-led helps guide the activities of AMA units across the organization, as well as AMA initiatives such as the Scope of Practice Partnership (SOPP). This stance is also evidence-based, since research shows that the use of teams (particularly physician-led teams) has great potential to improve quality and reduce costs. In primary care, improved teamwork holds the promise of alleviating patient access to health care challenges caused by the shortage of primary care physicians.³

Yet, the definition of what comprises a "physician-led" team has not been clearly articulated. Physician-led teams can take many shapes and forms.⁴ For example, at the Mayo Clinic, integrated, multidisciplinary teamwork takes place under the structure of physician-led governance.⁵ The organization is physician-led at all levels and operates through physician committees and a shared governance philosophy in which physician leaders work with administrative partners in a horizontal, consensus driven structure. Physicians serve in rotating assignments on committees and in leadership roles to promote broad participation and development of the workforce. A board of

governors comprised of primarily physician leaders provides high-level governance under the oversight of the Mayo Board of Trustees.

This physician-led governance also supports interdependent, multidisciplinary teamwork within subsets of the overall organization, such as in Mayo's diabetes care teams. These teams are led by an endocrinologist who depends on the expertise of primary care physicians, nurses, and diabetes educators who, together with patients, develop, share, and implement plans to achieve patient goals of care.⁶ These teams rely on team members taking on some non-traditional roles, such as nurses, who conduct outreach and pre-visit planning, and receptionists, who act as diabetes registry coordinators.⁷ The teams are also supported by a primary care council of physicians including internists, family physicians, pediatricians, and urgent care physicians, who identify and share best practices, and design care models.⁸ Mayo's use of physician-led teams in this way, with emphasis on each team member's unique capabilities, has led to improved diabetes care and metabolic outcomes.⁹ Similarly, organizations including Virginia Mason,¹⁰ Kaiser Permanente,¹¹ and Intermountain Medical Group¹² are built upon the use of physician-led teams that challenge each member of the team to achieve their fullest potential, all in the interest of quality, affordable, patient-centered care.

Physician-led teams recognize that healthcare is dynamic, and they must organize the responsibilities of each team member to align with the patient's best interests. With shared goals and clear roles, various members of the team can take lead responsibility for specific tasks or domains of care commensurate with their skill, training, education, and demonstrated competency. While certain tasks must be directly led by physicians to ensure patient care and safety, other tasks are more appropriately led by non-physician health care professionals. This is a reflection of the nuanced nature of "leadership" within teams carrying out complex or innovative work, in which hierarchies tend to flatten and there is room for (and an expectation of) some degree of leadership from all members of the team.¹³

El Rio Community Health Center in Tucson, Arizona is instructive in this regard. At El Rio, the clinical pharmacist serves as a primary care resource for patients with diabetes and comorbid conditions, such as hypertension and hyperlipidemia, requiring complex medication management.¹⁴ This occurs through a medical staff-approved collaborative practice agreement. Pursuant to this collaborative practice agreement, and with physician oversight, the pharmacist provides appropriate diagnostic, educational, and therapeutic management services, including prescribing medications and ordering laboratory tests, based on national standards of care for diabetes. This physician-led arrangement is focused on patient needs while maximizing the use of all the clinic's health professionals.

Similarly, at Duke Heart Center, a new "parallel model" leverages interprofessional teams by using health professionals working at the "top of their competency and licensure."¹⁵ Physicians develop plans of care for new patients, nurse practitioners (NPs) and physician assistants (PAs) see returning or acutely ill patients, and registered nurses (RNs) coordinate follow-up care, schedule procedures, and respond to triage calls. Team members consult each other as necessary and appropriate. Duke Heart Center represents yet another physician-led team that utilizes all of its members to increase access to care and improve patient satisfaction.

The AMA believes that all members of a physician-led health care team should be enabled to perform medical interventions that they are capable of performing according to their education, training, licensure, and experience to most effectively provide quality patient care.¹⁶ Similarly, the AMA recognizes that physicians working in high-functioning health care teams are both more reliant on others and more empowered to spend their time focused on carrying out the medical tasks that they are best trained to perform.¹⁷ To this end, it may be entirely appropriate for PAs and NPs in physician-led teams to certify Medicare beneficiaries' need for therapeutic shoes and/or inserts. As described thus far, the decision to allow PAs and NPs to perform this task is up to the physician's discretion, taking into consideration the PA and NPs skill, education, training, and demonstrated competency. In short, working in high-functioning health care teams helps physicians be physicians.

Leadership on teams of highly-skilled health professionals doing complex or innovative work does not require physician leaders to have all the right answers for every task the team needs to accomplish; rather, it requires physicians to ask the right questions, invite participation, communicate clearly, promote a culture of respect, reward excellence, and ensure accountability, among other important leadership skills.

With these concepts in mind, your Board proposes that our AMA define "physician-led," in the context of team health care, as:

The consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of contributions needed to help each patient achieve their care goals.

Supervision

Generally, there are three levels of “supervision” used by the Centers for Medicare & Medicaid Services (CMS) for professional services provided by non-physician or “auxiliary” personnel under physician supervision. The Code of Federal Regulations similarly uses three levels of “supervision” for inpatient and outpatient diagnostic services. These three levels of supervision are general, direct, and personal, and are defined as follows:¹⁸

1. General supervision means the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.
2. Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
3. Personal supervision means a physician must be in attendance in the room during the performance of the procedure.

CMS notes that in highly organized clinics, physician supervision may be the responsibility of several physicians as opposed to an individual attending physician.¹⁹ In this situation, for example, the physician ordering a particular service need not be the physician who is supervising the service. Services performed by auxiliary personnel and other aides are covered even though they are performed in another department of the clinic.

Your Board finds these federal definitions to be fitting, as well as an accurate description of the working relationships in clinical practice. However, it is worth noting that these definitions are focused on supervision of procedures, while team-based care is often also used for the delivery of evaluation and management services. Further, while ongoing training may be the responsibility of the supervising physician, initial training may not be. As such, your Board recommends that these definitions of supervision be adopted as AMA policy, with modification to reflect supervision of delivery of evaluation and management services and physicians’ obligations in training those under their direct supervision.

Collaboration

Collaboration in the context of health care is a term subject to a variety of definitions and interpretations. For example physicians and pharmacists each bring important expertise to collaborative drug therapy management. Physician leadership (as defined above) is an inherent part of the relationship between physician and pharmacist. Similarly, orthopaedic surgeons regularly collaborate with physical therapists and occupational therapists, and so on.

When discussing NP practice, collaboration is often used in terms of a collaborative practice agreement, whereby a physician and an NP describe the working relationship of the NP and the collaborating physician and authorize the categories of care, treatment, or procedures the NP may perform. Virginia’s groundbreaking 2012 law governing physician-led health care teams defines collaboration as follows:

Collaboration is the communication and decision-making processes among members of the patient care team related to the treatment and care of a patient, including: (i) communication of data and information about the treatment and care of a patient, including clinical observations and assessments, and (ii) development of an appropriate plan of care, including decisions regarding the health care provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies.²⁰

Still other states define collaboration loosely to describe a general working relationship with a physician and NP. For example, Pennsylvania defines collaboration as “a process in which an NP works with one or more physicians to deliver health care within the scope of the NP’s expertise.”²¹ Similarly, Wisconsin defines a collaborative

relationship as a process in which an NP works with a physician, in each other's presence when necessary, to deliver health care services within the scope of the NP's expertise.²²

The AMA believes that at the foundation of effective collaboration is mutual trust in the skills, knowledge, and capability of other team members who accept responsibility for specific tasks. While a certain level of trust might be assumed based on standard training or other markers of competency (status trust), the deep level of trust (interpersonal trust) that is necessary for strong collaborative relations and effective team-based health care often must develop over time. This is especially true where legal accountability is assumed by the physician for actions taken by another member of the team. Accordingly, systems must allow for teams to build trusting relationships, rather than assuming the existence of mutual trust based on criteria such as job categories. The exercise of judgment regarding the capabilities of each team member is an essential component of collaboration.

Your Board thus proposes that our AMA define "collaboration," in the context of team-based health care, as:

The communication and decision-making processes and actions carried out over time by and among members of the team related to the treatment and care of patients, including: (i) formal, often structured and multi-directional, communication and information about the treatment and care of patients, including clinical observations and assessments; (ii) development of appropriate plans of care, including decisions regarding the health care to be provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies; and (iii) coordinating the actions and responsibilities necessary to carry out these plans effectively, taking into account the proven skills, knowledge, and capabilities of each member of the health care team.

UNINTENDED BURDENS CREATED BY STATE-LEVEL POLICY AND STATUTES

The AMA has dedicated one of the organization's three strategic focus areas to helping physicians ensure sustainable practices that lead to improved health outcomes for patients and greater professional satisfaction for physicians. Research is underway to identify payment and delivery models that promote physician satisfaction and sustainability in a variety of practice settings. The results of this research will inform future AMA policy and help physicians successfully navigate the evolving health care environment while maintaining their clinical autonomy. In addition, the results of this research will inform AMA advocacy on state laws and regulations that have created unintended burdens and increased administrative hassles for physicians. In the interim, the AMA will continue to work with any state medical association or national medical specialty society interested in advocating for changes to state and federal laws and regulations to ease administrative burdens on physicians.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 213-I-12 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) officially adopt the following definition of "physician-led," in the context of team-based health care: The consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of contributions needed to help each patient achieve their care goals.
2. That our AMA officially adopt the following definition of "supervision," in the context of team-based health care: (i) General supervision means the health care is furnished under the physician's overall direction and control, but the physician's presence is not required during the delivery of care. Under general supervision, the ongoing training of the non-physician personnel who perform the health care and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician. (ii) Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the delivery of care. It does not mean that the physician must be present in the room when the care is being delivered. (iii) Personal supervision means a physician must be in attendance in the room during the delivery of care.
3. That our AMA officially adopt the following definition of "collaboration," in the context of team-based health care: A set of communication and decision-making processes and actions carried out over time by and among

members of a team related to the treatment and care of patients, including: (i) formal, often structured and multi-directional, communication of information about the treatment and care of patients, including clinical observations and assessments; (ii) development of appropriate plans of care, including decisions regarding the health care to be provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies; and (iii) coordinating the actions and responsibilities necessary to carry out these plans effectively, taking into account the proven skills, knowledge, and capabilities of each member of the health care team.

APPENDIX - Task Force Members

Board of Trustees
Joseph Annis, MD

Council on Medical Education
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Council on Legislation
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REFERENCES

- ¹ AMA Policy H-160.912, The Structure and Function of Interprofessional Health Care Teams.
- ² Mayo Clinic. Tradition and heritage: The needs of the patient come first. Available at www.mayoclinic.org/tradition-heritage/best-interest-patient.html.
- ³ Green LV, Savin S, Lu Y. Primary care physician shortages could be eliminated through use of teams, nonphysicians, and electronic communication. *Health Aff.* 2013;32(1):11-19. American Academy of Pediatrics. Scope of practice issues in the delivery of pediatric health care. *Pediatrics.* 2013;131(6):1211-16. Altschuler J, Margolius D, Bodenheimer T, et al. Estimating a reasonable patient panel size for primary care physicians with team-based task delegation. *Ann Fam Med.* 2012;10(5):396-400. American Academy of Family Physicians. Primary care for the 21st century: Ensuring a quality, physician-led team for every patient. September 18, 2012. Potta B, Adams R, Spadin M. Sustaining primary care practice: A model to calculate disease burden and adjust panel size. *The Permanente Journal.* 2011;15(1):53-56. James BC, Savitz LA. How Intermountain trimmed health care costs through robust quality improvement efforts. *Health Aff.* 2011;30(6):1-7. Commonwealth Fund. Mayo Clinic: Multidisciplinary teamwork, physician-led governance, and patient-centered culture drive world-class health care. 2009.1306(27):1-17. Commonwealth Fund. Geisinger Health System: Achieving the potential of system integration through innovation, leadership, measurement, and incentives. 2009;1233(9):1-13. Commonwealth Fund. Hill Physicians Medical Group: Independent physicians working to improve quality and reduce costs. 2009;1247(11):1-15.
- ⁴ The AMA Council on Medical Service will submit for consideration a report at the 2014 Annual Meeting of the House of Delegates on acceptable models of health care teams that value the expertise of the physician and models that could be used by medical teams that address specific issues such as patient safety, the nature of physician authority within the teams and the ethical and legal issues of the team model.
- ⁵ When there is a tie vote, the physician perspective wins out. Commonwealth Fund. Mayo Clinic: Multidisciplinary teamwork, physician-led governance, and patient-centered culture drive world-class health care. 2009.1306(27):1-17.
- ⁶ *Id.*
- ⁷ *Id.*
- ⁸ *Id.*
- ⁹ *Id.*
- ¹⁰ Kenney C. Transforming Health Care: Virginia Mason Medical Center's Pursuit of the Perfect Patient Experience. CRC Press. 2011.
- ¹¹ Kaiser Permanente's Northern California region improves care and outcomes for patients with chronic disease by emphasizing a proactive team approach that conserves physician time for face-to-face encounters by enhancing the contributions of medical assistants, nurses and pharmacists to conduct outreach to patients between visits. Care managers such as nurses, clinical social workers, or pharmacists support the primary care team to help patients gain control of their chronic condition. Commonwealth Fund. Kaiser Permanente: Bridging the quality divide. 2009;1278(17):1-27.
- ¹² Intermountain Medical Group similarly utilizes a range of healthcare professionals in its "Personalized Primary Care" teams. A physician leads each team of caregivers, which include a health advocate to review patient charts, answer questions and connect patients with resources; care managers who help patients manage their health needs; and clinical and office staff including medical assistants, lab and imaging staff, nurse practitioners and physician assistants, who schedule appointments, gather information for patient visits, draw labs, take imaging studies, work with insurance providers, and organize patient records. Intermountain Health Group. Personalized Primary Care. Available at <http://intermountainhealthcare.org/services/medicalgroup/personalized-primary-care/Pages/home.aspx>.

- ¹³ Heifetz RA. Leadership Without Easy Answers. Harvard University Press; 1994; Cambridge MA.
- ¹⁴ Mitchell P, Wynia M, Golden R, et al. *Core principles & values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washington, DC. 2012. www.iom.edu/tbc.
- ¹⁵ Robert Wood Johnson Foundation. Improving Patient Access to High-Quality Care: How to Fully Utilize the Skills, Knowledge, and Experience of Advanced Practice Registered Nurses. June 2013.
- ¹⁶ AMA Policy H-160.912 The Structure and Function of Interprofessional Health Care Teams.
- ¹⁷ *Id.*
- ¹⁸ 42 CFR 410.32(b)(3).
- ¹⁹ Medicare Benefit Policy Manual. Revised May 2013. www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf.
- ²⁰ Code of Virginia 54.1-2957.
- ²¹ P.A.C. § 21.282a.
- ²² Wisconsin Admin. Code N 8.10.

3. A MORE UNIFORM APPROACH TO ASSESSING PATIENTS FOR CONTROLLED SUBSTANCES FOR PAIN RELIEF (RESOLUTION 208-I-12)

Reference committee hearing: see report of [Reference Committee K](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 208-I-12 AND
REMAINDER OF REPORT FILED
*See Policies [H-120.960](#) and [D-120.947](#)***

Resolution 208-I-12 introduced by the American Academy of Pain Medicine and referred by the House of Delegates asked:

That our American Medical Association (AMA) seek a more uniform approach to assessing patients for controlled substances for pain relief, and

That our AMA work with federal and state entities to afford safe harbors to physicians who follow these steps in the event the patient has an adverse effect or outcomes from opioid therapy or the patient is discovered to be diverting the substances.

This report reviews recent trends in patient harms attributed to prescription opioid analgesics, briefly addresses the issue of opioid associated overdoses and deaths, and reviews relevant AMA policy. Some basic principles of pain management and the proper positioning of opioid therapy are also noted, along with several important responses and/or ongoing initiatives that have emerged in an attempt to better address the public health consequences of prescription opioid analgesic diversion and misuse. Taken together, these considerations create an imperative for the physician community to offer appropriate pain management, assist in minimizing the diversion of prescribed opioid analgesics, and better address current patterns of substance misuse.

THE INTERSECTION OF PAIN, OPIOID ANALGESICS, AND SUBSTANCE MISUSE

Pain is one of the most common reasons for patients to seek medical attention in the US. According to the 2011 Institute of Medicine Report-Relieving Pain In America, more than 100 million Americans are burdened with chronic pain. For the millions of Americans who experience persistent pain, the impact on function and quality of life can be profound. Pain is associated with high utilization of health care. The healthcare costs related to treatment are compounded by an estimated \$61 billion annually in lost productivity in patients with persistent pain; the overall economic cost associated with chronic pain most likely exceeds \$560 billion annually.

Opioid analgesics are commonly prescribed for acute pain and pain associated with advanced illness. However, the use of these drugs to help manage persistent noncancer pain has increased substantially. Over the last decade, prescriptions for opioid analgesics have increased three-fold with attendant increases in emergency department (ED) visits related to opioid-associated toxicity, unintentional overdoses and deaths, and in the number of patients seeking treatment for the primary abuse of prescription opioids.

Drug overdose deaths in the United States have increased steadily and now exceed 38,000 annually. Prescription drugs are involved in more than 57% of such deaths (~22,000). Opioids were associated with 75% of the prescription drug overdose deaths reported in 2010, or about 43% of drug overdose deaths overall. Among patients on chronic opioid therapy, the relative risk of an overdose increases with the average daily dose and use of multiple prescribers. Demographic variables (e.g., Caucasian, male sex, age 30-54, state and residence in a non-metro county, lower income) and personal characteristics (e.g., history of substance misuse or addiction, mental health disorder) also are markers for overdose risk. Although more men die from opioid overdoses than women, the percentage increase in deaths since 1999 is greater among women.

The trends in prescription opioid-related poisonings and deaths have been a primary driver in policy-related, regulatory, and legislative initiatives that have emerged to address prescription drug abuse and diversion and have prompted additional scrutiny of physician prescribing practices. While it is indisputable that prescription opioid analgesics are the primary cause of death in some of these patients, the methods used to ascribe harm attributable to opioid analgesics, particularly as a cause of death, vary from state to state. A standard approach to documentation and assessment of unintentional poisonings and deaths is needed, including more complete information on other contributing factors in such individuals who are exposed to prescription opioid analgesics, in order to develop the most appropriate solutions.

CURRENT AMA POLICY ON PAIN MANAGEMENT AND OPIOID PRESCRIBING

Multiple AMA policies encourage training across the continuum of medical education and availability of resources that: (1) promote appropriate pain management and prescribing practices; (2) help physicians recognize substance use disorders and promote their treatment; (3) address the diversion of controlled substances; and (4) encourage educating patients and the public on the risk and benefits of treatment with controlled substances, including the need for safe storage and disposal practices (Policies H-95.990, H-95.945, H-120.960, D-95.981, D-120.976, D-120.983).

Existing policy directs our AMA to collaborate with relevant medical specialty societies to develop continuing medical education (CME) programs aimed at reducing substance misuse and addiction; medical specialty societies themselves are encouraged to develop practice guidelines and performance measures that would improve the safe use of controlled substances (Policy D-95.981). States are encouraged to examine their pain policies with the intent of curtailing prescription drug abuse while promoting appropriate prescribing practices (Policy H-95.990). As part of this approach, states should establish prescription drug monitoring programs (PDMP), and encourage cooperative ventures among law enforcement, regulatory agencies, pharmacists and other professional groups to identify “pill mill” type activities (Policy H-95.990). Likewise, physicians are encouraged to query their state PDMP (Policy H-95.990). Existing policy also directs our AMA to “coordinate its initiatives with those of state medical associations and national medical specialty societies” with respect to pain management guidelines, and to develop a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice (Policy H-120.960). The AMA also supports research on identifying sources of diverted prescription controlled substances so that solutions can be crafted to address this problem (Policy D-95.981).

With respect to safe harbors, AMA policy supports the view that physicians who appropriately prescribe and/or administer controlled substances to relieve persistent pain should not be subject to excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution (Policy H-120.960). State medical societies and boards of medicine should develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve persistent pain before seeking the implementation of legislation to provide that protection (Policy H-120.960). Overall these policies establish a strong AMA commitment to patient safety and access to quality pain care through the promotion of enhanced education, informed clinical practice, and research.

PAIN MANAGEMENT STRATEGIES AND POSITIONING OF OPIOID THERAPY

Many potential therapeutic strategies for pain management exist including pharmacological, rehabilitative, psychological, neurostimulatory, interventional, surgical, and complementary and alternative approaches. These strategies can be incorporated into a multidisciplinary approach that is informed by appropriate and realistic goals for the patient. As more attention has been devoted to pain management and the use of opioid analgesics for persistent pain, a set of common standards based on a “universal precautions” approach has begun to emerge for patient selection, pain assessment, and treatment goals involving various functional domains. This approach

incorporates a risk assessment for substance use disorders and potential nonadherence, and the development of a patient-centered treatment plan with ongoing assessment, documentation of key outcomes, and a structure of care, including compliance monitoring, that is commensurate with perceived risks.

Long term controlled trials on the efficacy of opioids in persistent pain have not been accomplished and would be very difficult to do. The most reasonable conclusion from observational data (case series or open label extension studies) is that opioids can be efficacious for a period of several months in varied types of persistent pain; the available information about longer term treatment suggests only that benefit can be maintained in an ill-defined subgroup. Epidemiological evaluations based on administrative and clinical data derived from large population-based studies have tended to not support efficacy or functional improvement from chronic opioid therapy. These types of studies have indicated that opioid usage is significantly associated with the reporting of severe pain, poor self-rated health and quality of life, inactivity during leisure, unemployment, and higher health care utilization. Many patients who are started on opioids discontinue either because of adverse effects or inadequate pain relief, but a proportion who receive an opioid for several months may be continued on therapy for years.

RESPONSES TO THE PUBLIC HEALTH CONSEQUENCES OF OPIOID MISUSE

The harms attributable to prescription opioid analgesics have triggered numerous professional, regulatory, and legislative responses intended to address diversion, misuse, and addiction. Practice guidelines have been developed, and educational resources on pain management and responsible opioid prescribing have been offered by several national medical specialty societies and pain care organizations. These practice guidelines are usually focused (to a degree) on specific practice needs or settings. Our AMA updated and republished its pain management CME in June 2013. Our AMA also is offering a series of 12 webinars on various topics relevant to the intersection of pain, opioid prescribing and addiction through the Prescriber Clinical Support System for Opioid Therapies, a collaborative effort headed by the American Academy of Addiction Psychiatry funded by a grant from the Substance Abuse and Mental Health Services Administration.

At a national level, the White House Office of National Drug Control Policy authored its own strategic plan for addressing the prescription drug abuse epidemic. The Food and Drug Administration has revised drug labeling for prescription opioids and required a Risk Evaluation and Mitigation strategy for extended release/long-acting opioid products. This strategy is based on voluntary training offered through accredited CME providers, with the programs funded by industry. A Citizens Petition seeking changes to the product labeling that would modify the indication (“severe” pain only), maximal dosage amount, and duration of therapy (90 days) when opioids are prescribed for noncancer pain also has been submitted to the FDA. The Drug Enforcement Administration has cracked down on companies in the drug distribution chain that were supplying pharmacies in Florida and the pharmacies themselves that were dispensing prescription opioids originating from “pill mill” type activities. These enforcement actions have triggered a response among national pharmacy chains to institute policies intended to assure that prescriptions are being written for a “legitimate medical purpose.” The implementation of these policies has caused disrupted workflow in physician offices, led to numerous complaints from physicians and state medical associations, and impeded legitimate patient access.

At the state level, 10 states now require CME in pain management and/or opioid prescribing as a condition for relicensure. A survey conducted by our AMA revealed that 25 states offer opioid-related CME. Topics range from controlled substance management and preventing accidental lethal overdoses of pain medicine to the use of urine testing and state-specific responses to prescription drug abuse. Eight states offer (or have offered recently) seminars, conferences, or other live events on these topics through which physicians also can earn credit. The Federation of State Medical Boards released a revised Model Policy for the Use of Controlled Substances in the Treatment of Pain in July 2013. Virtually all states now have at least the architecture in place for a prescription drug monitoring program. Some states have used a legislative approach in an attempt to harness the activities of “pain clinics,” or create rigid guidelines for opioid prescribing.

Other influential organizations also have turned their attention to pain management and opioid prescribing including the National Conference of Insurance Legislators, the National Safety Council, and the National Governors Association.

SAFE HARBORS

With respect to the concept of “safe harbors,” our AMA has supported legislation providing liability protections for physicians who prescribe naloxone to patients, including extending the safe harbor to third parties (e.g., close family members) in an effort to reduce death from opioid overdose. Support for this type of “Good Samaritan” legislation encourages the provision of naloxone in community settings pursuant to AMA policy. As the guidelines and evidence surrounding appropriate pain treatment continues to evolve, our AMA believes that medical boards are best situated to evaluate the individual, unique circumstances in the event of an allegation of unprofessional conduct. Extending safe harbor protections to the prescribing of opioid analgesics or other controlled substances in this evolving field, therefore, may cause undue conflict with the appropriate role of state medical board oversight and regulation of physicians’ practices. Consequently, a recommendation is offered to reaffirm current AMA policy.

CONCLUSION

A substantial increase in opioid prescribing and disturbing trends in opioid-related harms have triggered a number of responses and activities in a wide variety of professional, private, and public sectors. A large array of educational resources has been developed on this topic. A public health-based approach is needed to improve the practice climate and the management of patients with persistent pain in order to assure their safety and provide appropriate access to controlled substances while minimizing diversion and misuse. A standard approach to documentation and assessment of presumed opioid-related poisonings and deaths also is needed to inform this approach. This effort must go beyond simple demand reduction and mandates. Practical training and guidance for prescribers and the development of coordinated programs and policies that have a public health focus are essential.

RECOMMENDATIONS

The Board of Trustees recommends that the following statements be adopted in lieu of Resolution 208-I-12 and the remainder of the report filed.

1. That our AMA consult with relevant Federation partners and consider developing by consensus a set of best practices to help inform the appropriate clinical use of opioid analgesics, including risk assessment and monitoring for substance use disorders, in the management of persistent pain.
2. That our AMA urge the Centers for Disease Control and Prevention to take the lead in promoting a standard approach to documenting and assessing unintentional poisonings and deaths involving prescription opioids, including obtaining more complete information on other contributing factors in such individuals, in order to develop the most appropriate solutions to prevent these incidents.
3. That Policy H-120.960 be reaffirmed.

4. DESIGNATION OF SPECIALTY SOCIETIES FOR REPRESENTATION IN THE HOUSE OF DELEGATES (BOARD OF TRUSTEES REPORT 11-A-13)

Reference committee hearing: see report of [Reference Committee F](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

See Policy [G-600.023](#)

At the American Medical Association’s (AMA) 2007 Annual Meeting, Policy G-600.135 was adopted, establishing a mechanism by which specialty society representation in the House of Delegates (HOD) would be determined. The mechanism for specialty society delegate allocation is based on a formula that looks at a society’s AMA membership as reported through the five-year review and the number of ballots cast for representation in each specialty (the specialty ballot is available online at www.ama-assn.org/go/ballot). The goal was to have allocation of specialty society delegates entirely based on the number of ballots cast for a society.

At the AMA's 2012 Annual Meeting, BOT Report 11-A-12 presented an update on the ballot process and the following recommendation was adopted as Policy G-600.021[4]:

The Board of Trustees recommends that the current ballot system remain in place while the Speakers, working with the Specialty and Service Society, examine other options for ensuring that each member of the American Medical Association is adequately represented by both a state medical association and national medical specialty society.

BACKGROUND

While it is a straightforward proposition to count the AMA members in a state using data on dues payments or members' addresses, enumerating individual members in specialty societies is considerably more difficult, because common data elements (other than name) in membership files of the AMA and most specialty societies are limited, which makes matching a complicated and time consuming process. In addition, an individual can belong to multiple specialty societies. Thus, when proportional representation for specialty societies was adopted in 1996, AMA members were to select, using a ballot, a specialty society to represent their interests in the HOD.

The number of delegates to which a specialty society is entitled depends on the number of AMA members who have designated that society for representation, but the designation (i.e., balloting) process has never functioned as well as planned; the proportion of AMA members who have designated any specialty society for representation has held steady at around thirty-eight percent (38%).

Specialty society delegates are allocated using an extrapolation process described in BOT Report 17-A-07. The number of designations each specialty society has obtained is adjusted annually based on targeted levels of participation by AMA members. In BOT Report 17-A-07, the Board anticipated that by 2012, at least eighty percent 80% of eligible AMA members would have designated a specialty society for representation (eligible members are those beyond their third year of medical school). Unfortunately, despite every effort to increase the number of ballots cast, the number has not increased. In fact, in 2007 when the report was adopted, approximately forty percent (40%) of members had cast ballots. At the end of 2012, the percentage of ballots was thirty-seven percent (37%).

SPECIALTY DELEGATE ALLOCATION

In BOT Report 11-A-13, it was suggested that the five-year review and delegate allocation processes be tied together to create one process that would streamline the two activities. The five-year review is the process which determines if a society that has been admitted to the HOD continues to meet the requirements for representation in the HOD. One of the requirements is the submission of membership data. These data are used to determine a specialty society's eligibility to be seated in the House; they are not currently used to determine delegate allocation directly.

The process recommended in BOT Report 11-A-13 would have eliminated the ballot and instituted a five-year rollout of a new delegate allocation process. Under the proposed process, each specialty society would be allocated one delegate per 1,000 AMA members or portion thereof, based on the membership numbers of the five-year review. Membership data would have only been submitted every five years in accordance with the five-year review. Delegate allocations would have then remained fixed for the five years until the next five-year review. While there was agreement that the current system is not ideal, the proposed system met with resistance due to some of the elements of the proposal that were not documented in the report. Therefore, the Board revisited the proposal, specifically examining how members of more than one specialty would be counted, what the estimated change in the size of the HOD would be, and the equity of the specialties having a five-year period of stability.

Careful consideration was given to the points raised at A-13 and modifications to the recommendations of BOT Report 11-A-13 have been made to respond to those concerns. This report recommends collecting membership data annually from the specialty societies, so that delegate allocation will accurately reflect each society's current AMA membership.

Allocation of physicians who belong to more than one specialty society continues to be the greatest challenge in determining a new process. A number of options including fractional counting and automatic assignment were considered. However, after examining the numbers and the potential impact of crediting more than one specialty

with the same physician member, it has been determined that the impact is not significant enough to increase any organization's delegation size. The majority of specialty societies (80) have less than 1,001 AMA members needed to receive a second delegate. In fact, fifty-three specialty societies have fewer than 500 members, and only four of the societies that have one delegate currently have more than 900 members.

A second concern was that the size of specialty delegations would remain the same during the period between five-year reviews. A requirement that specialty societies submit membership data to the AMA each year would create a burden on both AMA resources to process the data and the specialty societies to submit the data. The states do not have a requirement to submit data as state allocation is determined by AMA membership data. While, the recommendation of this report is that the specialties submit membership data each year to eliminate the five year stagnation, the data will only be used to determine delegate allocation and not to determine if a society meets the five-year review requirement. That will only happen when the society is scheduled for the five-year review.

To alleviate the data burden on both the AMA and the specialty societies, the AMA will work with the specialty societies on data elements that will make the data match simpler. Including specialty society unique identifier numbers or NPI numbers in the information that is submitted will help with this effort. In addition, societies that do not believe they will go over the 1,000 AMA member mark will not be required to submit data annually after 2014, as their delegate allocation could not exceed one delegate. However, societies with more than one delegate will be required to submit data annually. Any organization that does not submit data annually will only be eligible for one delegate. These organizations will be required to submit data for their scheduled five-year review.

Finally, there was a concern regarding how this change would impact the size of the HOD. If the ballot system and the formula that is currently in place to make up for the lack of ballots cast were to be discontinued and membership trends remain as they are currently, there could be approximately twenty-two new specialty delegates using data from July 2013 (attachment A). This is only an estimate, as real numbers will depend on collecting current membership data from all of the specialty organizations.

RECOMMENDATIONS

In light of the continuing difficulty in securing ballots from members, the Board of Trustees recommends that the following recommendations be adopted and the remainder of the report be filed:

1. That specialty society delegate allocation in the House of Delegates be determined in the same manner as state medical society delegate allocation based on membership numbers allowing one delegate per 1,000 AMA members or fraction thereof.
2. That specialty society membership data be submitted annually by all societies with more than one delegate or societies seeking to obtain an additional delegate or delegates as part of a two-year pilot program with a report back at the 2016 Annual Meeting of our AMA House of Delegates.
3. That the current specialty delegation allocation system (ballot and formula) be continued until the pilot program is completed and the 2016 Annual Meeting report is acted upon by the House of Delegates.
4. That this system be tested with all specialty societies with more than one delegate seated in the House of Delegates.
5. That organizations that would lose or gain one or more a delegates through this pilot delegate allocation system assist our AMA with documenting the impact. However, no actual changes to delegation allocation other than those which occur through the five-year review and balloting system will be implemented until the data are collected and presented for acceptance to our AMA House of Delegates at the 2016 Annual Meeting.
6. That in the future any system of delegate allocation continues to be monitored and evaluated for improvements.

APPENDIX

G-600.135 Specialty Society Delegate Representation in the House of Delegates

1. Our AMA will continue efforts to expand awareness and use of the designation mechanism for specialty society representation, working wherever possible with relevant members of the Federation. 2. The system of apportioning delegates to specialty societies be enhanced by a systematic allocation of delegates to specialty societies by extrapolating from the current process in which members designate a specialty society for representation. The recommended model will: (a) establish annual targets for the overall proportion of AMA members from whom designations should have been received; (b) adjust actual designations by increasing them proportionately to achieve the overall target level of designations; (c) limit the number of delegates a society can acquire to the number that would be obtained if all the society's AMA members designated it for representation; (d) be initiated with delegate allocations for 2008, following the expiration of the freeze, which ends December 31, 2007; and (e) be implemented over five years because this will result in the least disruption to the House of Delegates and allow the process to unfold naturally. 3. The Board of Trustees will prepare annual reports to the House describing efforts undertaken to solicit designations from members, characterizing progress in collecting designations, and recommending changes in strategies that might be required to implement existing policy on representation of specialty societies. In addition, the Board should, in these or other reports: (a) develop a system for use among direct members to solicit their designations of specialty societies for representation, with an eye on how that system might be expanded or adapted for use among other members; and (b) engage in discussions with specialty societies that will lead to enhanced data sharing so that delegate allocations for both state and specialty societies can be handled in parallel fashion. 4. Our AMA will include in the specialty designation system an option to permit those members who wish to opt out of representation by a specialty society to do so when any automatic allocation system is used to provide representation for specialty societies that are represented in the House of Delegates. 5. If any specialty society loses delegates as a result of the apportionment process, the specialty society shall have a one-year grace period commencing January 1, 2008. At the expiration of this one-year grace period, a phase-in period shall be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented. 6. AMA Bylaw 2.11111 grants state societies a one-year grace period following the freeze expiring December 31, 2007 (per Bylaw 2.121). At the end of the grace period, a phase-in period will be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented.

G-600.021 Specialty Society Representation in our AMA House

The number of AMA delegate positions allocated to the specialty societies in our AMA/Federation House will be determined in the following manner: (1) The number of delegates and alternate delegates allocated to a specialty society will be on the basis of one delegate and one alternate delegate for each 1000 AMA members, or portion of 1000 AMA members, who select that a particular specialty society on the annual ballot and return the ballot to our AMA; and (2) Each specialty society that meets the eligibility criteria and is represented in our AMA/Federation House will be assured of at least one delegate and alternate delegate position regardless of the number of AMA members who select the society on the ballot and return the ballot to the AMA. (3) Our AMA will: (a) continue to include the ballot postcard in the Member Welcome Kit; (b) continue to promote the online ballot application to increase specialty society designations; (c) work with all willing specialty societies to solicit additional specialty society designations, using both printed ballots and electronic communications vehicles; and (d) continue to send email ballot solicitations to members who have not yet cast a ballot. (4) The current ballot system will remain in place while the Speakers, working with the Specialty and Service Society, examine other options for ensuring that each member of the American Medical Association is adequately represented by both a state medical association and national medical specialty society.

Attachment A

Specialty Society	Designations 7/23/13	AMA membership*	I-13 Delegates**	Potential future # of delegates	Change
Academy of Physicians in Clinical Research	31	173	1	1	0
Aerospace Medical Association	109	183	1	1	0
American Academy of Allergy, Asthma and Immunology	313	362	1	1	0
American Academy of Child and Adolescent Psychiatry	287	1,144	1	2	+1
American Academy of Cosmetic Surgery	51	186	1	1	0
American Academy of Dermatology	1,622	2,186	4	3	-1
American Academy of Disability Evaluating Physicians	16	239	1	1	0
American Academy of Facial Plastic and Reconstructive Surgery	100	163	1	1	0
American Academy of Family Physicians	7,832	10,452	13	11	-2
American Academy of Hospice and Palliative Medicine	89	608	1	1	0

Specialty Society	Designations 7/23/13	AMA membership*	I-13 Delegates**	Potential future # of delegates	Change
American Academy of Insurance Medicine	91	60	1	1	0
American Academy of Neurology	1,354	2,285	4	3	-1
American Academy of Ophthalmology	1,841	3,306	5	4	-1
American Academy of Orthopaedic Surgeons	1,694	4,147	5	5	0
American Academy of Otolaryngic Allergy Inc.	42	382	1	1	0
American Academy of Otolaryngology-Head and Neck Surgery	1,770	2,448	4	3	-1
American Academy of Pain Medicine	133	453	1	1	0
American Academy of Pediatrics	2,654	6,170	7	7	0
American Academy of Physical Medicine and Rehabilitation	654	1,228	2	2	0
American Academy of Psychiatry and the Law	82	360	1	1	0
American Academy of Sleep Medicine	86	1,068	1	2	+1
American Association for Thoracic Surgery	49	268	1	1	0
American Association of Clinical Endocrinologists	283	841	1	1	0
American Association of Clinical Urologists,	69	799	1	1	0
American Association of Gynecologic Laparoscopists	12	558	1	1	0
American Association of Hand Surgery	12	175	1	1	0
American Association of Hip and Knee Surgeons	21	251	1	1	0
American Association of Neurological Surgeons	641	812	2	1	-1
American Association of Neuromuscular & Electrodiagnostic Medicine	102	995	1	1	0
American Association of Plastic Surgeons	30	164	1	1	0
American Association of Public Health Physicians	98	62	1	1	0
American Clinical Neurophysiology Society	12	156	1	1	0
American College of Allergy, Asthma and Immunology	301	385	1	1	0
American College of Cardiology	1,252	3,923	4	4	0
American College of Chest Physicians	378	2,075	1	3	+2
American College of Emergency Physicians	1,750	2,770	5	3	-2
American College of Gastroenterology	374	1,519	1	2	+1
American College of Legal Medicine	16	205	1	1	0
American College of Medical Genetics	178	253	1	1	0
American College of Medical Quality	36	137	1	1	0
American College of Mohs Surgery	31	212	1	1	0
American College of Nuclear Medicine	36	75	1	1	0
American College of Occupational and Environmental Medicine	367	654	1	1	0
American College of Phlebology	27	243	1	1	0
American College of Physician Executives	166	2,560	1	3	+2
American College of Physicians	4,516	10,909	12	11	-1
American College of Preventive Medicine	215	499	1	1	0
American College of Radiation Oncology	95	253	1	1	0
American College of Radiology	3,483	5,326	6	6	0
American College of Rheumatology	408	960	2	1	-1
American College of Surgeons	2,271	12,838	6	13	+7
American Congress of Obstetricians and Gynecologists	4,547	11,340	12	12	0
American Gastroenterological Association	252	1,499	1	2	+1

Specialty Society	Designations 7/23/13	AMA membership*	I-13 Delegates**	Potential future # of delegates	Change
American Geriatrics Society	186	845	1	1	0
American Institute of Ultrasound in Medicine	12	1,072	1	2	+1
American Medical Directors Association	148	899	1	1	0
American Medical Group Association	40	3,002	1	4	+3
American Orthopaedic Association	104	409	1	1	0
American Orthopaedic Foot and Ankle Society	41	210	1	1	0
American Psychiatric Association	3,237	5,443	7	6	-1
American Roentgen Ray Society	24	2,221	1	3	+2
American Society for Aesthetic Plastic Surgery, Inc.	26	332	1	1	0
American Society for Clinical Pathology	215	1,269	1	2	+1
American Society for Dermatologic Surgery	38	845	1	1	0
American Society for Gastrointestinal Endoscopy	88	1,193	1	2	+1
American Society for Radiation Oncology	183	863	1	1	0
American Society for Reproductive Medicine	91	841	1	1	0
American Society for Surgery of the Hand	157	463	1	1	0
American Society of Abdominal Surgeons	78	183	1	1	0
American Society of Addiction Medicine	177	493	1	1	0
American Society of Anesthesiologists	4,144	6,231	7	7	0
American Society of Bariatric Physicians	19	190	1	1	0
American Society of Cataract and Refractive Surgery	95	1,107	1	2	+1
American Society of Clinical Oncology	529	2,510	2	3	+1
American Society of Colon and Rectal Surgeons	194	217	1	1	0
American Society of Cytopathology	20	314	1	1	0
American Society of Echocardiography	0	1,135	1	2	+1
American Society of General Surgeons	176	450	1	1	0
American Society of Hematology	120	1,037	1	1	0
American Society of Interventional Pain Physicians	36	465	1	1	0
American Society of Maxillofacial Surgeons	69	155	1	1	0
American Society of Neuroimaging	25	123	1	1	0
American Society of Neuroradiology	121	528	1	1	0
American Society of Ophthalmic Plastic and Reconstructive Surgery	79	133	1	1	0
American Society of Plastic Surgeons	463	1,062	2	2	0
American Society of Retina Specialists	50	492	1	1	0
American Thoracic Society	101	1,185	1	2	+1
American Urological Association	1,145	1,175	2	2	0
Association of Military Surgeons of the United States	46	787	1	1	0
Association of University Radiologists	4	174	1	1	0
College of American Pathologists	1,898	1,929	3	2	-1
Congress of Neurological Surgeons	89	912	1	1	0
Contact Lens Association of Ophthalmologists, Inc.	4	25	1	1	0
The Endocrine Society	126	1,244	1	2	+1
Heart Rhythm Society	28	383	1	1	0
Infectious Diseases Society of America	139	890	1	1	0
International College of Surgeons - US Section	31	352	1	1	0
International Society of Hair Restoration Surgery	3	81	1	1	0
International Spine Intervention Society	31	528	1	1	0

Specialty Society	Designations 7/23/13	AMA membership*	I-13 Delegates**	Potential future # of delegates	Change
National Association of Medical Examiners	66	142	1	1	0
North American Spine Society	136	849	1	1	0
Radiological Society of North America	171	2,741	1	3	+2
Renal Physicians Association	251	611	1	1	0
Society for Cardiovascular Angiography and Interventions	8	453	1	1	0
Society for Investigative Dermatology, Inc.	17	263	1	1	0
Society for Vascular Surgery	128	375	1	1	0
Society of American Gastrointestinal Endoscopic Surgeons	34	1,001	1	2	+1
Society of Critical Care Medicine	106	1,417	1	2	+1
Society of Hospital Medicine	55	860	1	1	0
Society of Interventional Radiology	172	622	1	1	0
Society of Laproendoscopic Surgeons	4	1,275	1	2	+1
Society of Medical Consultants to the Armed Forces	22	32	1	1	0
Society of Nuclear Medicine and Molecular Imaging	84	569	1	1	0
Society of Thoracic Surgeons	392	1,063	1	2	+1
The Triological Society	10	131	1	1	0
Undersea and Hyperbaric Medical Society	15	187	1	1	0
United States and Canadian Academy of Pathology, Inc.	82	1,174	1	2	+1
TOTAL	59,262	161,581	211	233	22

*AMA membership data is based on data submitted by the organization for their five-year review, this may not be the actual current membership.

** I-13 delegation allocations were determined using the formula put in place by BOT 17-A-07 and based on year end 2012 numbers. The numbers in this chart are as of July 23, 2013.

Elements of 2013 Specialty Society Apportionment

Total AMA membership	224,503
Number members eligible to designate a specialty society (#eligible) ¹	182,796
Number members who have made a designation (#actual) ²	62,352
Percentage of eligible members who have designated	34.1%
Target percentage of designations (See BOT Report 17-A-07)	80.0%
Allocation factor ((#eligible / #actual) * target%)	2.345
2013 target percentage of designations	80%

Notes:

- 1 Members in or beyond the 4th year of medical school.
- 2 Includes members who have opted out of the designation process.

5. CONFLICT OF INTEREST DISCLOSURE FOR CANDIDATES (RESOLUTION 606-A-13)

Reference committee hearing: see report of [Reference Committee F](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 606-A-13 AND
REMAINDER OF REPORT FILED**
See Policy [G-610.020](#)

BACKGROUND

Resolution 606-A-13, “Conflict of Interest Disclosure for Candidates,” introduced by the Florida Delegation, was referred to the American Medical Association (AMA) Board of Trustees (BOT) for a report back to the House of Delegates (HOD) at I-13. Resolution 606-A-13 asks [1] that the AMA develop a conflict of interest (COI) declaration form to be completed each year by elected officers and those delegates appointed to office or running as candidates, and that the conflict of interest disclosures be available to members for review; and [2] that the AMA ensure that the members of the AMA HOD have access to the conflict of interest declaration forms of all candidates and all elected and appointed individuals.

While Reference Committee F acknowledged that the AMA currently utilizes conflict of interest disclosure statements, the Reference Committee favored referral of Resolution 606-A-13 in order to receive a report back as soon as possible detailing for the HOD what documentation and procedures currently exist, to whom the procedures apply, and to receive information and recommendations regarding access to such documentation.

This report will examine the content of the AMA COI disclosure form, the administrative process for completing and reviewing the COI disclosure form, who completes the COI disclosure form, and why “candidates” are not asked to complete the COI disclosure form in advance of election or appointment.

DISCUSSION

Conflict of Interest Process

The BOT has adopted a comprehensive COI policy (Policy) and an accompanying illustration of the application of the COI policy in various situations (the Principles). Both the Policy and the Principles are accessible on the AMA website at www.ama-assn.org/ama/pub/about-ama/our-people/board-trustees/conflict-interest-policy.page. The Policy extends to members of the BOT, Councils, Committees, and Task Forces. A Disclosure of Affiliations form must be completed annually by persons covered by the Policy. It is the responsibility of the person completing the Disclosure of Affiliations form to update the disclosures as needed to reflect changed circumstances occurring between the annual updates.

Candidates for elected and appointed office are apprised of the Policy and requirement to complete, upon election or appointment, a Disclosure of Affiliations form. Specifically, in January of each year, candidates who have declared their intention to seek election by the HOD are sent a memorandum by the Director, Office of House of Delegates, enclosing the Policy, the Principles, and the Disclosure of Affiliations form. The memorandum asks BOT candidates to review with the Office of General Counsel (OGC) any situation in which [i] an adverse action has been taken against their medical license in any state; [ii] an adverse action has been taken against them by a hospital or managed care company; and [iii] any other event that would be embarrassing to the candidate or the AMA if made public. Candidates are further informed that the OGC conducts a due diligence review to include a Google search by name, a check of the AMA Masterfile to confirm current unrestricted licensure in at least one state, a check of the National Practitioner Data Bank to confirm the absence of any adverse reports within the past five years, and a check of the website of the Office of Inspector General of the Department of Health and Human Services for any exclusions from federal health care programs. Finally, candidates are asked to confirm that they have reviewed the Policy and Principles and, if elected or appointed, will at that time complete a Disclosure of Affiliations form. Candidates are encouraged to contact the OGC if they have any questions about the Disclosure of Affiliations form or the process for completing same.

Candidates for election or appointment to Councils are directed to a nominations website which asks candidates to carefully review the Policy and Principles, asks them to consider the same things asked of BOT candidates, and informs them the OGC will conduct the same due diligence review which is done for BOT candidates. Finally, Council candidates are asked to confirm, by execution of the Council/Committee Nomination form, that they will, if elected/appointed, complete at that time the Disclosure of Affiliations form. Applicants for election or appointment to Councils are directed to the OGC if they have any questions regarding completion of the Disclosure of Affiliations form.

Review of Disclosure of Affiliation Forms

Disclosure of Affiliation forms are distributed in June to be completed immediately following the BOT and Council elections and appointments. Completed BOT Disclosure of Affiliation forms are returned to the Board Office, which then sends copies of the forms to OGC for review. Completed Council Disclosure of Affiliation forms are returned to the Council secretaries for review. Thereafter, the Council secretaries send copies to the OGC for review. The OGC reviews all of the BOT and Council Disclosure of Affiliation forms to determine whether any of the forms identify interests or affiliations which could create a conflict of interest with the member's BOT or Council responsibilities. The OGC prepares an omnibus report of its findings which is presented to the BOT Audit Committee for consideration. The Audit Committee makes its own assessment as to compliance with the Policy and Principles. As part of this process, the Audit Committee may ask individuals to appear and respond to questions. The Audit Committee submits a recommendation to the BOT for final decision. The Audit Committee's review typically occurs at the BOT's September meeting.

Access to Completed Disclosure of Affiliation Forms

Completed BOT Disclosure of Affiliation forms are maintained by the BOT office and are made available for BOT member review. Council secretaries retain completed Disclosure of Affiliation forms, which are available for review by the members of their respective Council. If BOT or Council member interests or affiliations change during the course of the year, the OGC sends the individual a copy of their most recently completed Disclosure of Affiliations form for updating. Updated Disclosure of Affiliation forms are reviewed by OGC, which prepares a memorandum identifying and analyzing the change, and advising whether the changes present a conflict of interest. OGC's reports are presented by the BOT Audit Committee and the full BOT in the same manner as described above for the annual review process.

Advance Completion of Disclosure of Affiliation Forms

Resolution 606-A-13's suggestion of advance completion of Disclosure of Affiliation forms is not a new idea. The AMA does not require advance completion because, in case of elected officers, through both the nomination process and the campaigning process, a broad cross section of the HOD has the opportunity to directly engage with each candidate. This includes an opportunity to review with candidates their acknowledgement of the Policy and need to complete a Disclosure of Affiliations form if elected. A less comprehensive but similar opportunity for vetting occurs through the process by which the BOT Awards and Nominations Committee recommends to the full BOT appointments by the BOT and nominations of Council candidates.

Requiring advance completion of Disclosure of Affiliation forms would not, by itself, be beneficial in the case of elected offices unless existing processes for due diligence review and assessment were also possible. This would be impractical if individuals are nominated on the HOD floor and could result in a perception of unequal treatment of all candidates [in terms of advance review of completed disclosure forms].

An informal survey of medical society counsel, undertaken by the OGC in response to Resolution 606-A-13 indicated that none of the responding societies use a process whereby candidates in an open election complete disclosure forms in advance of election. Importantly, the AMA has not encountered problems with the present approach.

Access to Disclosure of Affiliation forms

Completed Disclosure of Affiliation forms serve to assist peer group members as the peers consider/evaluate each other's comments when discussing matters coming before the peer group for decision. Accordingly, and as

explained above, completed Disclosure of Affiliation forms are currently accessible only to the other members of the peer group. However, nothing about the Policy, or its implementation through completion of Disclosure of Affiliation Forms, is secret. Since some HOD members (or other AMA members) may be interested in reviewing completed forms, accessibility of completed forms could be readily expanded by posting of completed forms on the “Members Only” section of the AMA website. The cost of posting would be minimal.

RECOMMENDATION

The Board of Trustees recommends that the following statements be adopted, in lieu of Resolution 606-A-13, and that the remainder of this report be filed:

1. That our AMA amend its current process for implementation of the Board of Trustees Conflicts of Interest Policy to require completion of Disclosure of Affiliation forms by all candidates for election to our AMA Board of Trustees and Councils prior to their election.
2. That our AMA expand accessibility to completed Disclosure of Affiliation information by posting such information on the “Members Only” section of the AMA website before election by the House of Delegates.

6. REDEFINING THE AMA’S POSITION ON ACA AND HEALTHCARE REFORM

Reference committee hearing: see report of [Reference Committee B](#).

HOUSE ACTION: FILED

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, which calls on our American Medical Association (AMA) to “develop a policy statement clearly outlining this organization’s policies” on a number of issues raised by the Affordable Care Act (ACA) and health care reform. Specifically:

- Opposition to all Pay-for-Performance or Value-Based Purchasing that fail to comply with the AMA’s Principles and Guidelines;
- Repeal and appropriate replacement of the sustainable growth rate (SGR);
- Repeal and replace the Independent Payment Advisory Board (IPAB); with a payment mechanism that complies with AMA principles and guidelines;
- Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act (“private contracting”);
- Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations; and
- Repeal the non-physician provider non-discrimination provisions of the ACA.

Furthermore, the resolution calls for the AMA to “immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals” and to report back at each meeting of the HOD.

This report will lay out in a clear and brief manner the broad range of policies that have been adopted by the HOD on these topics as well as current AMA activities on each item.

PAY-FOR-PERFORMANCE

The AMA opposes private payer, Congressional or Centers for Medicare & Medicaid Services (CMS) pay-for-performance initiatives if they do not meet our AMA’s “Principles and Guidelines for Pay-for-Performance.” These Guidelines and Principles are embodied in Policies H-450.947 and H-450.944.

As part of ongoing discussions with Congressional staff, our AMA continues to advocate that pay-for-performance programs must offer positive incentives as opposed to threatened cuts for physician participation. Key to this effort is the availability of timely and accurate data so that physicians may monitor their performance during the performance period and make adjustments so that they may be successful. Advocacy on this

issue has also stressed the need for evidence based measures, appropriate risk adjustment, and other key elements of the Guidelines and Principles.

REPEAL AND APPROPRIATE REPLACEMENT OF THE SGR

The AMA supports the repeal of the SGR and its replacement with a fair and equitable payment system that adequately reflects the increases in the costs of caring for Medicare beneficiaries and is backed by a fair, stable funding formula (Policies H-390.852 and H-165.838).

The AMA continues to engage Congress on the urgent need to replace the SGR. Proposals are currently making their way through the Congressional process. The House Committee on Energy and Commerce has unanimously reported legislation to repeal the SGR that includes numerous improvements that reflect AMA advocacy. At the time this report was prepared, the House Committee on Ways and Means and the Senate Committee on Finance are preparing proposals of their own in consultation with the AMA. The vast majority of members of Congress agree with the AMA that the time to replace the SGR is this year.

Additionally, the AMA has initiated grassroots and earned media campaigns during July and August Congressional recess periods and a fly-in for physicians in conjunction with the September AMPAC Federation meeting.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The third item in the requested policy statement relates to AMA policy on the Independent Payment Advisory Board (IPAB), calling for its repeal and replacement with a payment mechanism that complies with AMA principles and guidelines. The IPAB was created as part of the ACA to make recommendations to Congress on policies to reduce Medicare spending should spending growth top a predetermined rate. Should Congress not act on the recommendations by adopting them or replacing them with policies that achieved equivalent savings, the Secretary of Health and Human Services (HHS) is empowered to implement the proposals without Congressional action. The IPAB is prohibited from recommending savings that affect benefits or increase costs for beneficiaries. Furthermore, several large segments of the health care sector are excluded from cuts by the IPAB for the first several years of its operation.

The AMA has clear and specific policy calling for the repeal of the IPAB (H-165.833). However, the AMA has no policy calling for the replacement of the IPAB with any other entity similarly empowered. The AMA does have extensive policy, however, on reducing health care spending, which is discussed later in this report.

As part of this effort, the AMA has worked closely with Representative Phil Roe, MD (R-TN), and Senator John Cornyn (R-TX), both of whom have introduced legislation to repeal the IPAB. House action on IPAB repeal is expected this fall. The AMA will continue to work to advance these proposals in both chambers.

SUPPORT FOR MEDICAL SAVINGS ACCOUNTS, FLEXIBLE SPENDING ACCOUNTS, AND THE MEDICARE PATIENT EMPOWERMENT ACT

The fourth item of the policy relates to three arrangements that are complementary to traditional health insurance policies or Medicare.

Medical Savings Accounts

The AMA has extensive policy on Health Savings Accounts (HSAs), which are the current embodiment of Medical Savings Accounts. HSAs allow individuals, in conjunction with a high-deductible health plan, to save funds tax-free to meet uncovered medical expenses, including co-pays and deductibles.

The AMA supports the wide availability of HSAs (Policy D-165.963) as well as improvements and their integration into health care reform as a component of freedom of choice in health insurance (Policies H-165.833 and H-165.852).

Under the ACA, HSAs will be creditable coverage at the bronze level for consumers.

Flexible Spending Accounts

Similar to HSAs, Flexible Spending Accounts (FSAs) allow individuals to set money aside tax free to meet health care needs not covered by insurance. Unlike HSAs, there is no requirement of a linkage to a high-deductible health plan. However, the use of these funds is more limited and remaining funds are forfeited at the end of the calendar year. The AMA supports changes in law and regulation to allow these funds to be rolled over into an HSA at the end of the year as well as rescinding forfeiture requirements (Policy H-165.863).

The AMA continues to work as part of the Health Choices Coalition in support of legislation that would modify current restrictions on FSAs, including repealing the requirement that FSA funds cannot be used for over-the-counter drugs without a prescription, and bring them more in line with AMA policies. Similar legislation was reported out of the Ways and Means committee in the previous Congress. However, the reluctance of the current Congress to make any beneficial modifications to provisions of the ACA has limited the opportunity to advance these reforms.

Medicare Patient Empowerment Act

The AMA has multiple policies in support of allowing Medicare beneficiaries and others to privately contract with physicians without penalty to either party. These are embodied in H-165.833, D-380.997, H-385.961, H-380.989, H-383.991, D-390.957, D-390.960, and D-390.969.

The AMA continues to strongly support enactment of the Medicare Patient Empowerment Act. An AMA website, mymedicare-mychoice.org, has been established to allow physicians and consumers to express their support for private contracting arrangements under Medicare.

STEPS TO LOWER HEALTH CARE COSTS

The fifth item relates to AMA support for steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of health insurance coverage, and protect Medicare for future generations. Each of these is addressed below:

Steps that Will Likely Produce Reduced Health Care Costs

The AMA recognizes that successful cost-containment and quality-improvement must involve physician leadership and collaboration and supports four broad strategies – reduce the burden of preventable disease, make health care delivery more efficient, reduce non-clinical health system costs that do not contribute value to patient care, and promote “value-based decision-making” at all levels (Policy H-155.960). This policy has numerous components, including provision of life-style counseling, medical research funding, and HIT design that promotes clinical guidelines and protocols, cost-effectiveness information, quality measurement, and support for counseling, disease management, case management and alerts to avoid potential medical errors. Policy H-155.960 also supports the adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services to yield health savings, the use of targeted benefit design and ongoing investigation and cost-effectiveness analysis of non-clinical health system spending. These activities are supported, in part, by Policy H-155.996 which calls on the AMA to study these issues, including money spent on defensive medicine.

Additionally, the HOD has adopted extensive policies on specific actions that can be taken to help reduce health care spending. Among them are:

- D-155.995, Containing Catastrophic Care Costs;
- H-450.942, Patient Adherence to Treatment Plans;
- H-373.998, Patient Information and Choice;
- H-155.998, Voluntary Health Care Cost Containment;
- H-460.909, Comparative Effectiveness Research;
- H-450.938, Value-Based Decision-Making in the Health Care System;
- D-155.994, Value-Based Decision-Making in the Health Care System;
- H-210.986, Physicians and Family Caregivers - A Model for Partnership;

- H-480.984, Technology Assessment in Medicine;
- H-330.948, Three Day Prior Hospital Stay Requirement;
- H-440.991, Immunization Programs for Children;
- H-440.928 Update on Immunizations and Vaccine Purchases;
- H-180.953, Decreased Insurance Premiums for Nonsmokers;
- H-15.990, Automobile-Related Injuries; and
- D-515.984, Health Care Costs of Violence and Abuse Across the Lifespan.

The AMA continues to seek opportunities to advance these priorities through legislation and regulation. A major component of these activities is the Improving Health Outcomes strategic issues initiative. As part of this initiative, the AMA is seeking adoption of legislation that would provide Medicare coverage of counseling under the National Diabetes Prevention Program. This program seeks to identify individuals with or at risk for pre-diabetes and to work with them to modify behaviors and delay or prevent the onset of diabetes, thereby improving health and reducing the future cost of care.

Lower Health Insurance Premiums

Efforts to lower healthcare spending will have a positive effect on making health insurance premiums more affordable. AMA policy also supports additional efforts that have a positive effect on the cost and affordability of health insurance premiums, including tax credits that are inversely related to income and elimination of the tax code's discrimination against individuals who purchase their own insurance instead of receiving coverage through their employer (Policy H-165.920).

The AMA was directly engaged in legislative and regulatory efforts to establish medical loss ratios for health insurance plans. To date, these efforts have resulted in millions of dollars of rebates to policy holders where plans have spent excessively on activities not related to clinical care.

Provide for a Sustainable Expansion of Health Care Coverage

AMA policies regarding expansion of health insurance coverage focus on pluralism, freedom of choice, freedom of practice, and universal access for patients. These include:

- H-165.838, Health System Reform Legislation;
- H-165.845, State Efforts to Expand Coverage to the Uninsured;
- H-165.920, Individual Health Insurance;
- H-185.959, Health Care Benefit Discrepancies for Small Employers Under COBRA;
- H-185.989, Continuity of Insurance Coverage; and
- H-165.865, Principles for Structuring a Health Insurance Tax Credit.

During Congressional consideration of the ACA, the AMA was successful in including five of the seven essential elements of health care reform outlined in Policy H-165.838.

Protect Medicare for Future Generations

AMA Policy D-330.924 calls on the AMA to make Medicare reform a high priority on the AMA legislative agenda with reform efforts centered on our long-standing policy of pluralism (Policy H-165.844), freedom of choice (H-165.920, H-373.998, H-390.854), defined contribution (D-330.937), and balance billing (D-380.996, H-385.991, D-390.969). Policy H-330.896, Strategies to Strengthen the Medicare Program, calls for specific reforms in the Medicare program's structure:

Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services such as those recommended by the US Preventive Health Task Force should also be encouraged. Simultaneously, policymakers will need to consider modifications to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare's new cost-

sharing structure.

Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies would need to be developed, and sufficient resources allocated, to ensure appropriate government standard-setting and regulatory oversight of plans.

Restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits.

Additionally, AMA Policy H-330.889, Strengthening Medicare for Current and Future Generations defines necessary elements of a defined contribution program for Medicare, including choice of plans, preservation of traditional Medicare, and affordability.

The AMA has remained engaged with the appropriate committees of jurisdiction as they discuss possible structural changes to the Medicare program. Action is possible this fall as the committees look to entitlement spending as a component of a debt and deficit deal. The AMA will continue this engagement and work to ensure the any Medicare reform bill considered by Congress is consistent with these policies.

REPEAL NON-PHYSICIAN PROVIDER NON-DISCRIMINATION PROVISIONS OF THE ACA

The AMA supports repeal of Section 2706(a) of the ACA (Policies H-35.968 and H-165.833).

Legislation has been introduced by Representative Andy Harris, MD (R-MD) to repeal this section of the law. The AMA has informed Representative Harris of our support for the bill and will be working with other stakeholders to build additional support during the current Congress.

MULTI-PRONGED CAMPAIGN TO ACCOMPLISH THESE GOALS

The second part of Policy D-165.938 calls on the AMA to “immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals.”

Each of the items raised by the Policy is central to ongoing AMA efforts to improve the health care system for patients and physicians. Efforts to address these issues are currently underway as discussed above and in ongoing work through the AMA core areas of strategic focus and are covered by existing funding.

CONCLUSION

As discussed above, the issues raised by Resolution 231 are central to ongoing AMA efforts to make improvements in the Affordable Care Act, repeal the SGR, and encourage the development of a Medicare payment system that focuses on value and the long-term sustainability of the Medicare program. The AMA will update the HOD on these efforts at each future meeting.

7. NATIONAL INDIAN HEALTH BOARD: OFFICIAL OBSERVER STATUS IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

**HOUSE ACTION: RECOMMENDATION ADOPTED AND
REMAINDER OF REPORT FILED**
See Policy [G-600.025](#)

INTRODUCTION

The National Indian Health Board (NIHB) has requested official observer status in the American Medical Association (AMA) House of Delegates (HOD). The AMA and the NIHB share many goals when it comes to

improving healthcare outcomes. The following report: (1) discusses AMA Bylaws and Policy that address requests and establish guidelines for official observer status; (2) provides background on the NIHB and discusses if the NIHB meets the official observer guidelines; and (3) recommends that the NIHB be granted official observer status.

AMA BYLAWS AND POLICY

Our AMA Bylaws state the following regarding official observers:

- 2.20 Official Observer. National organizations may apply to the Board of Trustees for official observer status in the House of Delegates. Applicants must demonstrate compliance with guidelines for official observers adopted by the House of Delegates, and the Board of Trustees shall make a recommendation to the House of Delegates concerning the application. The House of Delegates will make the final determination on the conferring of official observer status.
- 2.201 Rights and Privileges. Organizations with official observer status are invited to send one representative to observe the actions of the House of Delegates at all meetings of the House of Delegates. Official observers have the right to speak and debate on the floor of the House of Delegates upon invitation from the Speaker. Official observers do not have the right to introduce business, introduce an amendment, make a motion, or vote.

Policy G-600.025 establishes the following criteria for selection of and attendance by official observers in our AMA-HOD:

- 1. Applications for official observer status will be reviewed using the following guidelines:
 - a. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both.
 - b. The organization should be national in scope and have similar goals and concerns about health care issues.
 - c. The organization is expected to add a unique perspective or bring expertise to the deliberations of the House of Delegates.
 - d. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.
- 2. An organization granted official observer status in the House shall automatically lose that status if no representative of the organization appears at six consecutive House of Delegates meetings.

A full list of official observers in the House of Delegates is available in the Appendix.

DISCUSSION

The NIHB is a 501(c) (3) not-for-profit, charitable organization which provides health care advocacy services, facilitates tribal budget consultation and provides timely information and other services to all tribal governments. Since 1972, the NIHB has advised the US Congress, Indian Health Service (IHS), other federal agencies and private foundations about health disparities and service issues experienced in Indian country. The NIHB advocates on behalf of all 566 federally-recognized tribes in the development of national Indian health policy. The future of health care for American Indians and Alaska Natives is intertwined with policy decisions at the federal level and changes in mainstream health care management. The NIHB advocates on behalf of all federally-recognized tribal governments, American Indians and Alaska Natives in their efforts to provide quality health care for all Indian people. For 40 years, NIHB has continuously played a central role in focusing national attention on Indian health care needs.

Whether tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the IHS, NIHB is their advocate. NIHB also conducts research and provides policy analysis, program assessment and development, national and regional meeting planning, training, technical assistance and program and project management. These services are provided to tribes, Area Health Boards, tribal organizations, federal agencies, and private foundations. The NIHB presents the tribal perspective while monitoring, reporting on, and responding to federal legislation and regulations.

Members of the NIHB have participated in the AMA-Minority Affairs Section (MAS) by attending meetings and providing testimony on MAS resolutions related to American Indian healthcare issues. The executive director of the NIHB met with the AMA-MAS Governing Council to work on issues of mutual concern and to seek other ways to participate in our AMA. The AMA has several policies that support the NIHB's efforts and goals, for example:

- D-350.987, Strong Opposition to Cuts in Federal Funding for the Indian Health Service;
- H-350.976, Improving Health Care of American Indians;
- H-350.981, AMA Support of American Indian Health Career Opportunities;
- H-350.977, Indian Health Service; and
- D-350.992, Medicaid Coverage for American Indian and Alaska Native Children.

The AMA-MAS has determined that the NIHB provides vital information to the House of Delegates and assists in helping determine appropriate policy to address improving health care outcome issues as it relates to American Indian and Alaska Natives. NIHB represents 2 million American Indian and Alaska Native health care consumers, providers and administrators and represents and serves hundreds of physicians who are engaged with the Indian and tribal health system. The NIHB's reach is national in scope, so the NIHB is not bound by narrow interests.

SUMMARY AND RECOMMENDATION

In summary, there has been a cooperative and productive relationship between our AMA and the NIHB. The Board of Trustees believes the NIHB would bring a unique perspective and would be a welcome addition to the deliberations of the AMA-HOD.

The Board of Trustees therefore recommends that our American Medical Association grant the National Indian Health Board official observer status in the House of Delegates and that the remainder of this report be filed.

APPENDIX - Official Observers to the House of Delegates

Organization	Year Admitted
1. Accreditation Association for Ambulatory Health Care	1993
2. Alliance for Continuing Medical Education	1999
3. Ambulatory Surgery Center Association	2005**
4. American Academy of Physician Assistants	1994
5. American Association of Medical Assistants	1994
6. American Dental Association	1982
7. American Health Quality Association	1987*
8. American Hospital Association	1992
9. American Nurses Association	1998
10. American Public Health Association	1990
11. Association of periOperative Registered Nurses	2000
12. Association of State and Territorial Health Officials	1990
13. Commission on Graduates of Foreign Nursing Schools	1999
14. Council of Medical Specialty Societies	2008
15. Educational Commission for Foreign Medical Graduates	2011
16. Federation of State Medical Boards	2000
17. Federation of State Physician Health Programs	2006
18. Medical Group Management Association	1988
19. National Association of County and City Health Officials	1990
20. National Commission on Correctional Health Care	2000
21. National Council of State Boards of Nursing	2000
22. PIAA (Physician Insurers Association of America)	2013
23. Society for Academic Continuing Medical Education	2003
24. US Pharmacopeia	1998

* Admitted in 1987 as the American Medical Peer Review Association

** Admitted in 2005 as the Federated Ambulatory Surgery Association. In 2008 merged with American Association of Ambulatory Surgery Centers to become Ambulatory Surgery Center Association.

8. ABUSE OF CPT DESCRIPTORS RELATED TO SURGERY (RESOLUTION 601-I-12)

Reference committee hearing: see report of [Reference Committee F](#).

HOUSE ACTION: RECOMMENDATION ADOPTED RESOLUTION 601-I-12 NOT ADOPTED AND REMAINDER OF REPORT FILED

At the American Medical Association (AMA) 2012 Interim Meeting, the House of Delegates (HOD) referred Resolution 601-I-12 “Abuse of CPT Descriptors Related to Surgery” regarding potential misinterpretation and misuse of the term surgery within the context of the CPT nomenclature. Resolution 601-I-12 was introduced by the American Academy of Ophthalmology, California Delegation, American Academy of Physical Medicine and Rehabilitation, American Society of Cataract and Refractive Surgery, and American Society of Anesthesiologists.

The primary reason for this resolution was to address the misuse of the CPT nomenclature to circumvent state licensing rules by a small group of professionals who use one or more non-surgical procedure codes in the Surgery Section of the code set to inappropriately promote that they actually perform surgery. This issue has also impacted some beneficiaries whose plans deny coverage due to misinterpretation of a service as “surgery” simply because the code is part of the Surgery Section of CPT where the service would be covered if it was not listed under the surgery heading.

Misuse and misinterpretation of surgery within the CPT code set has an extensive history. In recognition of frequent misuse of surgery within the code set nomenclature, an article entitled “The Great Debate: When is “Surgery” not “Surgery” was published in 1996 in *CPT Assistant* and explained that the Surgery Section in CPT includes many services that are not surgery as defined in AMA policy or other common definitions. Therefore, it is improper from an AMA and CPT perspective to use placement in the CPT code set as a rationale to claim that a service is or is not surgery as defined by many state practice acts, payer policies or others. *CPT Assistant* is the authoritative reference regarding the use of the CPT code set published by the AMA with oversight of a multi-stakeholder editorial board.

To further address the issues described in the resolution, a code change application was submitted at the January 2013 CPT Editorial Panel meeting to request revision of the nomenclature for publication in CPT 2014. The Panel accepted the following revisions to the CPT guidelines to discourage generalization and misinterpretation of descriptors based upon current code set subsection titles and directed that the 1996 *CPT Assistant* article be re-published.

It is equally important to recognize that, as techniques in medicine and surgery have evolved, new types of services including minimally invasive surgery as well as endovascular, percutaneous, and endoscopic interventions have challenged the traditional distinction of Surgery versus Medicine. Thus, the listing of a service or procedure in a specific section of this book should not be interpreted as strictly classifying the service or procedure as “surgery” or “not surgery” for insurance or other purposes.

The placement of a given service in a specific section of the book may reflect historical or other considerations (e.g., placement of the percutaneous peripheral vascular endovascular interventions in the Surgery/ Cardiovascular System section while the percutaneous coronary interventions appear in the Medicine/ Cardiovascular section).

In addition, given that there was confusion regarding the role of the CPT code set in scope of practice issues, the following clarifications were added into the CPT Guidelines in 2012 to address proper reporting of the code set.

It is important to recognize that the listing of a service or procedure and its code number in a specific section of this book does not restrict its use to a specific specialty group. Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician or other qualified health care professional or entity (e.g., hospital, clinical laboratory, home health agency). CPT does not determine qualifications (qualified or not qualified) by placement in a section. Payment policy, which is the cause of many scope of practice issues, is not in the domain of CPT.

A physician or other qualified healthcare professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These are standards most accept.

While a code change application was considered and approved by the CPT Editorial Panel, your Board of Trustees and Panel representatives continue to reinforce that CPT must remain independent and a resource to all stakeholders as described in Policy H-70.919, “Use of CPT Editorial Panel Process.”

RECOMMENDATION

The Board of Trustees recommends that Resolution 601-I-12 not be adopted.

9. PUBLIC HEALTH AND PRIMARY PREVENTION IN AMA’S STRATEGIC PLAN

Reference committee hearing: see report of [Reference Committee F](#).

HOUSE ACTION: FILED

Policy G-625.020 asks “that our AMA Board of Trustees be asked to consider whether our American Medical Association’s strategic plan adequately addresses public health and primary prevention and report back to the House of Delegates at the 2013 Interim Meeting.” The Board presents this report for information.

DISCUSSION

The AMA’s strategic plan describes the approach by which it carries out its mission to promote the art and science of medicine and the betterment of public health. The plan is informed by current and emerging health care environment trends and, importantly, is grounded by a broad and deep portfolio of policy established by the House of Delegates.

To implement its policy and achieve its mission, the AMA brings to bear the full strength of the organization through all of the means by which it reaches physicians (the “AMA Equation”):

- House of Delegates
- Membership
- Advocacy
- Practice Tools
- Research and Education

Notably, through the work of the House of Delegates and in particular the Council on Science and Public Health, the AMA has a strong foundation of policy on primary prevention and public health. That policy continues to inform and enable action ranging from medical student service projects to advocacy for patient access to preventive services to publication of leading-edge research that continues to shape the practice of medicine, whether viewed from the broad perspective of population health or the very personal interaction between physician and patient. (It is estimated that some 25% of the content published through the JAMA Network is related to public health.)

Sustained focus is critical to success for the AMA’s strategy. Accordingly, the rolling five-year strategic plan extends the commitment established in 2012 on three focus areas:

- Driving widespread innovation leading to improved health outcomes, as well as a reduction in health care costs, associated with significant disease burden in the US.
- Promoting innovation that better aligns education results with the changing needs of our health care system, starting with advances in undergraduate medical education.
- Shaping—and helping physicians navigate—existing and emerging delivery and payment models to preserve or restore professional satisfaction and practice sustainability.

Each of these focus areas aligns well with the mission and a broad base of physicians, and each is of urgent and critical importance to the future of health care. Each represents an opportunity for AMA to make a significant, measurable and positive impact and for AMA to be recognized for its leadership on behalf of America's physicians and patients. The goals of the three focus areas, and the means by which we will achieve them, are relevant to prevention and the health of the public.

The AMA is committing its resources, expertise, and reach to prevent heart disease, stroke and type 2 diabetes and to improve outcomes for those with disease. The work encompasses primary, secondary and tertiary prevention and is closely integrated with goals of other leading public health organizations, including the Centers for Disease Control and Prevention (through its National Diabetes Prevention Program) and the Department of Health and Human Services (through its "Million Hearts" initiative). At this stage our AMA's actions target prediabetes and hypertension—two markers which, if improved, can help significantly in reducing the burden of chronic disease in this country. These two diseases affect millions of Americans—far more than any other condition—and represent the most prevalent public health challenges for our population. Primary prevention interventions (such as healthy nutrition, physical activity, smoking cessation, and reduction of inappropriate substance use) deployed against prediabetes and hypertension apply also to other high-impact conditions such as obesity, cancer, COPD/asthma, and depression. If successful, this strategy will represent an extraordinary contribution to the discipline of public health and the health of the public.

The grant program underpinning the AMA's work in accelerating change in medical education will enable testing of a range of innovations aimed at improving the readiness of the next generation of physicians to meet the health care needs of the public. Examples of work represented by the eleven grant awards include new ways of educating physicians with both a primary care background and the skills to promote the health of the population they serve, and seamless integration between medical education and clinical practice with content to include preventive health skills and special emphasis on diverse and underserved populations.

Finally, it is difficult to imagine how a health care environment could adequately address primary prevention and public health if it does not also address the responsible evolution of care delivery and payment, professional satisfaction, and the sustainability of physician practice. The demands upon physicians must be balanced in a way that allows them to improve the health of the public by attending to the individual needs of their patients.

In short, the AMA is working to enable a better healthcare system that will improve the health of the nation. The strategic plan is described separately in Board of Trustees Report 10-I-13.

CONCLUSION

The AMA demonstrates its unwavering commitment to public health and primary prevention through policy set by the House of Delegates; AMA's educational and advocacy activities; the programs and projects of AMA's councils, sections and special groups; AMA's collaborations with other leading public health organizations; and in particular the work of the three focus areas described in AMA's strategic plan. Upon consideration, it is the view of your Board of Trustees that public health and primary prevention are indeed appropriately addressed in the strategic plan.

10. 2014 STRATEGIC PLAN

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

To promote the art and science of medicine and the betterment of public health.

These fourteen words define a mission that has brought together America's physicians for over 165 years. They underpin AMA policy as proposed, debated, adopted, reaffirmed, refined, and occasionally reversed or sunset over the course of hundreds of sessions of the House of Delegates. Just as the AMA's mission statement represents a longstanding legacy, the AMA's policy base establishes the current context in which this mission is carried out. Building upon both, the AMA's strategy plots a path forward toward a future that is better, stronger, and healthier for America's patients and the physicians who care for them.

In 2013, the AMA launched a multi-year strategy built around aspirations for the healthcare environment of 2018 and beyond, with specific targets in three focus areas: improving health outcomes, accelerating change in medical education, and shaping delivery and payment models that promote practice sustainability and professional satisfaction. Collectively, these focus areas encompass the approach to the AMA's mission in today's environment and respond to the imperative to achieve high, relevant impact for physicians, residents, medical students and patients.

Grounded in AMA policy, each of these focus areas aligns well with the mission and a broad base of physicians, and each is of urgent and critical importance to the future of health care. Each represents an opportunity for AMA to make a significant, measurable and positive impact and for AMA to be recognized for its leadership on behalf of America's physicians and patients.

Through this report, the Board of Trustees affirms AMA's multi-year strategy (BOT Report 9-I-12) and provides an update to the rolling five-year plan with emphasis on what is expected for 2014.

IMPROVING HEALTH OUTCOMES

The national imperative to improve both the quality and the cost of care, the growth of enabling data sources (such as registries), and the practical realization that process measures alone cannot drive better care are among the factors that have directed AMA's strategy in this area. The strategy calls for AMA to drive widespread innovation—teaming with physicians, patients, community organizations, delivery systems, government and private funders/payers, and others—to advance a professional movement and a comprehensive, replicable approach focused on preventing disease and improving health outcomes associated with a significant disease burden in the US.

The first wave of effort focuses on prevention of type 2 diabetes and cardiovascular disease and improving outcomes for patients with these diseases. These two diseases affect millions of Americans—far more than any other condition—and represent the most prevalent public health challenges for our population.

In an effort to magnify AMA's impact through well-designed teamwork, AMA has integrated these activities with the work of other leading organizations, including the Centers for Disease Control and Prevention (through its National Diabetes Prevention Program) and the Department of Health and Human Services (through its "Million Hearts" initiative). Together with these and other organizations, such as YMCA of the USA and Johns Hopkins Medicine, AMA will capture baseline data, implement and monitor targeted interventions at the community and practice level, and identify ways to scale the most effective actions for widespread adoption. Over time it is expected that a robust "peer network" of physicians will be deployed as local ambassadors for innovation among local physician practices, communities and healthcare systems throughout the country.

Examples of the expected impact of this work include a growing percentage of physicians screening for prediabetes; effective systems of referral and data flow among physicians, patients, and community-based diabetes prevention programs; a reduction in the percentage of patients with prediabetes who progress to diabetes; and a growing percentage of diagnosed hypertension patients—particularly those currently experiencing disparities in care—achieving improved blood pressure control. Over time, we will be able to tie the AMA-promulgated change strategies to a demonstrated increase in health and health system effectiveness, including more cost-effective use of health care resources.

ACCELERATING CHANGE IN MEDICAL EDUCATION

AMA continues to promote innovation that better aligns education results with the changing needs of our health care system, as demonstrated by ongoing commitment to a multi-year program to catalyze advances in undergraduate medical education (UME) through work with medical schools and other stakeholders.

Clearly, the timing is right and the medical education system's readiness to evolve is strong. A request for proposals issued in early 2013 drew responses from more than 80% of allopathic medical schools. Following a rigorous evaluation, AMA announced awards to eleven medical schools for:

- Developing new methods for teaching and/or assessing key competencies for medical students and fostering methods to create more flexible, individualized learning plans;

- Promoting exemplary methods to achieve patient safety, performance improvement and patient-centered team-based care;
- Improving medical students' understanding of the health care system and health care financing; and
- Optimizing the learning environment.

The AMA has committed to provide \$11 million over the next five years to fund promising innovations at these schools. Importantly, participating schools have agreed to work together to share information, collaboratively evaluate outcomes and widely disseminate successful innovations. While each school will pursue specific innovations of their own design, the consortium approach will speed the cycle through which successful ideas are developed and spread. Getting the eleven projects into the implementation phase and operationalizing the consortium in 2014 will represent a major milestone for the strategy.

The positive impact of this five-year program will be evidenced by dissemination and adoption of new models beyond the AMA consortium—at other medical schools, through new standards, or across the continuum of medical education. Around that time the first full cohort of medical students will matriculate to the next phase of lifelong learning, well prepared to serve the patients who await their competent care.

CARE DELIVERY AND PAYMENT

The third area of strategic focus in AMA's multi-year plan involves shaping—and helping physicians navigate—existing and emerging delivery and payment models with special attention to preserving or restoring professional satisfaction and practice sustainability.

Research commissioned by the AMA in 2013 establishes an evidence base that documents care delivery and payment challenges faced by physicians across a broad spectrum of geographies, specialties and practice settings. Examples include:

- Escalating time pressure that detracts from the care experience;
- Lack of a sense of control over day-to-day decisions affecting patient care;
- Deficiencies in health information technology;
- The cumulative burden of regulatory burdens;
- Inadequate payment methodologies; and
- Less than optimal relationships with hospitals and health systems.

Some of these challenges are targeted by AMA's advocacy efforts, which seek to influence federal legislation and regulation that will be central to transition to new payment and delivery systems in both the public and private sectors. For example, the advocacy team continues working to influence legislation that would permit private contracting, regulations around “meaningful use” of health information technology, and getting “usability” included in the criteria for certification of electronic health record products.

In the near term and at the federal level, our work toward repeal and replacement of the sustainable growth rate (SGR) Medicare payment update regulation remains intense. This is essential to developing a high-performing Medicare program. Equally critical is defining and implementing a replacement that meets patients' health care needs—one in which Medicare invests and supports physician practice infrastructure and provides for payment updates that reflect progress on quality improvements and managing costs. This work continues to be guided by policies established by the House of Delegates, with ongoing input from AMA councils and advisory groups convened in collaboration with the Federation.

In addition, 2014 will be a period of formulating and piloting new ideas involving delivery innovation within the practice setting as well as resources to improve interactions and relationships among physicians and practice leaders, hospitals, systems, payers, and, ultimately, patients. Following the credo “think nationally, act locally,” we seek a range of options that allows physicians to choose models that fit the needs of their practice and patients.

The long-term goal is to identify, support, and grow the models of care delivery and payment that promote the long-term sustainability of and satisfaction with medical practice, and lead to improvement in the cost and quality of American health care.

ORGANIZATIONAL SUCCESS FACTORS

Previously the AMA introduced the “AMA Equation” as a means to define the ways by which we reach, influence and serve the practice of medicine. Each of these elements remains critical to the mission and to the success of this strategic plan:



Other business and operational elements of this strategy call for greater focus and integration within and across activities related to the House of Delegates, membership, practice tools, research and education, and advocacy. Areas of emphasis for 2014 include:

- Continued stabilization and growth in membership fostered through targeted physician engagement activities, many emphasizing a theme of physician solidarity with respect to the patient-physician relationship.
- Showcasing the significance of AMA’s contribution to medicine through engaging and impactful communications that demonstrate AMA’s leadership in improving the health of the nation. Examples range from the JAMA Network’s dissemination of ground-breaking scientific research to stepped-up efforts toward publication of other AMA mission work in the broader healthcare literature.
- Enhancing the AMA’s portfolio of products and services to increase the AMA’s relevance for physicians
- Maintaining a sustainable revenue stream needed to achieve the mission objectives.
- Continued cultivation of productive partnerships not only with the state and specialty medical societies that comprise the Federation, but also with other organizations and health care sectors whose interests align with those of the AMA and whose collaboration is needed to achieve our strategic objectives.
- Building on AMA’s legacy of leadership in ethics, performance excellence, and medical science to serve as the premier voice for the core values of the medical profession.

In summary: the AMA is working to enable a better healthcare system that will improve the health of the nation.

11. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES: FIVE-YEAR REVIEW

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

See Policy [D-600.984](#)

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) scheduled to submit information and materials for the 2013 American Medical Association (AMA) Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020 and AMA Bylaw 8.50.

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of national medical specialty organizations is also required as set out in AMA Bylaw 8.20.

The following organizations were reviewed for the 2013 Interim Meeting:

American Academy of Allergy, Asthma and Immunology
 American Academy of Ophthalmology, Inc.
 American Academy of Orthopaedic Surgeons
 American Academy of Otolaryngology–Head and Neck Surgery, Inc.
 American Academy of Pain Medicine

American Academy of Pediatrics
 American Academy of Physical Medicine and Rehabilitation
 American Association of Neurological Surgeons

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that the: American Academy of Allergy, Asthma and Immunology, American Academy of Ophthalmology, Inc., American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology–Head and Neck Surgery, Inc., American Academy of Pain Medicine, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, and American Association of Neurological Surgeons meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

That the American Academy of Allergy, Asthma and Immunology, American Academy of Ophthalmology, Inc., American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology–Head and Neck Surgery, Inc., American Academy of Pain Medicine, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, and American Association of Neurological Surgeons retain representation in the American Medical Association House of Delegates.

APPENDIX

Exhibit A - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership	
American Academy of Allergy, Asthma and Immunology	390 of 1,700	(23%)
American Academy of Ophthalmology, Inc.	3,396 of 16,492	(21%)
American Academy of Orthopaedic Surgeons	4,709 of 23,231	(20%)
American Academy of Otolaryngology–Head and Neck Surgery, Inc.	2,111 of 7,960	(27%)
American Academy of Pain Medicine	505 of 1,711	(30%)
American Academy of Pediatrics	4,577 of 41,052	(11%)
American Academy of Physical Medicine and Rehabilitation	1,755 of 8,015	(22%)
American Association of Neurological Surgeons	889 of 3,033	(29%)

Exhibit B - Summary of Guidelines for Admission to the House (Policy G-600.020). Specialty Societies

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

4. The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C - Responsibilities of National Medical Specialty Organizations (Bylaw 8.20)

1. To cooperate with the AMA in increasing its AMA membership.
2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organization so that the delegate can properly represent the organization in the House of Delegates.
3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.
4. To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
5. To provide information and data to the AMA when requested

Exhibit D - AMA Bylaws on Specialty Society Periodic Review

Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.50 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.20. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society or the professional interest medical association has discharged the responsibilities required under Bylaw 8.20.

8.51 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting, or may take such other action as it deems appropriate.

8.52 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.20, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.53 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.20 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.531 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.20, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.532 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.20, the House may take one of the following actions:

8.5321 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.531.

8.5322 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.