REPORTS OF THE BOARD OF TRUSTEES

The following reports, 1–33, were presented by Steven J. Stack, MD, Chair:

1. AUDITOR'S REPORT

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: FILED

The Consolidated Financial Statements for the years ended December 31, 2012 and 2011 and the Independent Auditor's report have been included in a separate booklet, titled "2012 Annual Report." This booklet is included in the handbook mailing to Members of the House of Delegates and will be discussed at the Reference Committee F hearing.

2. AMA 2014 DUES

Reference committee hearing: see report of Reference Committee F.

**HOUSE ACTION: RECOMMENDATION ADOPTED AND
                  REMAINDER OF REPORT FILED**
                  See Policy G-635.130

Our American Medical Association (AMA) last raised its dues in 1994. In recent years, AMA has invested significantly in improving the value of membership. As AMA's membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

RECOMMENDATION

2014 Membership Year

The Board of Trustees recommends no change to the dues levels for 2014, and that the following be adopted, and that the remainder of this report be filed:

Regular Members	$ 420
Physicians in Their Second Year of Practice	$ 315
Physicians in Military Service	$ 280
Physicians in Their First Year of Practice	$ 210
Semi-Retired Physicians	$ 210
Fully Retired Physicians	$ 84
Physicians in Residency Training	$ 45
Medical Students	$ 20

3. PHYSICIAN INSURERS ASSOCIATION OF AMERICA: 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 Physician Insurers Association of America (PIAA) has requested official observer status in the House of Delegates (HOD). The American Medical Association (AMA) and the PIAA have had a long-standing, collaborative relationship and share many of the same goals when it comes to improving the current medical liability system and patient safety. The following report: (1) discusses AMA Bylaws and Policy that address requests and establish guidelines for official observer status; (2) provides background on the PIAA and discusses if the PIAA meets the official observer guidelines; and (3) recommends for consideration by the HOD that the PIAA be granted official observer status.

AMA BYLAWS AND POLICY

Our AMA Bylaws state the following regarding official observers B-2.20 and 2.201:

> 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.

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

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 to the House of Delegates is available in the Appendix.

DISCUSSION

The PIAA is an insurance industry trade association representing domestic and international medical professional liability (MPL) insurance companies, and it is seeking official observer status to help the PIAA become even more aware of our AMA's views on, and concerns about, the numerous issues affecting physicians today. The PIAA also

believes that official observer status will allow it to enhance our AMA's understanding of medical liability issues and the insurance upon which so many physicians rely.

The PIAA was created in 1977 and is directed by MPL insurance companies owned and/or operated by physicians, hospitals, dentists, and other healthcare providers. PIAA domestic member companies include large national insurance companies, mid-size regional writers, single-state insurers, and specialty companies that serve specific healthcare-provider niche markets. Collectively, these companies provide insurance protection to more than 60 percent of America's private practice physicians across many states, and write approximately 46 percent or $5.2 billion of the total industry premium.

The PIAA is an advocate for sound public policy that fosters a healthy and competitive insurance marketplace and has been an ally for the AMA as we seek to advance our legislative, judicial, and research goals related to medical liability reform and patient safety. Both groups have advocated for traditional medical liability reforms that maintain a stable liability climate for physicians and patients and have sought demonstration grants to advance pilot projects on innovative medical liability concepts. Both groups have also sought to defend currently enacted medical liability reforms at the state level through both legislative and judicial efforts. AMA economists routinely make use of PIAA closed claim summary reports in their work and consult with PIAA staff to better understand that data. AMA and PIAA staff attend each other's advocacy conferences. Finally, AMA and PIAA staff belong to coalitions that focus their efforts on improving the medical liability system. For example, AMA and PIAA staff serve on the Board of the Health Coalition on Liability and Access (HCLA), with a PIAA staffer currently serving as chair. Both our AMA and the PIAA belong to the American Tort Reform Association (ATRA) as well, which is another prominent coalition advocating for medical liability reform. So there are both formal and informal relationships between AMA and PIAA staff, and these relationships have been very helpful to our advocacy efforts over the years.

With 60 MPL companies as members and the broad number of physicians that these companies insure, the PIAA has keen insight into the current state of the medical liability market and sees developing trends much sooner than other organizations based on the size and number of claims in its database. Recognizing and addressing potential new liability exposure for physicians are important tasks as our nation's health care system transitions to new payment and delivery models and incorporates new technology into the practice of medicine. The PIAA can provide vital information to the House of Delegates as it monitors the medical liability climate moving forward and determines appropriate policy to address any potential issues.

As stated above, PIAA member companies represent 60 percent of U.S. private practice physicians, and its members' reach is national in scope, so the PIAA is not bound by narrow interests. Further, it is expected that the House of Delegates would welcome the expertise that the PIAA brings on an issue that is so vital to physician practice.

SUMMARY AND RECOMMENDATION

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

The Board of Trustees therefore recommends that our American Medical Association grant the Physician Insurers Association of America official observer status in the House of Delegates and that the remainder of the 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. Society for Academic Continuing Medical Education	2003
23. 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.

Other groups that had official observer status, but no longer do:
• American Osteopathic Association - granted in 1983 but never took its seat; became a member of the House in 1996. Although AOA typically sends a representative to HOD meetings, as yet the AOA has not named a delegate or accepted delegate credentials.
• National Medical Association - granted in 1983; became a member of the House in 1996.
• American Medical Women's Association - granted in 1983; became a member of the House in 1996.
• American Medical Care and Review Association - granted in 1985; organization no longer exists through mergers with other organizations
• US Conference of Local Health Officials - granted in 1990, but merged with National Association of County Health Officials to form the National Association of County and City Health Officials in 1994. NACCHO is an official observer.
• The American Association for Accreditation of Ambulatory Surgery Facilities had been admitted as an official observer in 1995 as a result of Board of Trustees action in response to a resolution that was referred for decision. At I-12 the AAAASF resigned as an official observer in a letter to the House office. Notice of the resignation is noted in the I-12 Proceedings.

4. CLEAR AND CONVINCING EVIDENCE
(RESOLUTION 207-A-12)

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
                  IN LIEU OF RESOLUTION 207-A-12 AND
                  REMAINDER OF REPORT FILED**
                  See Policy H-435.965

INTRODUCTION

At the 2012 American Medical Association (AMA) Annual Meeting, the Kentucky Delegation introduced Resolution 207. Resolution 207 called for the following:

   That our American Medical Association support the application of a clear and convincing evidence standard to all medical liability cases; and

   That our AMA develop state malpractice legislation that would include the principle of clear and convincing evidence for utilization in state malpractice actions.

The House of Delegates referred the resolution for further study regarding the following questions:

1. How such a shift to the clear and convincing standard for all medical liability claims would affect patients who did experience harm and have a legitimate claim to compensation;

2. How such a shift would affect other components of the current legal system;

3. How the clear and convincing standard has worked in states that have enacted it for emergency care; and

4. How AMA advocacy for the clear and convincing standard in all medical liability claims would be received by states that have already enacted proven reforms and how it would affect those reforms.

BACKGROUND

The legal standard of proof known as "clear and convincing evidence" requires that a party making a claim persuade the trier of fact that the claim is highly and substantially more likely to be true than not. To date, no states have adopted a "clear and convincing evidence" standard for general medical liability cases; instead, states use a "preponderance of the evidence" standard, which calls for proof that a claim is more probably true than not. Four states—Arizona, Georgia, North Carolina and Utah—have adopted the more stringent "clear and convincing evidence" standard for emergency care liability cases.

Proponents of the clear and convincing evidence standard contend that raising the evidence standard from "preponderance of the evidence" could substantially improve the medical liability climate. Specifically, proponents argue that a more stringent evidentiary standard will reduce the number of meritless claims without affecting patients who have been truly harmed from recovering the damages they deserve. Proponents reason that fewer meritless claims will reduce trial costs, resulting in lowered insurance premiums and accordingly, a less frequent practice of defensive medicine.

AMA POLICY AND ADVOCACY EFFORTS

AMA policy addresses the clear and convincing evidence standard in certain medical liability situations involving punitive damages, disaster care, emergency care and medical board investigations. AMA policy does not address the clear and convincing evidence standard in general medical liability actions.

Punitive Damages

AMA policy supports the use of the clear and convincing standard for medical liability cases involving punitive damages. Specifically:

> H-435.965 Clear and Convincing Standard of Proof in Medical Liability Cases
> The AMA continues to support the use of the clear and convincing evidence standard of proof in medical negligence cases in which the plaintiff seeks punitive damages and will continue to advocate civil justice reform designed to prevent non-meritorious claims from being filed or to quickly resolve them before extensive litigation proceeds.

> H-435.973 Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability
> (3) Punitive Damages Awards: Punitive damages in medical liability cases should not be awarded unless the party alleging such damages meets the burden of producing clear and convincing evidence of the opposing party's intent to do harm.

Disaster Care

The AMA has also adopted the clear and convincing standard related to disaster care:

> D-435.976 Protection From Liability Arising From Care Rendered to Patients During Officially Declared Disasters
> Our AMA will develop and disseminate to state medical societies model legislation to give qualified physicians (MDs and DOs) automatic medical liability immunity in the event of a state or federally declared disaster or

emergency, unless it is proven by clear and convincing evidence that a physician acted with malicious intent, wanton disregard for a patient's well being, or similar willful misconduct.

The resultant model state bill, the "Act to Protect Physicians from Civil Liability Arising from Health Care Provided During a Disaster," is on file with the AMA state Advocacy Resource Center (www.ama-assn.org/go/arc) and available upon request.

Emergency Care

AMA policy adopted in 2006 called on the AMA to push for liability protections for physicians providing EMTALA-mandated care:

> D-130.971 The Future of Emergency and Trauma Care, Resolve 3:
> That our AMA will continue to advocate for … federal and state liability protections for physicians providing EMTALA-mandated care.

In response to this directive, the AMA has supported the clear and convincing standard for emergency care in several states.

Medical Board Investigation

At the 2008 AMA Annual Meeting, the House of Delegates adopted Policy D-275.964, which calls on the AMA to explore ways to establish principles of due process that must be used by a state medical board prior to the restriction or revocation of a physician's medical license, including strong protections for physician rights. AMA resultant principles for medical board investigations, which the AMA Board of Trustees adopted in 2009, include discussion of the clear and convincing standard as follows:

> The standard of proof shall be the clear and convincing standard in either a temporary or a final state medical board action affecting a physician's practice rights.

The AMA has also drafted a model bill on point. This bill, the "Medical Board Due Process Model Act," provides that the standard of proof in state medical board investigation shall be the clear and convincing evidence standard in either a temporary or a final state medical board action affecting a physician's practice rights.

ANALYSIS

The AMA was unable to find empirical evidence from literature or state claims data that addresses application of the clear and convincing evidence standard to general medical liability cases. Because claims data were unavailable for Arizona, Georgia, North Carolina and Utah—the four states that adopted the heightened evidence standard with respect to emergency care actions—the AMA surveyed the medical associations in those states in an attempt to gather relevant anecdotal information (the survey and responses are on file with the AMA Advocacy Resource Center at www.ama-assn.org/go/arc). The survey queried whether state medical associations had access to or were aware of any data showing the effects of adopting the more stringent evidentiary standard. Specifically, the survey sought data showing positive changes in liability insurance premiums rates, claims frequency, claims severity (indemnity payments) and the number of practicing emergency physicians.

No state medical association provided data showing a direct correlation between the evidence standard reform and the number of practicing emergency physicians. In both states in which medical associations responded to the survey, the evidence standard was passed as part of a broad package of liability reforms, including in one state, a cap on non-economic damages, and in another state, an affidavit of merit requirement and expert witness standards. Survey respondents suggested that any subsequent changes to the liability climate were likely attributable to the entire package of medical malpractice reforms. Anecdotal evidence indicates that of the comprehensive reforms, the cap on non-economic damages has had the greatest positive impact for physicians. That said, anecdotal reports also indicate that the heightened evidence standard for emergency physicians has helped to bring emergency physicians back to at least one state.

Due to the lack of data showing how the clear and convincing standard has worked in states that have enacted the standard for emergency care, the AMA is unable to determine how a shift to the clear and convincing standard for all medical liability claims would affect: (1) patients who did experience harm and have a legitimate claim to compensation; (2) other components of the current legal system; or (3) states that have already enacted proven reforms.

CONCLUSION

While our AMA remains fully committed to the enactment of proven MLR laws, such as MICRA, our AMA is also calling for the implementation and evaluation of innovative reforms to see if they are able to improve the nation's medical liability climate. Our AMA has called for federal funding for pilot projects to test concepts such as health courts, liability safe harbors for the practice of evidence-based medicine, early disclosure and compensation models, expert witness guidelines and affidavits of merit, to name some of the more promising options. These reforms could either complement traditional MLR provisions, such as caps, or improve the liability climate in a state that is not able to enact traditional MLR provisions for political or judicial reasons. Implementation and evaluation of these innovative reforms are needed to determine their effectiveness.

A clear and convincing evidence standard has been proposed as an innovative option that states might use to address the liability climate for specific situations. However, the AMA has not seen any efforts to use the clear and convincing evidence standard in all medical liability cases and has not been able to obtain empirical evidence showing the effect of such a reform. Moreover, the AMA has not been able to obtain empirical evidence demonstrating the effect of the clear and convincing evidence standard in emergency care cases. While AMA survey data produced anecdotal evidence of physician recruitment and retention in one state that adopted the clear and convincing evidence standard, it is impossible to directly attribute this change to the heightened standard reform because such reforms were passed as part of broader reform packages. Indeed, survey respondents maintained that such positive changes were likely attributable to the entire package of medical liability reforms. The AMA will continue to monitor the effect of the clear and convincing evidence standard on the liability climate in those states that have adopted the standard.

The AMA will also continue to collaborate with state and national medical specialty societies to pursue traditional medical liability reforms, as well as assist states as they investigate and implement promising innovative reforms, including evidence standards reform. The AMA will continue to work with interested state and specialty societies on legislation adopting the clear and convincing evidence standard.

RECOMMENDATION

The Board of Trustees believes that this report fulfills the request for additional study regarding the implications of adopting Resolution 207-A-12 and recommends:

1. That our American Medical Association will continue to work with interested state and specialty societies on legislation adopting the clear and convincing evidence standard;
2. That Resolution 207-A-12 not be adopted, and
3. That the remainder of this report be filed.

5. PHYSICIAN PRACTICE DRIFT

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

HOUSE ACTION: **RECOMMENDATIONS ADOPTED AND**
REMAINDER OF REPORT FILED
See Policies [E-5.02](#), [E-9.132](#) and [H-410.951](#)

At the 2012 American Medical Association (AMA) Annual Meeting, the House of Delegates (HOD) adopted Policy H-410.952, "Practice Drift," which recommends that our AMA study the issue of physician drift and report back with recommendations to include, but not be limited, to: (1) whether AMA policy or the AMA *Code of Medical Ethics* should be modified; and (2) model language, if appropriate, to amend state Truth in Advertising laws to ensure patients are properly informed when making healthcare decisions about a physician's training.

PHYSICIAN PRACTICE DRIFT

The practice of medicine is dynamic with respect to scientific and technological advancements. Physician practice patterns are changing with evolving medical knowledge and treatment modalities, new technologies, and fluctuations within health care specialties and the healthcare workforce. Consumer demand, economic pressures, business opportunities, lifestyle considerations and access to care are all reasons that physicians move into new areas of practice. "Physician practice drift" describes the phenomenon of physicians undertaking to perform new procedures, use new technologies, or migrate into areas of practice for which they have not received formal graduate medical education. This may include areas in which these physicians are neither trained nor certified.

Physician practice drift is on the radar of state medical boards.[1] In Arizona and North Carolina, for example, the state medical boards have adopted policy statements on practice drift.[2,3] Other state medical boards have considered adopting policy on this issue.[4] These statements support the principle that physicians who practice in specialty areas, whether or not they received formal training, must be competent in all procedures they perform regardless of where they received their training.[5,6] The statements also contain considerations for physicians who are contemplating expanding their practice to an area outside of their graduate medical education. As the health care workforce continues to evolve, these and other physician practice issues will continue to be a topic of discussion and examination by state medical licensing boards.

CODE OF MEDICAL ETHICS

Physicians' obligations pertaining to competency and ethics are woven throughout the AMA *Code of Medical Ethics* (the Code). Principle I states that physicians shall be dedicated to providing competent medical care. Principle II, requires physicians to "deal honestly with patients," can reasonably be considered to encompass candid disclosure of the physician's level of training and competence with respect to services he or she offers to patients.[7] Further, according to the Code provisions on advertising and publicity, physicians' representation of their services, including claims about their education and competence, should be objective and not misleading.[8] The Code similarly provides that physicians "should make no intentional misrepresentations to increase the level of payment they receive."[9]

The Code is not an appropriate vehicle for addressing more particular scope of practice issues relating to particular medical specialties. Such specific questions are most appropriately handled by the relevant national medical specialty societies and/or licensing and credentialing bodies. For these reasons, the Board believes that new ethics policy is not required to accomplish the stated aim of Resolution 242 of promoting transparency.

While it is critical for physicians to remain competent and current in the practice of medicine, this training may not be adequate for physicians trying to practice specialty care far afield from their formal post graduate/residency training. Physicians, whether or not they received formal training, must be competent in all procedures they perform regardless of where they received their training.

TRUTH IN ADVERTISING

The AMA Truth in Advertising (TIA) model bill, known as the "Health Care Professional Transparency Act," highlights the need for health care providers to clearly and honestly state their level of training, education and

licensing.[10] The model state bill promotes clarity and transparency for patients, helping to ensure that patients are promptly and clearly informed of the training and qualifications of their health care practitioner.

Since the inception of the AMA Truth in Advertising campaign in 2009, 11 states have enacted laws based in whole or in part on the AMA model bill. In addition, the federal Healthcare Truth in Transparency Act of 2011[11] remains pending in Congress.

There are two main requirements under the TIA model bill. First, the health care practitioner must wear a name tag during all patient encounters that clearly identifies the type of license held by the health care practitioner. Second, the health care practitioner must display in his or her office a writing that clearly identifies the type of license held by the health care practitioner.

Recognizing the interest in extending the ideal of transparency to marketing and advertising related to specialty certification, the model bill includes a drafting note[12] that addresses transparency in specialty certification. The drafting note provides that a medical doctor or doctor of osteopathic medicine may not hold oneself out as board certified unless the advertisement states the full name of the certifying board, and the certifying board either:

1.   is a member of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA); or
2.   requires successful completion of a postgraduate training program approved by the Accreditation Commission for Graduate Medical Education or the AOA that provides complete training in the specialty or subspecialty certified, followed by prerequisite certification by the ABMS or AOA board for that training field and further successful completion of examination in the specialty or subspecialty certified.

This drafting note is based on current state laws regarding disclosure of board certification status and was created with the input and feedback of state and national medical specialty societies as well as the AMA Scope of Practice Partnership.[13]

Therefore, the AMA TIA model bill as currently written adequately ensures that patients are properly informed when making healthcare decisions about a physician's training. The AMA state Advocacy Resource Center (www.ama-assn.org/go/arc) will continue to work with interested states and specialty societies to advance such legislation.

RECOMMENDATIONS

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

1.   That our American Medical Association Policies E-5.02 and E-9.132 be reaffirmed.

2.   That our AMA continue to work with interested state and national medical specialty societies to advance truth in advertising legislation.

3.   That our AMA continue to monitor legislative and regulatory activity related to physician practice drift.

4.   That Policy H-410.952 be rescinded.

REFERENCES

1   O'1Donnell J. States lax in regulating cosmetic surgery. USA Today. December 28, 2011. ("This is on the radar of many state boards," says Humayun Chaudhry, a physician and CEO of the Federation of State Medical Boards (FSMB). "What doctors should or shouldn't do when they change their area of focus is a concern for everyone.")
2   Arizona Medical Board. Scope of Practice Guidelines. 2008.
    www.azmd.gov/Files/Guidelines/ScopeOfPracticeGuidelines.pdf.
3   North Carolina Board of Medical Examiners. Position Statement: Physician Scope of Practice. March 1, 2011.
    www.ncmedboard.org/position_statements/detail/physician_scope_of_practice/.
4   See Minutes, Nevada State Board of Medical Examiners. October 3-4, 2008. Available at
    www.medboard.nv.gov/Meeting%20Minutes/2008/October%203%20&%204,%202008.pdf.
5   Arizona Medical Board. Scope of Practice Guidelines. 2008.
    www.azmd.gov/Files/Guidelines/ScopeOfPracticeGuidelines.pdf.

6   North Carolina Board of Medical Examiners. Position Statement: Physician Scope of Practice. March 1, 2011.
     www.ncmedboard.org/position_statements/detail/physician_scope_of_practice/.
7   "I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and
     rights. II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to
     report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities." AMA
     Principles of Medical Ethics. Available at www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-
     ethics/principles-medical-ethics.page.
8   AMA Policy E-5.02. Advertising and Publicity. Available at www.ama-assn.org/ama/pub/physician-resources/medical-
     ethics/code-medical-ethics/opinion502.page.
9   AMA Policy E-9.132. Health Care Fraud and Abuse. Available at www.ama-assn.org/ama/pub/physician-
     resources/medical-ethics/code-medical-ethics/opinion9132.page.
10   AMA members are invited to visit www.ama-assn.org/go/tia to learn more about the AMA Truth in Advertising Campaign.
11   H.R. 451 (112th Congress, 1st Session).
12   Drafting notes are voluntary and for use at the discretion of state medical associations and state lawmakers.
13   See, Ca Bus. & Prof. Code, §680.5; Fla. Admin. Code. Ann. 64B8-11.001 (2010); 30-17 Miss. Code. R. § 1:24 (2008); and
     Utah Code Ann. 58-67-806 and 58-68-806.

6. NEW SPECIALTY ORGANIZATION REPRESENTATION 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 D-600.984

The Board of Trustees and the Specialty and Service Society (SSS) considered the application of the American Society of Echocardiography and the Gay and Lesbian Medical Association for representation in the American Medical Association (AMA) House of Delegates. The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the House Policy G-600.020 for national medical specialty organizations and House Policy G-600.022 for Professional Interest Medical Associations. A summary of the guidelines is attached under Exhibit A. Objective guidelines are: numbers 1, 3, 4, 5, 6, 7, 8, 9, and 10. The subjective guideline is number 2.

Organizations seeking admission were asked to provide appropriate membership information to the AMA. That information was analyzed to determine AMA membership, as required under criterion 3.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by the organization's explanation of how it meets each criterion.

Before a society is eligible for admission to the House of Delegates, it must participate in the SSS for three years. The American Society of Echocardiography and the Gay and Lesbian Medical Association both meet that requirement and have been members in good standing.

Review of the materials and discussion during the SSS meeting at the 2012 Interim Meeting indicated that the American Society of Echocardiography and the Gay and Lesbian Medical Association meet all the criteria for representation in the House of Delegates.

RECOMMENDATIONS

Therefore, the Board of Trustees recommends that the American Society of Echocardiography and the Gay and Lesbian Medical Association be granted representation in the AMA House of Delegates and the remainder of this report be filed.

APPENDIX

Exhibit A – Guidelines for Representation in and Admission to the House of Delegates

1. The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.
2. The organization must (a) represent a field of medicine that has recognized scientific validity; and (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 5 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.

Guidelines for Representation in and Admission to the AMA House of Delegates for Professional Interest Medical Associations

Professional Interest Medical Associations (PIMAs) are organizations that relate to physicians along dimensions that are primarily ethnic, cultural, demographic, minority, etc., and are neither state associations nor specialty societies. The following guidelines will be utilized in evaluating PIMA applications for representation in our AMA House of Delegates (new applications will be considered only at Annual Meetings of the House of Delegates):

1. The organization must not be in conflict with the Constitution and Bylaws of our AMA;
2. The organization must demonstrate that it represents and serves a professional interest of physicians that is relevant to our AMA's purpose and vision and that the organization has a multifaceted agenda (i.e., is not a single-issue association).
3. The organization must meet one of the following criteria: (i) the organization must demonstrate that it has 1,000 or more AMA members; or (ii) the 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 our AMA; or (iii) that the organization 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 our 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 the profession, 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 meet the above guidelines.

Exhibit B – Responsibilities of National Medical Specialty Organizations

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 organizations 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 to the actions taken by the House of Delegates at each meeting
5. To provide information and data to the AMA when requested.

7. 2012 GRANTS AND DONATIONS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This informational financial report details all grants or donations received by the American Medical Association during 2012

Grants & Donations for the Year Ended December 31, 2012
Amounts in thousands

Funding Institution	Project	Amount Received
Agency for Healthcare Research and Quality	Patient Safety Organization Privacy Protection Center	$ 118
Centers for Disease Control	Communications & Training Grant on Terrorism	4
Centers for Disease Control	Health Information Security Card	520
Centers for Disease Control	Disaster Medicine and Public Health Preparedness Journal – June 2012 Issue	20
Centers for Medicare & Medicaid Services (via Brandeis University)	Episode Grouper for Medicare Project	137
Centers for Medicare & Medicaid Services (via Mathematica Policy Research, Inc.)	ARRA HITECH Eligible Professional Clinical Quality Measures	641
Department of Veterans Affairs	Disaster Medicine and Public Health Preparedness Journal – 10th Anniversary of 9/11	40
National Highway Transportation Safety Administration	Engage Physicians in Addressing Older Driver Safety	99
Office of the National Coordinator for Health Information Technology (via Booz Allen Hamilton)	Hospital and Ambulatory Electronic Clinical Quality Measures	63
Substance Abuse and Mental Health Services Administration (via American Academy of Addiction Psychiatry)	Prescribers' Clinical Support System for Opioid Use	39
Substance Abuse and Mental Health Services Administration (via Synergy Enterprises, Inc.)	Technical Assistance Guidelines on Billing Systems	138
Government Funding		1,819
All Children's Hospital, Inc.	Study of Alternative Immunization Schedules	8
Fenway Health	GLBT Grand Rounds Program	2
Immunization Action Coalition	National Influenza Vaccine Summit	31
Respiratory Health Association of Metropolitan Chicago	Chicago Tobacco Prevention Project	66
Nonprofit Contributors		107
Pfizer, Inc.	GLBT Grand Rounds Program	35
Pharma Funding		35
Association of Pakistani Physicians of North America	AMA International Medical Graduates Section Reception	6
Educational Commission for Foreign Medical Graduates	AMA International Medical Graduates Section Reception	5
Kessenick Gamma & Free, LLP	Educational Seminar for Resident and Fellow Section	2
Contributions less than $5,000	AMA International Medical Graduates Section Reception	12
Other Contributors		25
Total Grants and Donations		$ 1,986

8. VIRTUAL REFERENCE COMMITTEES IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of Reference Committee F.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND
                   REMAINDER OF REPORT FILED**
                   See Policy G-600.045

At the 2009 Annual Meeting the House of Delegates adopted several elements from the report of the Speakers'
Special Advisory Committee, one of which called for virtual reference committees (VRCs) to be pilot tested in the
House. (Formerly catalogued as an American Medical Association (AMA) policy, the specific language was sunset
by Joint Report 1-A-12 of the Council on Constitution and Bylaws and Council on Long Range Planning and
Development because the practice has been incorporated into routine House procedures.) This report is provided as
part of the promised evaluation of the VRC process. It reviews the overall experience with the VRCs and
recommends their continued use.

BACKGROUND

The Speakers' Special Advisory Committee had been established in 2008 to "to study ways to improve the various
processes that the House uses to conduct its business." One of the Committee's proposals was to establish virtual
reference committees, stating:

> Modern technology enables an organization to do work online that was previously done on-site. This not only
> saves time during on-site meetings, it also enables the work to be spread out over a longer period, making better
> use of people's time and often improving the quality of the deliberative process by expanding the sources of
> input. The reference committee process used in the HOD could be done virtually. This process has been very
> successfully used by the Young Physicians Section and offers a model to the House and to other AMA sections.
> The process of gathering testimony would be virtual, and the reference committee reports to the HOD would be
> drafted in advance by the reference committees based on testimony received in this manner. The draft reference
> committee reports would become the agenda for the on-site reference committee hearings. This would hopefully
> make the on-site hearings shorter and more focused. Eventually, as the virtual process is evaluated, further
> refinements to the reference committee process could be considered.

The Committee specifically recommended "that virtual reference committees be conducted online in advance of
HOD meetings and that pre-prepared reference committee reports become the agenda for the on-site reference
committee hearings." The House did not adopt this language, opting instead simply to call for VRCs to be pilot
tested in the House (i.e., the adopted language was silent on the issue of draft reports) and encouraging all the
sections to do likewise. VRCs were launched the following year.

EXPERIENCE WITH VIRTUAL REFERENCE COMMITTEES

The inaugural VRCs were offered at the 2010 Annual Meeting, at which time three (of eight) reference committees
accepted online comments. That initial pilot was marred by what might charitably be called an unfriendly user
interface that required potential users to request login credentials and then wait for permission to access the site, and
it was immediately clear that for the VRC process to take root, different software was necessary. Participation was
minimal; for example, Reference Committee B had a total of seven comments. No specific use was made of the
comments that were submitted, save a single mention in the report of the Reference Committee on Amendments to
Constitution and Bylaws.

For the 2010 Interim Meeting only a single reference committee launched a VRC, but it used different software.
Users were still required to sign in but used the same login credentials as any other members-only section of the
AMA website, and that system includes the capability of generating a (or recovering a forgotten) user ID. Thus,
users experienced only a minimal delay in accessing the system. While this dramatically eased access to the system,
participation remained quite low. The VRC included 19 items of business, but only seven items drew comments,
with two items responsible for 14 of the 28 total comments. The reference committee report included two specific
comments taken from the VRC.

Like the previous meeting, only a single reference committee hosted a VRC at the 2011 Annual Meeting, but the experiment was expanded by using the online testimony to prepare a preliminary report "for consideration at the on site hearing." The intent was not to limit testimony at the live hearing but to gauge the value of the online commentary and test the limits of a VRC. As the *Speakers' Letter* noted,

> free and complete testimony will be allowed at the on-site reference committee hearing, which will not in any way be limited by the virtual process. We believe this process will allow everyone to address the business in [the reference committee], including those who must attend other reference committee hearings on Sunday.

Participation increased over the preceding meeting. Eighteen items were posted online, and all elicited at least one comment, with the total number of comments climbing to 51 spread more or less evenly across the items. More telling was the preliminary report, which rather closely paralleled the final report of the reference committee, and in the House, the presentation of the report saw no extractions for the 20 items of business.

Following this relatively successful experience, the same plan was expanded to include all reference committees for both the 2011 Interim Meeting (New Orleans) and the 2012 Annual Meeting. That is, each reference committee solicited online comments for proposed items of business via the VRC and prepared a preliminary report. Ideally the preliminary report was meant to be the focus of onsite hearings, although it was again specified that free and complete testimony on either the reference committee's preliminary report or the original item of business would be acceptable. Clarification on the role of a preliminary report was also provided at the latter meeting, namely, that the report was not to be considered reference committee's settled recommendation but only that it reflected the testimony provided to that point. In fact, at the 2011 Interim Meeting two final reports changed dramatically from the preliminary versions, and similar, non-trivial changes were common at the 2012 Annual Meeting.

While the results at neither meeting matched the exceptional case from the 2011 Annual Meeting, the number of participants in the VRCs continued to increase for both meetings (i.e., I-11 and A-12) as did the overall number of comments. For the 2012 Annual Meeting, for example, 648 total comments were posted on the items proposed for consideration, which for the first time included eight reference committees. Not every item received a comment, but most did. For both meetings, a few non-delegates provided a handful of comments, thus opening the AMA policymaking process to the general member.

The final experiment with VRCs was conducted at the 2012 Interim Meeting in Honolulu, which had five reference committees, all of which included a VRC. Planning for that meeting, however, called for only three of the reference committees to prepare a preliminary report. Thus, the meeting offered a combination of the early and the later experience. No clear effect of a planned report is apparent in the following table, which details the VRC participation for each reference committee, separately for reports and resolutions.

Reference Committee	Reports	Comments[*]	Resolutions	Comments[*]	Preliminary Report
Con & Bylaws	4	40	0	-	Yes
B	1	4	15	79	No
F	2	13	0	-	Yes
J	6	30	12	44	No
K	7	25	12	43	Yes

*Not including postings providing background (e.g., related policy)

Common Elements Across all Virtual Reference Committee Trials

As outlined above, slight operational changes in the VRCs were made at each meeting. At the same time several elements were consistent across all trials. Most importantly, the VRCs have been open only to AMA members; not even Federation staff, who can access many members-only elements of the AMA website, are allowed access to the VRCs (unless they are member physicians). This means that the general membership has a chance to submit comments, offering them a voice in the development of AMA policy. Over the last several meetings, specific outreach has been directed to the general membership, and while the response is far from overwhelming, a number of members who are not part of the House of Delegates have submitted comments and engaged the process.

The items included in the VRCs have of necessity been restricted to those appearing in the initial Handbook, which generally contains those items of business submitted by about 45 days before any given HOD meeting. This allows 16-18 days for items to appear online and spans three weekends, during which time people may post comments, and it allows another week for the reference committee to prepare a preliminary report that can in turn be made available to the House several days ahead of the opening of the HOD meeting. This timeframe, although tight, seems to have been functional and balanced the time allowed to post comments with need for timely turnaround.

Relative to the number of items posted in the VRCs, the number of comments has increased at each meeting, albeit quite slowly. The average number of comments per item for the 2012 Interim Meeting was 4.7, not including background information provided by reference committee staff or council members. At the same time the overall level of participation is rather small. Among members of the House, posting multiple comments across a number of items is fairly common. Whether this reflects an individual delegate's particular interests, reference committee assignments or a willingness to go online is unknown. To the extent other AMA members have participated, comments seem to be limited to a single item. A few contributors have used the VRCs to post relatively extensive comments, sometimes including a link or reference to an external document or other website. It was expected that this would be an advantage in the operation of the VRCs, but most people have not used the option. The bottom line is that the posting of comments—whether by members of the House or the general membership—is minimal.

Notwithstanding the low frequency of posts in the VRCs, the number of views—people looking at an item of business—is relatively high. While the number of unique individuals cannot be determined, the average number of views per item has ranged between 88 and 114 over the last three HOD meetings.

VIRTUAL REFERENCE COMMITTEE CONCERNS AND BENEFITS

Some concerns about the use of VRCs have been expressed from the beginning, and they can be thought of as practical considerations and bylaws concerns. In the former realm have been concerns related to the role of the VRCs. Some people have expressed the view that an online forum is qualitatively different from the live hearing, lacking the give and take of a live hearing and limiting participation to a subset of the House, which may not be representative.

Arising more recently are concerns about the preliminary reports. Specifically, preliminary reports have created unease among some members of the House who believe that the reports are based on too small a set of comments and that the reference committee has consequently settled on a recommendation with insufficient input. A related concern has been that the preliminary report has become the focus of discussion in the live hearing, downplaying the original item of business.

While these concerns are without question well meaning, actual operation of the reference committees and current House procedures have effectively blocked anticipated ill effects and rendered the issues moot. Reference committees have on multiple occasions modified preliminary reports to reflect the totality of commentary, whether submitted online or provided in the live hearing. In addition, the live hearings have always allowed a speaker to choose to address the original item or the preliminary report; no options have been foreclosed. More to the point, the reference committee report—no matter what its basis—is not definitive until the House acts. This is readily apparent in the number of extractions that arise in the presentation of reference committee reports to the House and the debate that routinely eventuates in changes to a reference committee's suggested action.

Concerns about the authority to employ VRCs under the AMA's bylaws were initially raised in the whereas clauses of Resolution 605 at the 2012 Annual Meeting. In essence, the propriety of accepting testimony and preparing a report prior to the opening of the House of Delegates was questioned. Neither the AMA's Office of the General Counsel nor the Council on Constitution and Bylaws thought the process violated the bylaws, particularly in light of the fact that discussion of any item of business in the onsite committees was the norm. The resolution was not adopted, with the reference committee noting that research "indicated that the use of virtual reference committees does not violate AMA Bylaws, and this fact was confirmed by on-site testimony provided by the Council on Constitution and Bylaws."

Benefits of Virtual Reference Committees

At least two benefits of VRCs are apparent. First, a VRC affords the general membership an opportunity to provide input on proposed AMA policy. While hardly normative, a few members have participated. This opportunity for member engagement should not be undervalued, as considerable evidence suggests that member voice and engagement are attractive considerations, particularly among younger members and those who prefer not to travel to meetings. Second, the VRCs seem to have allowed the onsite hearings to move along more quickly. In 2012's meetings, the reference committee hearings took about an hour less time than had been the case previously. The VRCs may lessen the likelihood of repetition during the onsite hearings, or they might permit noncontroversial or straightforward items to move along more quickly, accelerating the overall pace of the hearing.

DISCUSSION

The virtual reference committee process has gone through several trials, with irregular results. On the one hand, participation in the form of comments has been low, and some members of the House doubt the validity of the process, particularly preliminary reports. On the other hand, the number of people submitting comments or looking at the online material—the latter of which is considerably larger than the former—is increasing over time, and the VRCs afford the only current mechanism by which a member can be engaged in the AMA's policymaking process.

The Speakers' Special Advisory Committee had proposed the VRCs to make better use of people's time and expand sources of input. The VRCs piloted thus far seem to have succeeded on both counts. Moreover these benefits have accrued with minimal additional costs and without disadvantaging anyone in the House. The VRCs have the specific advantages of allowing small delegations to provide input on any item of interest by avoiding the problems associated with concurrent reference committee hearings as well as allowing reference to supporting materials that members of the House can independently evaluate, something that is rarely possible in a three or four hour hearing.

Some have suggested that the VRCs be restricted to discussion only and that preliminary reports not be prepared. The advantages of such a process are not apparent, and such a step would likely discourage participation in the online forums. Preliminary reports only suggest the direction of the reference committee's recommendations in light of the commentary provided up to that point in time, and experience has shown that changes are common; preliminary reports may also reveal those items for which there is general agreement and likely adoption, with the attendant benefit of shortening the onsite hearing.

In a similar vein preparing preliminary reports for only some of the reference committees has been proposed. Again advantages are not apparent, and no evidence thus far indicates that the VRCs benefit only some of the reference committees and not others.

RECOMMENDATIONS

The Speakers' Special Advisory Committee recommendation for virtual reference committees and attendant House action led to the piloting VRCs. As a committee of the House of Delegates (established under §2.66 of the bylaws) the Speakers' Committee ceased to exist at the end of 2009, and in the absence of another House committee, the Board of Trustees has provided this review of the virtual reference committee experience. It is not, however, the purview of the Board to determine House procedures; those are solely the province of the House itself. This report then is primarily a vehicle to allow the House to decide on the future of the VRC process.

The Board recommends that the VRC process continue, with every reference committee collecting comments online and preparing a preliminary report. This recommendation stems from the fact that virtual reference committees are described in current House procedures, and as just noted, changes in House procedures are at the discretion of the House. In the absence of harm to the Association, your Board supports the House of Delegates' earlier decision to deploy VRCs. Whether the House chooses to retain the VRCs or to terminate the experiment, your Board is prepared to implement the decision.

With those caveats in mind and after reviewing the experience with virtual reference committees, the Board of Trustees recommends the following statements be adopted and the remainder of the report filed.

1. That virtual reference committees be incorporated into every House of Delegates policymaking meeting, using the following parameters:
    - Each reference committee should participate in the virtual reference committee process;
    - Each virtual reference committee should cover as many items of business as possible, including, at minimum, those items that appear in the initial compilation of the Delegate Handbook;
    - Comments submitted to a virtual reference committee should be used to prepare a summary report that reflects the comments received up to that point;
    - Full, free and complete testimony should be allowed in the onsite hearings; and
    - The Speakers should experiment with alternative procedures to enhance and improve the overall virtual reference committee process.

2. That the Council on Constitution and Bylaws review the virtual reference committee process to ensure compatibility with the AMA Bylaws and propose amendments if deemed necessary.

9. PAIN MANAGEMENT AND THE HOSPITAL VALUE BASED PURCHASING PROGRAM (RESOLUTION 708-A-12)

Reference committee hearing: see report of Reference Committee G.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 708-A-12 AND
REMAINDER OF REPORT FILED**
See Policies H-450.982 and D-450.962

INTRODUCTION

Resolution 708-A-12 introduced by the Illinois Delegation and referred by the House of Delegates asked:

That our American Medical Association work with the Centers for Medicare & Medicaid Services to support the development of an accurate and meaningful evaluation tool to assess pain control and management during hospital and emergency department visits as well as remove reimbursement decisions that are related to such subjective surveys.

Resolution 708-A-12 was prompted by the development and implementation of the hospital value-based purchasing program (VBP) and its use of performance measures, including patient experience surveys that incorporate metrics on satisfaction with pain management services. This report briefly reviews the VBP, its associated patient experience survey instrument, and some related issues involving pain management, patient satisfaction, physician behavior, and healthcare facility practices.

HOSPITAL VALUE-BASED PURCHASING PROGRAM

In April 2011, the U.S. Department of Health and Human Services formally launched a new initiative designed to adjust hospital Medicare reimbursement on the basis of quality measurements. The Hospital VBP program, established by the Affordable Care Act and administered by the Centers for Medicare & Medicaid Services (CMS), seeks to reward hospitals that meet or exceed performance standards on a set of quality measures. This is accomplished by redistributing a portion of Medicare dollars via value-based incentive payments starting with FY 2013 for inpatients discharged on or after October 1, 2012. To determine whether a hospital meets or exceeds performance standards, its achievement (as well as its improvement) is assessed during a specific performance period compared with its performance during a 3-quarter baseline period (July 1, 2009 to March 31, 2010). For FY 2013, the available funding pool equals 1.00 percent of the base-operating diagnosis-related group (DRG) payments, which are initially withheld from all participating hospitals. The funding pool increases to 1.25 percent of base-operating DRG payments for FY 2014, 1.50 percent for FY 2015, 1.75 percent for FY 2016, and 2.0 percent for FY 2017 and successive fiscal years.

The Hospital VBP Total Performance Score (TPS) for fiscal year 2013 has two domains: the Clinical Process of Care Domain (accounting for 70% of the score) and the Patient Experience of Care Domain (accounting for 30% of

the score). Both an "achievement" and "improvement" score are derived using a linearly transformed 10 point scale. The achievement score is based on the difference between the measure's *achievement threshold* (i.e., minimum level of performance for consideration) and a *benchmark* that is established according to the highest levels of performance among hospitals during the baseline period. The improvement score is based on how a hospital's current performance compares with its prior performance during the baseline period. Hospitals are scored on each measure to determine a score for each domain, weighting each score (70% or 30% depending on the domain) to calculate the TPS. The TPS is determined by combining the greater of the hospital's achievement or improvement points for each measure. CMS converts each hospital's TPS into a value-based incentive payment percentage.

Clinical Process of Care Measures

Hospitals are already familiar with measuring quality based on the Hospital Inpatient Quality Reporting (IQR) program implemented by CMS in 2005. Twelve clinical process of care measures were adopted from CMS's IQR program for the initial VBP program. Measures may be added, changed, or retired over time. Indeed, the VBP Program as currently outlined contains an evolving framework of quality measures through 2016, including new process measures, mortality outcome measures, and an efficiency measure (Medicare spending per beneficiary). The framework for FY 2015 and beyond is subject to additional rulemaking.

Patient Experience Measures-The HCAHPS Survey

Patient experience measures for the VBP program are derived from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, also known as the CAHPS® Hospital Survey. HCAHPS is a national, standardized, publicly reported survey of patients' perspectives of hospital care during a (recent) overnight stay. The 27 question survey, developed by a broad partnership of public and private organizations and endorsed in 2005 by the National Quality Forum, is designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to patients. Patients are contacted to complete the survey after they leave the hospital. Hospitals can self-administer the survey or use an approved vendor, but data analysis is accomplished by CMS.

HCAHPS addresses patient perspectives on eight composite topics. In addition to pain management, communication with doctors or nurses, responsiveness of hospital staff, communication about medicines, provision of discharge information, and the cleanliness and quietness of the hospital environment are measured.

The three survey questions on pain management are:
- During this hospital stay, did you need medicine for pain? (Yes, No)
- During this hospital stay, how often was your pain well controlled? (Never, Sometimes, Usually, Always)
- During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? (Never, Sometimes, Usually, Always)

The survey also includes a question about the patient's overall rating of the hospital and whether they would recommend the hospital to a friend. Publicly reported HCAHPS results are based on four consecutive quarters of patient surveys (www.hospitalcompare.hhs.gov). Public reporting of survey results is designed to create incentives for hospitals to improve their quality of care. The current VBP Program framework retains use of HCAHPS to evaluate patient experiences through at least 2016.

Joint Commission Pain Management Standards

Prior to the development and use of HCAHPS, standards on the assessment and monitoring of pain went into effect in 2001 for The Joint Commission (TJC) accredited ambulatory care facilities, behavioral health care organizations, critical access hospitals, home care providers, hospitals, office-based surgery practices, and long term care providers. The standards require organizations to:

- recognize the right of patients to appropriate assessment and management of pain;
- screen patients for pain during their initial assessment and, when clinically required, during ongoing, periodic re-assessments;
- educate patients suffering from pain and their families about pain management;
- address the individual's needs for symptom management in the discharge planning process; and

- integrate pain management into the organization's performance measurement and improvement program.

Few studies have examined whether adoption of TJC pain management standards *per se* improved the quality of pain management; some "before and after" retrospective chart reviews found little evidence of significant improvements.

PAIN MANAGEMENT IN HEALTHCARE FACILITIES

Pain is one of the most common reasons for patients to seek medical attention and one of the most prevalent medical complaints in the U.S. The goals of pain management vary from patient to patient. When pain is acute, the overriding goal is to reduce pain intensity as quickly as possible, often in association with amelioration of its underlying cause. In those with persistent pain related to a serious medical illness, such as cancer, the goal of comfort may become linked to other concerns, such as the relief of other symptoms and management of diverse problems undermining physical, psychosocial and spiritual well-being. Although systemic pharmacotherapy is the mainstay approach in the treatment of acute and many types of persistent pain, optimal pain management includes diverse nonpharmacologic therapies. These include an array of non-invasive strategies and a large number of invasive approaches that can be administered in a multidisciplinary manner. The HCAHPS survey focuses on the use of pharmacotherapy.

As a perception, pain may or may not correlate with an identifiable source of injury. The distinction between nociceptive and neuropathic pain represents an important clinical inference about the pathophysiology that is likely to be sustaining the pain and which treatments are appropriate. Pain is modified by individual experiences, medical and psychiatric comorbidities, genetics, cultural beliefs, cognition, expectations, emotions and memory. As a result, pain management must be tailored for each individual. The clinical challenge in doing so may be increased in those populations particularly vulnerable to inadequate assessment or management. These populations include newborns and young children, the elderly (including those with cognitive impairment), racial/ethnic minorities, and other groups that share characteristics that may increase the risk of poorly controlled pain. The latter include cancer patients and those with advanced illnesses of other types, those with English as a second language and those with relatively low socioeconomic status.

Pain Assessment

There is another important implication of the concept of pain as perception–it is almost always best to believe that the patient is experiencing what is being reported, unless there is strongly compelling evidence to the contrary. Because there is no objective indicator for pain (and pain cannot be proved or disproved), experts agree that the best clinical approach in most circumstances is to assume that the patient is reporting a true experience, even in the absence of a clear pathologic explanation. Accepting a patient's complaint of pain as valid does not require clinical identification of a physical cause or demand the initiation of a specific treatment.

This assessment process can be straightforward and brief in the setting of acute pain related to trauma or surgery. It increases in complexity and the time required as the pain becomes persistent, fails to respond to conventional therapy, or occurs in a biomedical or psychosocial context that complicates the understanding of the pain or otherwise poses challenges in management.

Assessing Pain Intensity

Pain is inherently subjective and patient self-reports are the gold standard in assessment. Quantifying the intensity of pain is an essential part of initial and ongoing pain assessment. A variety of validated pain scales are available to assist in the measurement of pain including simple unidimensional scales or multidimensional questionnaires (e.g., McGill Pain Questionnaire, Brief Pain Inventory). Pain measurement should include both the time-frame and the clinical context of the pain. Patients with acute pain are usually asked to describe their pain "right now" and may be asked about the average intensity over a fixed period of time in order to provide information on the course of the pain. With persistent pain, experts often find it useful to inquire about pain over the previous week and obtain separate measures for pain "on average," pain "at its worst," and pain "at its least."

Unidimensional scales used in measuring pain intensity include the Verbal Rating Scale (VRS), Numeric Rating Scale, Visual Analog Scale, or a Pictorial Scale. The choice of pain scale may depend on the patient's age, ability to

communicate, or other specific circumstances. The VRS (i.e., "none," "mild," "moderate," and "severe") is the simplest measure, but the finer gradations in the other scales may provide additional information; a numeric scale is usually applied in hospitals.

Adequacy of Pain Management

Many disease-specific or syndrome-specific guidelines for pain management have been published, some of which are based on good evidence and some of which have become widely accepted. Despite the availability of practice guidelines, and notwithstanding the current public health harms attributable to prescription drug abuse, undertreatment of pain remains a problem in some settings and for some prevalent conditions. Most attention has been directed to patients presenting to the emergency department with acute pain, pain management after surgery, cancer pain, and end-of-life care. Complicating factors for the emergency department (ED) include patients with persistent noncancer pain who are experiencing painful exacerbations, and patients with substance use disorders who are either seeking additional medication or are experiencing discomfort from withdrawal. Pain management in the ED is important as patients responding to the HCAHPS survey generally do not differentiate by area of the hospital, so if they get admitted through the ED, survey questions they answer reflect their entire experience with the hospital. Patients suffering from persistent pain may end up hospitalized for various reasons and then experience clinical deterioration during hospitalization. Pain management in these types of patients, both in the ED and once hospitalized, is very challenging and is unlikely to result in patient satisfaction.

Barriers to Pain Management

Several barriers contributing to disparities in pain management or undertreatment of acute pain have been identified involving clinicians, patients, or other aspects of the healthcare system. Physicians and other healthcare providers may consider pain an inevitable and accepted part of life, or be influenced by biases. Biases that affect therapeutic decision-making may be based on race, ethnicity or culture, age or gender. Additional clinician barriers include inadequate pain assessment and/or training in pain management and overreliance on behavioral cues.

INFLUENCE OF PATIENT SURVEYS ON OPIOID PRESCRIBING

In addition to the use of HCAHPS to measure inpatient experiences, hospitals may use other survey instruments to regularly evaluate patient satisfaction, including their satisfaction with pain management. Such survey instruments may be used to structure compensation (or job retention/promotion) based on whether physicians meet benchmarks on certain performance measures, including patient satisfaction. They also may be used as an integral part of marketing and benchmarking of hospital services. Physicians' clinical skills also may be rated based on results obtained from anonymous patient surveys on publicly available, for-profit physician-grading websites.

Physicians who refuse to prescribe opioids to certain patients may pay the price in the form of a poor rating. Consequently, some physicians may feel pressured into prescribing opioids in order to meet satisfaction metrics by which they (and their practices) are judged. Ethical tensions are created by the challenges of trying to satisfy patients, while refusing inappropriate requests.

COMMENT

The Joint Commission's introduction in 2001 of a hospital accreditation standard that requires monitoring of pain prompted hospitals to assess patients' pain, a practice that was further promoted when CMS began publicly reporting HCAHPS results in 2006. The Medicare VBP program is now established with an underlying framework in place extending several years into the future. Several competing interests intersect in the use of patient satisfaction surveys such as HCAHPS and in decisions about how prominently they should factor into healthcare pay-for-performance incentives. As mentioned, HCAHP was endorsed by the NQF, of which our AMA is a member. Questions related to pain management comprise <4% of the hospital's TPS for the VBP program. Poor performance on this metric is likely not due to the lack of validated instruments for measuring pain, a process which is based on subjective report.

As with any survey, limitations to the HCAHPS exist. Some analyses suggest that HCAHPS has unintended biases. For example, some of the nation's most prestigious hospitals receive poor patient reviews despite getting high scores on clinical quality metrics and conversely, many hospitals that receive high patient satisfaction ratings have low

clinical quality marks. Safety net hospitals perform more poorly than other hospitals on nearly every HCAHPS measure of patient experience. Teaching hospitals and other large hospitals also score more poorly, on average, than do small community hospitals. Unexplained geographic disparities in patient satisfaction scores exist as well. Therefore, questions about the general applicability of HCAHPS as an indicator of quality of care persist, but there is general agreement that the survey targets important patient experience dynamics.

Few would argue that adoption of TJC standards failed to increase the frequency of pain assessment, documentation, and monitoring. However, unless practices and care-based approaches are in place that promote communication with patients and appropriate pain management, patient satisfaction on this metric will suffer. The reimbursement implications of the HCAHPS survey should promote the development and implementation of protocols and processes for optimal pain management.

While not a specific endorsement, current AMA policies are consistent with the broad objectives of the Medicare VBP Program. Policy H-450.982, "Patient Satisfaction and Quality of Care," notes that much may be gained by encouraging physicians to be sensitive to the goals and values of patients, and that "efforts should be continued to improve the measurement of patient satisfaction and to document its relationship, if any, to favorable outcomes and other accepted criteria." Policy H-285.951, "Financial Incentives Utilized in the Management of Medical Care," supports the view that the "use of financial incentives in the management of medical care should enhance the provision of high quality, cost-effective medical care." Finally, Policy H-140.872, "Physicians Pay-for-Performance Programs," supports the view that "compensation arrangements should be designed to improve health care quality and patient safety by linking remuneration to measures of individuals, group, or organizational performance" and "to uphold their ethical obligations, physicians who are involved with pay-for-performance programs must take appropriate measures to promote patients' well-being." As the Medicare VBP program continues to evolve, efforts should be made to more formally evaluate how patient experience measures are related to hospital performance on clinical quality measures.

RECOMMENDATIONS

The Board of Trustees recommends that the following statements be adopted in lieu of Resolution 708-A-12 and the remainder of the report be filed.

1. That our American Medical Association urge the Centers for Medicare & Medicaid Services to: (a) evaluate the relationship and apparent disparity between patient satisfaction, using the Hospital Consumer Assessment of Health Providers and Systems survey, and hospital performance on clinical process and outcome measures used in the hospital value based purchasing program; and, (b) reexamine the validity of questions used on the HCAHPS survey related to pain management as reliable and accurate measures of the quality of care in this domain.

2. That our AMA urge the Centers for Medicare and Medicaid Services to suspend the use of HCAHPS measures addressing pain management until their validity as reliable and accurate measures of quality of care in this domain has been determined.

3. That Policy H-450.982, "Patient Satisfaction and Quality of Care," be reaffirmed.

10. PREVENTING DEATHS AND INJURIES FROM DISTRACTED WALKING

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND
**   REMAINDER OF REPORT FILED**
                            See Policy H-15.952

Policy D-10.992, adopted at the 2012 Annual Meeting, asks that our American Medical Association (AMA): (1) as a champion of public health, will include distracted walking as one of the preventable hazards in its published and distributed materials on lifestyle medicine; (2) will utilize established channels of communication with internal and external media to increase public awareness of the hazards caused by distracted walking; (3) will write to

appropriate federal and state agencies encouraging them to reevaluate the safety of the roads and intersections for the walking public in their respective jurisdictions; and (4) will report back at the 2013 Annual Meeting summarizing actions which are likely to make walking safer for people.

Limited testimony was offered on the resolution. While the resolution was well-intended, no published evidence was presented to support the requested actions. Considering the AMA's new strategic direction, the reference committee had concerns about limited resources to implement this resolution and therefore recommended that it not be adopted. However, debate on the floor of the House of Delegates led to an adoption of this resolution.

This report reviews current data regarding the prevalence of pedestrian injury in the U.S. as related to the safety of roads and intersections and provides an overview of national efforts to reduce such injury. It also summarizes the current policies and efforts of the AMA with regard to injury prevention and road safety.

INTRODUCTION

In 2010, the National Highway Traffic Safety Administration (NHTSA) reported that 4,280 pedestrians died and approximately 70,000 were injured in motor vehicle accidents on public traffic ways.[1] According to NHTSA, there are multiple factors which influence pedestrian injuries and fatalities, to include land use (urban vs. rural), non-motorist location, weather, time-of-day, day-of-week, age, gender, and substance use and/or abuse (either for the driver or the pedestrian).[1] As a result, NHTSA offers a number of resources on pedestrian, bicycle, and motorist safety awareness, as well as guidelines for road safety, and even a Safe Routes to School program for children and parents.

ELECTRONIC DEVICES AS CONTRIBUTORS TO DISTRACTED WALKING

Use of electronic devices may be a growing cause of walker distraction, which can be seen as a threat to pedestrian safety. A recent study found that the incidence of pedestrians who have suffered serious personal injury in traffic accidents while wearing headphones had more than tripled in the last six years.[2] The author cites two likely causes, "inattentional blindness" where the pedestrian is distracted by the device, and sensory deprivation where the pedestrian is unable to hear warning sounds which are masked by the device. In addition to auditory distraction, there is also growing concern about cell phone texting while walking. Another study revealed that cell phone use by pedestrians led to more than 1,000 ER visits throughout the country in 2008.[3]

As this is an emerging field of research, there is little science on the effective policies to address accidents related to distracted walking. Some states have begun safe walking campaigns, while others are addressing the problem through police enforcement of "careless walking." This issue has received increased media attention. National organizations such as the U.S. Department of Transportation, Federal Highway Administration, and American Association of State Highway and Transportation Officials' have been working with agencies at the state, regional, and local levels to in order to improve pedestrian safety. Such efforts include the development of guidelines for sidewalk improvement and installation, as well as the funding of such projects.[4] A multi-faceted approach, incorporating both public education and awareness as well as lasting improvements to the built environment, should contribute to improved safety for all individuals.

AMA POLICY AND EFFORTS

The AMA has numerous policies pertaining to injury prevention, particularly regarding the safety of roads/highways as well as the vehicles and drivers on the nation's roads. Such policies address motor vehicles, motorcycles, trucks, bicycles, skating, impaired drivers, and older drivers. The AMA also has policies pertaining to the built environment for recreational exercise and texting while driving. Detailed information regarding these policies is available in the Appendix. In August 2012, the AMA sent a letter to NHTSA encouraging federal and state agencies to reevaluate the safety of the roads and intersections for the walking public in their respective jurisdictions.

CONCLUSION

Early data indicate that distracted walking is a public health concern, and the number of injuries resulting from distracted walking may increase as more Americans are encouraged to increase their physical activity. More

research is needed, however, to understand the contributors to the problem as well as effective strategies to prevent injury. Other organizations are better suited to conduct this research and propose and promote effective strategies.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public.

2. That our AMA encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.

3. That AMA Policy D-10.992 be rescinded.

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APPENDIX – Related AMA Policies

H-10.982 Injury Prevention
Our AMA (1) supports the CDC's efforts to (a) conduct research, (b) develop a national program of surveillance and focused interventions to prevent injuries, and (c) evaluate the effectiveness of interventions, implementation strategies, and injury prevention programs; (2) supports a Public Health Service public information campaign to inform the public and its policymakers of the injury problem and the potential for effective intervention; (3) supports the development of a National Center for Injury Control at the CDC; and (4) encourages state and local medical societies to support, in conjunction with state and local health departments, efforts to make injury control a priority, and advise the leadership of the United States Congress of this unqualified support; and the AMA remains open to working with all interested parties in efforts to deal with and lessen the effects of violence in our society. (Res. 410, A-92; Reaffirmed by BOT Rep. 19 - I-94; Reaffirmed by BOT Rep. 34, A-95; Modified and Reaffirmed by BOT Rep. 52, I-95; Reaffirmed: CSA Rep. 8, A-05)

D-470.993 Government to Support Community Exercise Venues
Our AMA will encourage: (1) towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities; and (2) governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities. (Res. 423, A-04)

H-15.990 Automobile-Related Injuries
The AMA (1) Encourages physicians to increase their awareness of the still largely overlooked problem of motor vehicle-related injuries and to discuss with their patients how they can avoid or prevent such injuries. (2) Calls for the establishment of a reduction in motor vehicle injuries as a national goal. (3) Reaffirms its support for the development of effective passive crash protection systems for occupants of motor vehicles. (4) Strongly endorses and encourages the use of active restraints, such as lapbelts, lapbelt-shoulder harnesses, and those that are approved for children. (5) Encourages motor vehicle manufacturers to develop automobiles with stronger passenger compartments that would more effectively protect occupants, and with interiors having fewer protuberant objects and hard surfaces that could cause injuries in crashes. (6) Continues to support state and federal legislative efforts to strengthen drunk driving laws and their enforcement. (7) Encourages national and federal organizations, such as the National Institutes of Health, the National Highway Transportation Safety Agency, and the National Science Foundation, and appropriate private groups, to devote more of their resources to research concerning vehicle-related injuries and their prevention. (8) Urges states to review their standards for the construction and maintenance of roads and highways. The standards should be based on current engineering knowledge and good practice, particularly as related to use of skid-resistant surfaces; shoulder grading; drivers' lines of vision; removal of obstructions; and separation of opposing traffic streams. (9) Encourages state and local officials to monitor streets, roads, and highways to identify sites with disproportionate risks of crashes, in order to take appropriate remedial actions. (10) Encourages continued study of the effect of increasing the legal age at which young

persons may drink alcoholic beverages and supports increased study of behavioral factors in crashes, such as those relating to education, training and driving experience; school, family and work problems; aggression; depression and personality disorders; use of drugs; and criminal behavior. (11) Believes that, before the adoption of passive crash protection systems and devices to reduce motor vehicle injuries, industry and government demonstrate through field studies that such systems and devices are effective, safe, cost-effective and acceptable to drivers. (CSA Rep. I, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-15.952 Ban the Use of Hand-Held Devices While Driving
1. Our American Medical Association encourages physicians to educate their patients regarding the public health risks of text messaging while operating motor vehicles or machinery and will advocate for state legislation prohibiting the use of hand held communication devices to text message while operating motor vehicles or machinery. 2. Our American Medical Association will endorse legislation that would ban the use of hand-held devices while driving. (Res. 217, I-08; Appended: Res. 905, I-09)

D-15.999 Options for Improving Motorcycle Safety
Our AMA: (1) encourages the National Highway Traffic Safety Administration to work with medical and public health organizations, national motorcycle rider organizations, state motor vehicle licensing agencies, law enforcement officials, and the motorcycle industry to develop a comprehensive national motorcycle safety plan that addresses rider education, training, and licensing; use of motorcycle helmets and other protective gear; public awareness of motorcycles; alcohol use among motorcyclists and other motor vehicle drivers; measures to increase the visibility of motorcyclists and motorcycles to other drivers; engineering and design of motorcycles and highway environments; and research to determine the effectiveness of current and proposed safety measures; and (2) encourages physicians to (a) be aware of motorcycle risks and safety measures and (b) counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs. (CSA Rep. 6, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

See also:
- H-15.978 Voluntary Highway Lights-On Campaign
- H-15.970 Trucks and Highway Safety
- H-15.954 Older Driver Safety
- D-15.996 Impaired Drivers
- H-10.969 In-Line Skating

11. DESIGNATION OF SPECIALTY SOCIETIES FOR REPRESENTATION IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

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 policy also directed the preparation of annual reports, "describing efforts undertaken to solicit designations from members, characterizing progress in collecting designations and recommending changes in strategies that are required to implement existing policy on representation of specialty societies."

The mechanism for specialty society delegate allocation is based on a formula that looks at the societies' 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 is to increase the number of ballots cast 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 the recommendation of BOT 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%).

The mechanism that allocates specialty society delegates uses 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 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%).

Members continue to be encouraged through a variety of AMA publications, including *Morning Rounds, AMA Wire* and *AMNews,* to visit the ballot website and make their designation. All specialties have been encouraged to use both electronic communications and their websites to promote the ballot to their members. The paper ballot continues to be included in the AMA Welcome Kits sent to all new and renewing members and ballots continue to be distributed at specialty society meetings when possible. Despite strong efforts and a steady flow of ballots coming into the AMA, the numbers have failed to move and suggest that it may be time to examine the current system.

TIE TO THE FIVE-YEAR REVIEW

The data collected for the five-year review is often confused for data used for determining a society's delegate allocation. While both processes count specialty society members and are a part of determining the society's representation in the House of Delegates, they are separate processes. The five-year review requires specialty societies to submit membership data and a letter proving that they are compliant with the requirements of the AMA bylaws for continued representation in AMA House of Delegates. The five-year review process determines a specialty society's eligibility to have representation in the House of Delegates. The ballot process then determines how many seats the society is entitled to in the House of Delegates. Often, the two processes are confused as being the same because of the membership requirements.

Combining the two activities would clarify and streamline the specialty society representation and delegate allocation processes, saving time and resources that could be directed towards increasing membership. If the five-year review data were to be used to determine both eligibility and allocation, specialty society representation would be more representative of specialties' AMA membership. One single process would provide the specialty societies with a greater incentive to meet the requirements of specialty societies seated in the HOD, which in addition to meeting a twenty percent (20%) membership threshold, would also call for organizations to cooperate with the AMA in increasing AMA membership.

Consideration was given to looking at each member's self-designated specialty selection to determine the allocation. However, it was determined that the five-year review data will provide a better assessment of which specialties should receive credit for each member. The strongest factor in this determination is that the representation is of the specialty society itself, not the practice of that specialty. It is a fact that some members will be counted for more than one specialty, but upon close examination, those numbers are not substantial enough to significantly increase a subspecialty's delegation size. Most subspecialties represented in the House of Delegates have fewer than 1000 (AMA) members and will therefore not gain additional delegates. Further study of this issue is called for, but beyond the purview of this report.

RECOMMENDATIONS

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

1. That the current specialty delegation allocation ballot system be discontinued and that specialty society delegate allocation be determined in the same manner as state medical society delegate allocation based on membership numbers allowing one delegate per 1000 AMA members.

2. That the membership data used to determine the delegate allocation be the data that the specialty societies are required to submit every five years to determine their representation in the House of Delegates.

3. That this system is implemented beginning with the delegate allocation process for 2014.

4. That organizations that do not meet the five-year review criteria be allowed a one-year grace period to meet the requirements and that their delegation is frozen until the end of the grace period.

5. That this 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.

12. SEPARATE PALLIATIVE DEATHS FROM THE MORTALITY STATISTICS
(RESOLUTION 225-A-12)

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
                   IN LIEU OF RESOLUTION 225-A-12 AND
                   REMAINDER OF REPORT FILED**
                   See Policy D-70.962

At the 2012 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 225 to the Board of Trustees for the development of a report back to the House at the 2013 Annual Meeting. Introduced by the Michigan Delegation, the resolution asks that:

> Our AMA work with the Centers for Medicare & Medicaid Services (CMS) to develop a separate mortality statistic for hospital patients receiving comfort care so that mortality data reported in the quality reporting sites depicts the actual quality of care delivered.

Testimony on this resolution expressed support for the general concept of improved quality data reporting, particularly with mortality statistics. The reference committee reported that it agreed with testimony that the concept of a separate palliative death measurement needs further study and definition before our AMA proceeds in this regard, particularly with advocacy to external organizations.

This report summarizes briefly the measure development and methodology for the CMS 30-day risk-standardized mortality measures and the challenges in constructing a separate mortality measure for hospital patients receiving comfort care.

CMS MORTALITY MEASURES AND METHODS USED TO ACCOUNT FOR PALLIATIVE CARE

The CMS 30-Day Risk-Standardized Mortality Measures for Acute Myocardial Infarction (AMI), Heart Failure (HF), and Pneumonia were developed by a team of clinical, quality, and statistical experts from Yale and Harvard Universities, who worked in collaboration with CMS. The all-cause mortality measures are based on three years of administrative Medicare claims data that hospitals submit to CMS for payment and Veterans Health Administration (VA) administrative data for the calculation of the measures. Using three years of data increases the number of admissions per hospital which increases the precision of the estimated mortality rates. Using administrative claims data makes it possible to calculate the mortality measures without requiring manual chart abstraction or requiring hospitals to report additional data to CMS.

The measures are also aligned with the American Heart Association and the American College of Cardiology published standards for statistical models used for calculation and public reporting of health outcome measures. The measures are also validated by models based on clinical data. The National Quality Forum (NQF) endorsed the AMI, HF, and pneumonia mortality measures in 2007. The NQF re-endorsed the AMI and HF mortality measures after additional review as part of standard measure maintenance in January 2012. The pneumonia mortality measure is expected to undergo maintenance and review in the near future.

Organizations developing and reporting hospital mortality measures use a variety of approaches to account for palliative care (PC) in calculating hospital mortality.[1] For example, HealthGrades excludes cases that were coded with the V66.7 ''Palliative Care Encounter'' ICD-9 CM diagnostic code.[2] CMS only excludes patients who were enrolled in the Medicare hospice program at any time during the 12 months prior to the index admission or who enrolled in the hospice program on the first day of the index admission.[3] Starting in 2013, the measures also exclude those patients who were enrolled in VA hospice programs prior to or on the day of admission to a VA facility. Patients in those two cohorts make up about 0.8% of cases for AMI, 1.4% for HF, and 1.6% for pneumonia in the years 2008-2010.[4] On an average annual basis, these percentages also represent relatively small numbers of patients for each condition; less than 1,800 for AMI, and less than 7,000 for both HF and pneumonia.

CHALLENGES IN CONSTRUCTING A SEPARATE MORTALITY MEASURE
  FOR PATIENTS RECEIVING COMFORT CARE

CMS is aware of the stakeholder interest in also excluding patients who choose comfort care at any point during the index admission. CMS opposes this approach based on the methodological position presented in a section from their response to Frequently Asked Questions on the mortality measures, which states …"consistent with guidelines for health care quality outcome measures, the 30-day mortality measures do not exclude patients who transitioned to hospice or palliative care during their hospital stay because such transitions may be the result of quality failures that have led to poor clinical outcomes, and, thus, excluding these patients could mask quality problems. Importantly, use of palliative care is not necessarily an indication that a patient is no longer seeking life-sustaining measures. Palliative care is focused on providing patients relief of symptoms. It is increasingly used by patients who are not at the end of life and, therefore, should not be used to exclude patients from a mortality measure." [5]

Evidence exists that PC is related to mortality.[6] But, upon manual review of hospital stay records Kroch and co-authors found patients who received PC services were not always identified by a V66.7 code. [7] This could be at least partially explained by the V66.7 code not being included high enough along the secondary diagnoses on the Medicare data files.[8] The Agency for Healthcare Research and Quality (AHRQ) also questions the reliability of the V66.7, and does not include the code in Quality Indicator (QI) calculations partially because it does not specifically identify hospice care. [9] AHRQ provides additional support for excluding V66.7 from QI based on AHA Coding Clinic for ICD-9-CM, 1Q 1998, Volume 15(1):11: "Terms such as comfort care, end-of-life care, and hospice care are all synonymous with palliative care. These, or similar terms, need to be written in the record to support the use of code V66.7." Hence, using V66.7 and the signal it provides fails to provide a clear indication of the goals of care during a specific hospital stay.

There is not a separate code for comfort care. As a result, data are not readily available for calculating a separate mortality measure for hospital patients receiving comfort care. Code V66.7 can be used to include "comfort care," "end-of-life care," or "hospice care," but would require the additional burden of abstracting hospital stay records for documentation.

AMA POLICY

Policy H-85.974 (1) supports the position that efforts to improve cause of death statistics are indicated and necessary; (2) endorses the concept that educational efforts to improve death certificates should be focused on physicians, particularly those who take care of patients in facilities where patients are likely to die, namely in acute hospitals, nursing homes and hospices; and (3) endorses the concept that training sessions in completion of death certificates should be (a) included in hospital house staff orientation sessions and clinical pathologic conferences; (b) integrated into continuing medical education presentations; (c) mandatory in mortality conferences; and (d) included as part of in-service training programs for nursing homes, hospices and geriatric physicians.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 225-A-12 and that the remainder of this report be filed:

1. That our American Medical Association continue to monitor the development and performance on the CMS 30-day mortality measures, and enrollments in the Medicare hospice program and the VA hospice programs.

2. That our AMA support efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care."

3. That our AMA continue to work to have CMS exclude palliative patients from mortality measures.

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[8] Cassel JB, Jones AB, Meier DE, et al. Hospital mortality rates: how is palliative Care Taken into account? J Pain Symptom Management. 2010; 40(6):914-925.
[9] Agency for Healthcare Research and Quality, Quality Indicator Development, FAQ questions. 2012. (http://www.qualityindicators.ahrq.gov/FAQs_Support/FAQ_QI.aspx)

13. MEDICARE/MEDICAID COVERAGE OF MULTI-USE TECHNOLOGY PLATFORMS (RESOLUTION 707-A-12)

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: **RECOMMENDATION ADOPTED**
                      IN LIEU OF RESOLUTION 707-A-12 AND
                      REMAINDER OF REPORT FILED
                      See Policy H-480.948

At the 2012 Annual Meeting, Resolution 707, Advocacy for Medicare/Medicaid Coverage of Multi-Use Technology Platforms for Augmentative and Alternative Communication Devices, was referred. The resolution, introduced by the Wisconsin Delegation, asked:

> That our American Medical Association support promoting the medical application of consumer technologies through new strategies for reimbursing the functionality software for multi-use platforms, which will increase consumer choices in medical equipment and cost-savings while allowing for seamless integration of healthcare technology into daily living; and

> That our AMA discuss these measures at the 2012 (*sic*) Annual Meeting.

Reference Committee G noted that limited testimony had been provided on the resolution and suggested referral for a report that could address several complex issues such as potential payment options for consumer electronics and associated medical applications.

BACKGROUND

According to the whereas clauses of the resolution, more than 2.5 million US citizens require an augmentative and alternative communication device for their normal daily functions, and traditional devices cost several thousand dollars, have no other uses and are not portable in some settings. At the same time, newer consumer electronic devices such as smartphones and tablet computers can be loaded with appropriate software (applications or "apps"), which makes them useable as assistive devices. Under current regulations from the Centers for Medicare and Medicaid Services, however, such devices are ineligible for reimbursement because they are functional for other uses in the absence of an illness or injury.

Though not intended, the reference committee's commentary accurately captures a key issue with this resolution, namely that the question is complex. Our AMA lacks suitable in-house expertise to study the matter and therewith

develop a meaningful, articulate rationale for such regulatory changes, notwithstanding the fact that on the surface, lobbying for such may seem reasonable.

RECOMMENDATION

Your Board of Trustees recommends that the following policy be adopted in lieu of Resolution 707-A-12 and the remainder of the report be filed.

> That AMA policy be that third party payers, including the Medicare and Medicaid programs, should investigate the possibility of allowing patients to use common consumer electronic devices as assistive devices and reimburse patient expenses related to the acquisition of such devices when used for bona fide health care needs.

14. DIRECT-TO-CONSUMER ADVERTISING OF DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES (RESOLUTION 505-A-12)

Reference committee hearing: see report of Reference Committee A.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 505-A-12 AND
REMAINDER OF REPORT FILED**
See Policies H-330.945, H-330.955, H-330.960 and D-330.913

At the 2012 Annual Meeting, the AMA House of Delegates (HOD) referred Resolution 505-A-12 to the Board of Trustees (BOT). Resolution 505-A-12 was sponsored by the North Carolina Delegation and asked that our AMA pursue legislation or regulation as appropriate to require that direct-to-consumer advertising (DTCA) for durable medical equipment (DME) and other medical supplies in any media:

1. include a disclaimer statement to the effect that eligibility for and coverage of the illustrated product is subject to specific criteria and that only a physician can determine if a patient meets those criteria;
2. whenever feasible list the actual criteria (or a summary thereof) from the appropriate Certificate of Medical Necessity;
3. note that patients who knowingly obtain DME or other supplies without meeting the eligibility criteria and the physicians who inappropriately certify such patients may be subject to civil and/or criminal penalties for fraud; and
4. refrain from statements to the effect that only a physician order or signature is required to obtain the desired items.

This report provides a brief overview of the significant growth in health care costs associated with coverage of DME and supplies, the current scope of government regulation of DTCA for DME and supplies, the corresponding regulatory burdens imposed on physicians as a result of increased oversight by insurers such as Medicare because of this growth, and the benefits and risks of the policy proposed in Resolution 505-A-12.

BACKGROUND

Medical products that are sold through retail channels typically are ineligible for insurance reimbursement. In order for a product to be covered and paid for by an insurer (in full or in part), it must be classified into a benefit category by the insurer. DME and supplies are a benefit category that is defined by payers such as Medicare. (Medicare typically groups policies concerning DME, prosthetics, orthotics, and supplies together and refers to them with a catch-all acronym—DMEPOS, but applies different coverage standards.)

CMS identifies DME as equipment which: (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; (3) generally is not useful to a person in the absence of an illness or injury; and (4) is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be DME by Medicare. The DME must also be medically necessary and prescribed by a physician in order to be covered. The majority of Medicare beneficiaries participate in Medicare Part B, which helps pay for DME items and

supplies. DME and supplies that are covered by insurers such as Medicare include oxygen, wheelchairs, hospital beds, walkers, prosthetics/orthotics, and supplies. Other public and private insurers may use different criteria to define and cover DME and supplies.

Rapid Growth in DME and Supplies Costs

Industry analysts have reported that DME and supplies sales reached $26 billion in 2010 and the forecasted 2013 sales are projected to reach $31 billion. Rapid growth in this area may be attributed to an aging population, insurer coverage policies, as well DTCA. As a result of the growth in this area and other concerns, Congress has passed legislation that expands the federal government's authority and regulatory oversight over DME and supplies in the Medicare program.

The heightened scrutiny by the federal government has imposed substantial paperwork and documentation burdens on physicians. For example, as part of a demonstration project, Medicare is requiring physicians' orders for power wheelchairs and scooters in seven states to undergo a prior authorization process by a contractor before suppliers can fill the orders. Thus, as the documentation requirements become more onerous for physicians, the demand by patients for certain DME and supplies is growing prompted by DTCA, among other things such as aging population, insurer coverage policies.

Oversight and Advertising of DME and Supplies

In addition to the insurance coverage requirements and program integrity related oversight activities of CMS and other insurers, at the federal level DME and supplies categorized as medical devices are subject to oversight and regulation by the Food and Drug Administration (FDA) and the Federal Trade Commission (FTC). At the state level DME and supplies may also be subject to oversight authority by regulators charged with enforcement of state consumer protection laws. Medical devices that are regulated by the FDA and/or the FTC include a wide range of products. For example, dental floss, hospital beds, and liquid bandages are all included under the umbrella of medical devices.

The FDA regulates labeling as well as the advertising of a subset of medical devices under the Food, Drug, and Cosmetics Act. Medical devices are classified by the FDA into one of three risk-based classes depending on the regulatory oversight the agency concludes is needed to ensure that the product can be safely and effectively used as intended. The FDA has the legal authority to prohibit advertisements of restricted devices that are "false or misleading in any particular." The FDA requires that advertisements for such devices must include: (1) a true statement of the device's established name; and (2) a brief statement of the intended uses of the device and relevant warnings, precautions, side effects, and contra-indications.

The FTC regulates advertising of most devices (excluding the FDA categorized restricted devices that are regulated directly by the FDA) and requires, among other things, that advertisements not be false or misleading. Under the Federal Trade Commission Act, advertisements must have "competent and reliable scientific evidence" to support health and safety claims.

DISCUSSION

Although there are a number of federal agencies that regulate DME and supplies, including any related DTCA if categorized as medical devices, the proposed DTCA disclaimers and disclosures outlined in Resolution 505-A-12, for the most part, are not required currently by any of the federal regulatory bodies for all DME and supplies. Furthermore, the following proposed disclaimers and disclosures contained Resolution 505-A-12 would increase the accuracy and the quality of information that consumers and patients receive and would minimize misleading and false conclusions often drawn from DTCA:

- eligibility for and coverage of the illustrated product is subject to specific criteria and that only a physician can determine if a patient meets those criteria;
- a list of the actual criteria (or a summary thereof) from the appropriate Certificate of Medical Necessity, where feasible; and,
- exclusion of statements to the effect that only a physician order or signature is required to obtain the desired items.

The last provision should be current practice in order to ensure that regulated DTCA is accurate in light of the documentation often required by Medicare and other insurers to obtain coverage for certain DME and supplies.

There have been periodic accounts by physicians that DTCA for drugs, implantable devices, and DME and supplies may contribute to unrealistic patient expectations. Most recently, the U.S. Senate Special Committee on Aging held a hearing on "Eliminating Waste and Fraud in Medicare: An Examination of Prior Authorization Requirements for Power Mobility Devices" where a geriatrician offered testimony describing the impact of misleading DTCA, including disruption and, in some cases, termination of an established physician-patient relationship because his patient relied on inaccurate DTCA that minimized or failed to accurately advertise insurance coverage requirements. Physicians have reported patients are disgruntled when they conclude that the patient does not qualify for the requested DME based on existing Medicare criteria.

There is one proposed disclaimer included in Resolution 505-A-12 that attempts to summarize the various legal standards governing health care civil and criminal health care fraud—specifically, it is the resolve calling for a statement to accompany DTCA "that patients who knowingly obtain DME or other supplies without meeting the eligibility criteria and the physicians who inappropriately certify such patients may be subject to civil and/or criminal penalties for fraud." The laws governing health care fraud and abuse are numerous, complex, and varied.

The above disclaimer attempts to summarize the various federal and state legal standards governing fraud. Our AMA's adoption of this disclaimer could be viewed as either an implicit or explicit endorsement of a new or arbitrarily low legal standard to support federal or state efforts to impose civil or criminal liability for misunderstandings or determinations that may be open to reasonable disagreement among well-intentioned practitioners. For example, if a patient knows they are not eligible for DME and a physician who is unaware that a patient is "knowingly" seeking items, but inadvertently (and "inappropriately") certifies such patient, this disclaimer provides that the physician "may be subject to civil and/or criminal penalties for fraud." Also, there are a host of reasons why a physician's inadvertent certification may be deemed "inappropriate," including confusion over regulations or the eligibility criteria, inaccurate or misleading information supplied by the patient or another person, or a transcription or typographical error, for example. Thus, the disclaimer is overly broad and may create incorrect inferences with regard to applicable legal standards for establishing liability for fraud.

Further, the incorporation of such a disclosure into AMA policy concerning DTCA DME could result in unintended consequences. Physician-patient discussions should focus on the appropriate medical treatment for the patient, and therefore the appropriate use of DME. The language in the proposed disclaimer may influence patients to seek opinions from their physicians on what may or may not constitute fraud. It is more consistent with current AMA policy to emphasize the physician's role to deliver health care services and not serve as a legal advisor.

Relevant Policy

The AMA has extensive policy concerning DME and supplies including two policies that concern DME DTCA and are generally consistent with three of the disclaimers/disclosures recommended for adoption in Resolution 505-A-12. First, H-330.955 Prescription of Durable Medical Equipment provides that the AMA will call on physicians to be aware of the abuses caused by product-specific advertising by manufacturers and suppliers of durable medical equipment, the impact on the consumers of inappropriate promotion, and the contribution such promotion makes to unnecessary health care expenditures. In addition, H-330.945 Durable Medical Equipment Requirements provides that our AMA will: (1) continue to seek legislation to prohibit unsolicited contacts by durable medical equipment suppliers that recommend medically unnecessary durable medical equipment to Medicare beneficiaries; and (2) reaffirm the concept that physicians are solely responsible for the medical needs of their patients and should be the initiators of orders for durable medical equipment. (Sub. Res. 205, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmation A-04). Both H-330.945 and H-330.955 are consistent with the first, second, and fourth disclaimers/disclosures in Resolution 505-A-12, because all three would minimize misleading and potentially false DTCA without imposing additional regulatory burdens on physicians.

RECOMMENDATION

In view of these considerations, the Board of Trustees recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That policies H-330.945 Durable Medical Equipment Requirements, H-330.955 Prescription of Durable Medical Equipment, and H-330.960 Cost of Medically Related Services and Supplies be reaffirmed.

2. That Resolution 505-A-12 be amended by addition and deletion to read as follows and adopted:

    That our American Medical Association pursue legislation or regulation as appropriate to require that direct-to-consumer advertising and any other media for durable medical equipment and other medical supplies:

    (a) include a disclaimer statement to the effect that eligibility for and coverage of the illustrated product is subject to specific criteria and that only a physician can determine if a patient meets those criteria;
    (b) ~~whenever feasible~~ list the actual criteria (or a summary thereof) from the appropriate <u>source, such as the applicable</u> Certificate of Medical Necessity<u>, DME Information form (DIF), "Dear Physician Letter" from DME Contractor Medical Directors, Local Coverage Determination or associated policy article</u>; and
    (c) ~~note that patients who knowingly obtain DME or other supplies without meeting the eligibility criteria and the physicians who inappropriately certify such patients may be subject to civil and/or criminal penalties for fraud; and,~~
    (d) ~~~~refrain from statements to the effect that only a physician order or signature is required to obtain the desired items.

3. That our AMA recommend that DME companies stop coercive acts which in appropriately influence physicians to sign these prescriptions for their patients.

REFERENCES

H-330.945 Durable Medical Equipment Requirements - The AMA will: (1) continue to seek legislation to prohibit unsolicited contacts by durable medical equipment suppliers that recommend medically unnecessary durable medical equipment to Medicare beneficiaries; and (2) reaffirm the concept that physicians are solely responsible for the medical needs of their patients and should be the initiators of orders for durable medical equipment. (Sub. Res. 205, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmation A-04)

H-330.955 Prescription of Durable Medical Equipment - (1) The AMA continues to voice its objection to CMS regarding its onerous requirement that physicians initiate and complete the entire certification of medical necessity form for durable medical equipment. (2) The AMA calls for CMS to revise its interpretation of the law to permit that the physician's prescription be the only certification of medical necessity needed to initiate an order for and to secure Medicare payment for durable medical equipment. (3) The AMA calls on physicians to be aware of the abuses caused by product-specific advertising by manufacturers and suppliers of durable medical equipment, the impact on the consumers of inappropriate promotion, and the contribution such promotion makes to unnecessary health care expenditures. (Res. 203, I-92; Reaffirmation A-97; Reaffirmation A-04)

15. EQUAL ACCESS TO ORGAN TRANSPLANTATION FOR MEDICAID BENEFICIARIES (RESOLUTION 1-I-11)

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: RECOMMENDATION ADOPTED AS FOLLOWS
                            IN LIEU OF RESOLUTION 1-I-11 AND
                            REMAINDER OF REPORT FILED
                            See Policy H-370.962

At the 2011 Interim Meeting, the House of Delegates (HOD) referred Resolution 1-I-11, which was introduced by the Florida Delegation. Resolution 1-I-11, "Equal Access to Organ Transplantation for Medicaid Beneficiaries," asked that our American Medical Association (AMA) urge the Centers for Medicare & Medicaid Services (CMS) to designate organ transplantation care and services, which are covered by Medicare, to be designated as mandatory benefits under Medicaid and deemed life-saving and essential, such that Medicaid coverage throughout the United States be uniform, predictable, and enabling regarding access to life-saving care. Although the Reference Committee on Amendments to Constitution and Bylaws recommended adoption, the HOD voted to refer Resolution 1-I-11 for the development of a Board report to the HOD at the 2012 Annual Meeting. The HOD considered BOT Report 27-A-12 addressing Resolution 1-I-11, and referred the report back to the Board.

BACKGROUND

Resolution 1-I-11 was precipitated by controversy created when the state of Arizona cut funding for optional services, including certain organ transplantation services, for Medicaid beneficiaries in 2010 in the face of a looming budget crisis and revenue shortfalls. The action to cut specific transplants affected nearly 100 Arizona Medicaid patients on the transplant waiting list. Critics, including the American Society of Transplantation, the American Society of Transplant Surgeons, and the United Network for Organ Sharing, argued that in its attempt to balance the budget, Arizona had relied on flawed and outdated data, which had led to coverage decisions with no medical justification. In April 2011, after a concerted lobbying campaign and public pressure, the state restored funding for the previously defunded organ transplantation services.

Medicaid Coverage of Organ Transplantation

The Medicare program generally offers coverage for transplant of the eight types of organ transplants: kidneys, kidney-pancreas, pancreas, heart, heart-lung, liver, and intestines. To receive full Medicare benefits for a transplant, a beneficiary must go to a Medicare-approved transplant program. Unlike the Medicare program, which is federally financed and administered, Medicaid is a jointly financed partnership between the federal government and states. The federal government provides matching dollars for allowable state spending on Medicaid, while states administer the program on a day-to-day basis. States have a fair amount of flexibility to design and administer their own programs; thus, state variation is the rule rather than the exception in terms of covered services and how those services are delivered and reimbursed. To participate in Medicaid, states are required to meet federal core requirements, which include covering a specified set of core eligibility groups—e.g., children, pregnant women, parents, elderly individuals, and individuals with disabilities up to specified minimum income levels. States are further required to cover specified benefits: inpatient and outpatient hospital services, physician services, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children. In light of the diverse health needs of enrollees, states may also choose to cover a broad range of optional benefits for which they may receive federal matching funds, including, but not limited to, prescription drugs, clinic services, dental services, and long-term care services and supports.

Organ transplants are not included in the list of mandatory services, nor are they included in the definitions of any of the mandatory categories, such as inpatient hospital services. Organ transplantation is not specifically listed under optional services either, although states and CMS treat coverage for organ transplantation as an optional service under Medicaid.[1] However, transplant services for children may be required under EPSDT even if they are not otherwise covered by the state's Medicaid plan, insofar as EPSDT requires coverage of any medically necessary services, treatment, and care.[2]

If a state chooses to cover organ transplants in its Medicaid plan, the plan must meet the following requirements in order to receive federal financial assistance for these types of procedures: 1) written standards for coverage of organ transplants must be provided; 2) the standards must treat similarly situated individuals alike; and 3) restrictions on the facilities or practitioners who may perform transplants must not deny recipients access to high quality care.[3] The meaning of this provision—e.g., whether it is an express grant of discretion to the states in their decisions to fund organ transplants under Medicaid, or simply sets out the conditions for federal matching funds in transplant procedures, should the states choose to cover them—has been the subject of litigation in federal courts, with the appellate courts reaching different conclusions, and remains unsettled.[4] Some transplants may be excluded from Medicaid coverage as experimental, and states may also impose standards relating to medical necessity.[5] However, few, if any, states systematically deny coverage for organ transplantation.

As one of the top-line items in most state budgets, Medicaid programs have been subject to cuts for several years as states have faced declining revenues. The most common cost containment strategies have included reducing provider payment and expanding managed care, but states have also closely examined their optional services. According to the Kaiser Family Foundation, over a third of states reduced physician payment rates for at least one year from fiscal year 2010 through fiscal year 2012.

The Patient Protection and Affordable Care Act (ACA) includes significant coverage expansions under Medicaid, as well as new eligibility and enrollment systems that coordinate with the state-based or federal Health Insurance Exchanges (Exchange), but at the same time prevents states from cutting existing eligibility requirements. As a result, states confronting budget challenges are effectively limited to considering cuts in optional benefits and

provider reimbursement in their Medicaid programs. In addition, ongoing Congressional efforts to reform entitlement spending could result in future cuts in Medicaid funding and further increase financial pressure on states.

Essential Health Benefits

Beginning January 1, 2014, the ACA requires that all non-grandfathered individual and small group health insurance plans sold in a state, including those offered through an Exchange, offer a core package of items and services, known as "essential health benefits" (EHBs). Under the statute, EHBs, at a minimum, must include items and services within the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. EHBs must be equal in scope to benefits offered by a "typical employer plan." To meet this requirement in every state, the final CMS rule implementing the ACA EHB provision defines EHB based on a state-specific benchmark plan. States can select a benchmark plan from among several options, including the largest small group private health insurance plan by enrollment in the state. The final rule provides that all plans subject to EHB requirements offer benefits substantially equal to the benefits offered by the benchmark plan and also gives issuers the flexibility to offer innovative benefit designs and a choice of health plans. EHBs also must be provided to certain categories of Medicaid beneficiaries, including those newly eligible under the ACA's provision expanding Medicaid coverage up to 133 percent of the federal poverty level (i.e., in those states that opt to expand their Medicaid programs). Rather than imposing a single, nationwide uniform set of benefits, CMS has allowed states to choose a benchmark plan, as long as it covers the ten essential health benefits categories.

AMA POLICY

AMA policy in Opinion E-2.16 (Organ Transplantation: Guidelines) provides that organs should be allocated to recipients in keeping with Opinion E-2.03 (Allocation of Limited Medical Resources), which holds that decisions to allocate limited medical resources should be based on medical criteria, including likelihood of benefit, urgency of need, change in quality of life, and duration of benefit. E-2.03 specifically prohibits the use of non-medical criteria "such as ability to pay, age, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources." These provisions are reiterated in Policy H-370.982 (Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources among Patients).

Our AMA also has long-standing policy regarding physicians' ethical obligation to support access to medical care for all people. Principle IX of AMA's *Principles of Medical Ethics* holds that physicians "shall support access to medical care for all people." Opinion E-9.0651 (Financial Barriers to Health Care Access) similarly holds that "As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means." AMA policy also calls for reducing health care disparities (E-9.121 [Racial and Ethnic Disparities in Health Care], H-350.974 [Racial and Ethnic Disparities in Health Care]) and observes that health insurance coverage can play a role in creating or perpetuating disparities (H-350.989 [Health Insurance Differences Contribute to Health Care Disparities and Poorer Outcomes]).

At the same time, however, AMA policy recognizes that in addition to their obligations to individual patients, physicians and the medical profession as a whole have obligations to promote public health and responsible stewardship of heath care resources. E-9.0651 calls on the profession to "ensure that societal decisions about the distribution of health resources safeguard the interests of <u>all</u> patients and promote access to health services" (emphasis added). E-9.0652 (Stewardship of Health Care Resources) acknowledges physicians' dual responsibility to individual patients and the public and calls on physicians to be "prudent stewards of the societal resources with which they are entrusted."

Opinion E-2.03 does not prohibit considerations of cost in allocating scarce resources, such as organs for transplantation, noting that "in some cases, the amount of resources required for successful treatment" may justifiably play a role in allocation decisions. The opinion goes on to note that decision-making mechanisms for allocating limited resources should be "objective, flexible, and consistent to ensure that all patients are treated equally."

AMA policy with respect to Medicaid addresses both the scope of the program and benefits covered. Policy both supports sustaining and expanding Medicaid as a safety net program, in H-290.974 (Status Report on the Medicaid Program), H-290.971 (Expanding Enrollment for the State Children's Health Insurance Program [SCHIP]), H-290.979 (Strategies for Increasing Access and Expanding Health Insurance Coverage), and H-290.986 (Medicaid and Efforts to Ensure It Maintains Its Role as a Safety Net), and encourages alternatives to public sector expansion, including federally issued tax credits to allow acute care patients to purchase individual coverage of their choice (H-165.855 [Medical Care for Patients with Low Income]).

AMA policy supports equity in health care, through adoption of basic national standards of uniform minimum adequate benefits and the establishment of national standards that result in uniform eligibility, benefits, and adequate payment mechanisms for services across jurisdictions (H-290.997 [Medicaid—Toward Reforming the Program]). However, more recent AMA policy and advocacy with respect to benefits packages, including "essential health benefits" under the ACA, has focused on maximizing patient choice, minimizing benefits mandates, and supporting flexibility in the design of benefit plans (H-165.856 [Health Insurance Market Regulation]) and in the choice by states of EHB packages, rather than defining a new, specific benefits package for purposes of what should be included as part of the essential health benefits package. Moreover, our AMA does not have policy relative to prioritizing benefits or services in state Medicaid programs or in support of delineating specific services or benefits as mandatory in Medicaid. AMA policy has long supported state autonomy in other areas, such as medical licensure (H-275.973 [State Control of Qualifications for Medical Licensure]) and state regulation of health insurers with respect to solvency (H-180.998 [Regulation of Insurance Carriers and Health Plans]).

DISCUSSION

Taken as a whole, the body of relevant AMA policy reflects the responsibility to balance the needs of individual patients with the needs of the community of patients. AMA policy supports the dedication of each physician to serving the needs of unique, individual patients, but also recognizes the responsibility of physicians, the medical profession, and public policymakers to equitably address the needs of all patients.

AMA policy also endorses allowing flexibility in the design of benefits packages, within certain limits, and has long supported state autonomy in other areas, such as medical licensure and regulation of health insurers' solvency. AMA policy does not generally seek to prioritize or mandate benefits, especially those covered by public programs such as Medicaid. Support for mandating organ transplantation as a mandatory benefit under Medicaid would be inconsistent with AMA policy and advocacy activities relating to essential health benefit packages, where our AMA has supported a significant amount of state flexibility. Moreover, a national mandate that all states cover organ transplantation could put at risk states' ability to provide other much-needed, basic medical services for Medicaid beneficiaries. While ensuring that each patient receives timely, high quality care to meet his or her unique needs remains the ultimate aspiration, states, confronting ongoing fiscal challenges, must take on the difficult task of providing access to a wide range of services to meet the needs of populations. As states continue to confront fiscal challenges and the need to balance state budgets, they may have to make some very difficult decisions to meet short-term budget goals. Mandating that state Medicaid programs cover organ transplants could result in possible negative consequences, such as cutbacks in other critical services or to provider payment, which could further exacerbate beneficiary access to basic Medicaid services and benefits.

The Board notes that Resolution 1-I-11 calls on our AMA to urge CMS to designate organ transplantation as a mandatory and essential benefit under Medicaid. However, CMS does not have clear authority to designate organ transplantation as a mandatory benefit without Congressional action to amend federal Medicaid law (Title XIX). Also, given the focus in Congress on reducing spending for entitlement programs such as Medicaid, it is unlikely that such an amendment would pass. Further, in implementing the EHB provisions of the ACA, CMS has not specifically designated organ transplantation as an essential health benefit.

Finally, the Board notes that the action taken by Arizona, which was ultimately reversed, appears to be an isolated, albeit severe, response to one state's fiscal crisis. There have been no indications that other states that currently cover organ transplants are considering defunding such services.

In summary, to be consistent with AMA policy and recent advocacy efforts regarding the EHB package under the ACA, especially with respect to supporting state flexibility and limiting benefit mandates, your Board concludes that, on balance, policy and strategic considerations weigh against adoption of this resolution.

RECOMMENDATION

The Board of Trustees recommends that our American Medical Association support federal funding of organ transplants for Medicaid patients, that Resolution 1-I-11 not be adopted and that the remainder of the report be filed.

REFERENCES

[1] CCH Online 2012 Wolters Kluwer, WK_Medicare and Medicaid AnswersNow Medicaid - Coverage 21040 When are organ transplants covered under Medicaid.pdf. Also, correspondence from Peter W. Thomas dated March 2, 2012, outside counsel for American Society of Transplant Surgeons, Principal with Powers Pyles Sutter & Verville PC

[2] 42 U.S.C. § 1396d(r)(5)

[3] 42 U.S.C. 1396b(i); 42 C.F.R §441.35; CCH Online 2012 Wolters Kluwer, WK_Medicare and Medicaid AnswersNow Medicaid - Coverage 21040 When are organ transplants covered under Medicaid.pdf. In addition, as a condition of participation in the Medicare and Medicaid programs, hospitals must establish protocols for encouraging organ and tissue donation; payment under Medicare and Medicaid is prohibited with respect to costs for procuring organs, for an organ procurement organization that does not meet the national organ transplant network standards. 42 C.F.R. §486.301 *et seq.*

[4] Wong, Melissa. Coverage for Kidneys: The Intersection of Insurance and Organ Transplantation, 16 Conn. Ins. L.J. 535 (Spring, 2010)

[5] CCH Online 2012 Wolters Kluwer, WK_Medicare and Medicaid AnswersNow Medicaid - Coverage 21040 When are organ transplants covered under Medicaid.pdf.

16. INVASIVE PROCEDURES
(RESOLUTION 218-A-11)

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 218-A-11 AND
REMAINDER OF REPORT FILED**
*See Policies H-160.947, H-160.950, H-360.987, H-410.950, H-410.958, H-475.983
H-475.986, H-475.988, H-475.989, D-35.984 and D-35.990*

INTRODUCTION

This report stems from the referral of Resolution 218-A-11, "Physician Extenders." In Resolution 218, the New York Delegation asked our AMA to examine programs developed by government or managed care organizations where physician extenders practice independently and insist that there be Level I evidence to demonstrate that there is no diminution in the quality of patient care by programs that use non-physician providers. Resolution 218 was referred for report back on physician-led, team-based care.

In addition this report reviews several resolutions and reports of the Board of Trustees since the 2010 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD). Appendix A describes the history of these resolutions and reports. The most recent outstanding resolution is Resolution 218-A-11. The most recent HOD action–adoption of Policy D-35.984–recommended that our AMA convene a task force of appropriate AMA councils and interested state and medical specialty societies to develop principles to guide advocacy efforts aimed at addressing the appropriate level of supervision, education, training and provision of other invasive procedures by non-physician providers including those employing radiologic imaging and report back to our HOD. This report will:

1. Discuss supervision of non-physician health care professionals including advanced practice nurses and physician assistants;

2. Outline the education and training necessary to perform fluoroscopic procedures;

3. Discuss chronic interventional pain management, including the education and training necessary to perform these procedures, relevant state laws and regulations, and recent case law; and propose new AMA policy on the provision of these procedures;

4.   Define invasive procedure and propose a modification to AMA policy on the definition of surgery;

5.   Evaluate available data on patient access to anesthesia care and the effect on access to care of the opt-out of the federal requirement that physicians supervise anesthesia services; and

6.   Provide available data on the type and complexity of care provided by nurse anesthetists (CRNAs) in the opt-out states.

DISCUSSION OF HOD ACTIVITY

Policy D-35.984

At the 2011 Interim Meeting, the HOD adopted Policy D-35.984 which directed:

1.   That our AMA: (1) advocate that interventional chronic pain management including those techniques employing radiation (e.g., fluoroscopy or CT) is within the practice of medicine and should be performed only by physicians; and (2) develop appropriate model state legislation with interested state and medical specialty societies that reflects this policy.

2.   That our AMA convene a task force of appropriate AMA councils and interested state and medical specialty societies to develop principles to guide advocacy efforts aimed at addressing the appropriate level of supervision, education, training and provision of other invasive procedures by non-physicians including those employing radiologic imaging and report back to our House of Delegates.

Testimony regarding the underlying report (BOT 10-I-11) reflected agreement that interventional pain management employing radiation was an invasive surgical procedure to be performed only by physicians. Testimony also identified the need for further study, warranting the creation of a task force. Inasmuch as the AMA works closely with its state and specialty society partners to provide guidance to policymakers regarding scope of practice issues, the Board welcomes the opportunity to provide further clarity to better define concepts and terms such as "invasive procedure" to ensure that any potential new AMA policy complements existing policy on surgery.

Policy D-35.985

At the 2011 Interim Meeting, the HOD adopted Policy D-35.985, which directed the AMA to:

1.   Identify and review available data to analyze the effects on patients' access to care in the opt-out states to determine whether there has been any increased access to care in those states.

2.   Identify and review available data to analyze the type and complexity of care provided by CRNAs in the opt-out states compared to the type and complexity of care provided by physicians in the opt-out states.

Given the relation of the issues presented in Policies D-35.984 and D-35.985, your Board has chosen to address the directives of both in this combined report.

Task Force on Invasive Procedures

Pursuant to the directive of Policy D-35.984, the AMA Board created a task force consisting of members from the Council on Medical Education (CME), Council on Medical Service (CMS), Council on Legislation (COL) and Board of Trustees, as well as the American Society of Anesthesiologists, Society of Interventional Radiology/American College of Radiologists (SIR/ACR) (one task force member representing both SIR and ACR), Iowa Medical Society and Tennessee Medical Association. This report contains the recommendations of the task force.

SUPERVISION

As noted extensively in AMA communications and advocacy initiatives, the AMA strongly supports physician-led, team-based care as the optimal model of how health care ought to be delivered in the United States. This

unwavering principle helps guide the activities of AMA units across the organization, as well as AMA initiatives such as the Scope of Practice Partnership (SOPP).

Definitions of Supervision

While specific focus on AMA policy and the definition of "supervision" will be discussed below, the Board provides the following background regarding other organizations' definitions. First, the Accreditation Council for Graduate Medical Education (ACGME) defines "clinical supervision" as "time spent supervising/watching residents during patient care activities. According to ACGME, this could include rounding with residents, and time spent supervising/teaching on call."[1]

It bears noting that ACGME Program Requirements for Graduate Medical Education in Anesthesiology emphasize that supervision of resident physicians is a graduated approach of increasing responsibility. Importantly, the reason for this graduated approach is girded in patient safety.[2] These underlying principles for supervision can also be found in the ACGME program requirements for pain medicine, surgery, physical medicine and rehabilitation and diagnostic radiology, to name a few.[3]

Generally, there are three levels of "supervision" within the Centers for Medicare & Medicaid Services. This guidance provides that "direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide."[4] This guidance, which applies to billing "incident to" a physician's services, goes on to clarify that "the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services."[5]

For diagnostic services, both inpatient and outpatient, the Code of Federal Regulations generally provides three levels of supervision:[6]

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.

Overview of AMA Policy

The AMA believes that it is in the public interest to oppose enactment of legislation that authorizes the independent practice of medicine by any individual who has not completed the state's requirement for licensure to engage in the practice of medicine and surgery.[7] Accordingly, the AMA continues to actively collaborate with state and national medical specialty societies in opposing legislation allowing non-physician groups to engage in the practice of medicine.[8]

Through legislative and regulatory efforts, the AMA also vigorously supports and advocates for team-based care and the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.[9] The AMA believes that physicians–as leaders of the health care team–must retain ultimate authority for patient care in any team care arrangement (e.g., integrated care) to assure patient safety and quality of care, and that this authority must not be diluted.[10] In fact, at its 2012 Interim Meeting, the AMA adopted the following principles, from a joint report of CME/CMS, to guide physician leaders of health care teams:

> H-160.912 The Structure and Function of Interprofessional Health Care Teams
> 1. Focus the team on patient and family-centered care.
> 2. Make clear the team's mission, vision and values.
> 3. Direct and/or engage in collaboration with team members on patient care.

4. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
5. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
6. Encourage adherence to best practice protocols that team members are expected to follow.
7. Manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.
8. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
9. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
10. Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
11. Review measures of "population health" periodically when the team is responsible for the care of a defined group.

The AMA also defined "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."

New policy on physician-led teams adopted at the 2012 Interim Meeting pursuant to the Joint CME/CMS Report also included the following:

H-160.912 The Structure Function of Interprofessional Health Care Teams
1. That our AMA advocate that the physician leader of a physician-led inter-professional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform.
2. That our AMA advocate that all members of a physician-led inter-professional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
3. That our AMA encourage independent physician practices and small group practices to consider opportunities to form health care teams, such as through independent practice associations, virtual networks or other networks of independent providers.
4. That our AMA study innovative payment mechanisms that appropriately compensate the physician and/or team for team-based health care.
5. That our AMA advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members.

The AMA has strong policy that identifies non-physician health care professionals such as physician assistants (PA) and advanced practice nurses[11] (APRN) as effective and valued members of the health care team that bring unique skills and perspective to patient care. The AMA has long-standing guidelines for collaboration with PAs and APRNs, through reports of the Board,[12] as well as the following policy:

H-160.947 Physician Assistants and Nurse Practitioners
1. The physician is responsible for managing the health care of patients in all settings.
2. Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
3. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
4. The physician is responsible for the supervision of the physician assistant in all settings.
5. The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
6. The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.

7. The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
8. Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
9. The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
10. The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.

H-160.950 Guidelines for Integrated Practice of Physician and Nurse Practitioner
Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners:
1. The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
2. The physician is responsible for managing the health care of patients in all practice settings.
3. Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
4. In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
5. The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
6. The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
7. These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
8. At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
9. Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
10. In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
11. Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

Physician Supervision of PAs

Working as members of physician-led teams, PAs seek and embrace a physician-delegated scope of practice.[13] The Board notes that the American Academy of Physician Assistants (AAPA) supports physician supervision, maintaining that a PA's scope of practice should be up to the "supervising physician, consistent with the PA's education and experience, facility policy and state laws."[14] This is consistent with AMA policy on PAs, which provides:

The physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician (see Policy H-35.989 Physician Assistants).

The Board notes that AMA policy allows for remote supervision of PAs, and that the determination of whether such supervision is appropriate should be made on an individual basis. The Board lauds the AAPA's support of physician-led, team-based care and fully supports the continuation of future AMA-AAPA collaborative efforts in support thereof.

Physician Supervision of APRNs

For APRNs there are several guiding AMA policies supporting physician-led, team-based care. For the purposes of this report, the Board highlights the policy provisions that state physicians must retain ultimate authority for patient care in any team care arrangement,[15] and that there should be mutual cooperation and respect.[16] Protecting patient safety through appropriate physician supervision is a key reason why, for example, the AMA created the SOPP– allowing medicine to collaborate in its vigorous opposition to any efforts that would weaken or eliminate physician-led, team-based care.

Major nursing groups representing APRNs, however, do not necessarily support physician-led, team-based care. The American Academy of Nurse Practitioners (AANP), for example, suggests that there is no difference in the quality of care provided between physicians and APRNs.[17] The AANP also suggests that APRNs are the solution to the nation's primary care access challenges.

The AMA strongly supports and values the contributions that APRNs make in the US health care system. However, the AMA remains concerned that national APRN organizations and their state chapters continue to argue that there is no meaningful difference between physician and APRN education.[18] The AMA disagrees with such assertions. A physician undergoes four years of medical or osteopathic medical school, followed by three-to-seven years of residency and fellowship training comprising over 10,000 hours of clinical experience. By contrast, many APRNs have three years of postgraduate education, less than 1,000 hours of clinical training, and less clinical experience than that obtained in the first year of medical residency. While both professions bring unique skills and perspectives to patient care, they are not interchangeable.

The American Association of Nurse Anesthetists (AANA), which represents CRNAs, believes that CRNAs can provide the same quality anesthesia care to patients as physicians.[19] As the American Society of Anesthesiologists (ASA) highlighted to Colorado then-Governor Ritter, "[t]he differences in the training of an anesthesiologist and nurse anesthetist also should not be overlooked and must be considered in assessing patient safety."[20] The ASA contrasted nurse anesthetists' 2.5 years of graduate training with physician anesthesiologists who receive "a minimum of eight years."[21] Perhaps most importantly, "[t]he education and training of the physician is broad and includes direct responsibility for the overall care of medical, surgical, pediatric and obstetric patients and the range of conditions they experience. It is this extensive background that equips physicians to intervene and manage the medical complications that exist before, during and after surgery."[22]

While refuting the claims of the AANP and AANA is beyond the scope of this report, the Board points out that several AMA units, as well as the SOPP, have detailed information regarding the differences in education and training between physicians and non-physicians, including APRNs and CRNAs. The AMA believes that communicating these differences in education and training to policymakers is a key component in helping policymakers understand the potential risks to patient safety when non-physicians attempt to expand their scope of practice beyond their education and training.

Given that AMA policy strongly supports physicians retaining ultimate authority for patient care as well as appropriate physician supervision of APRNs in all practice settings, the Board endorses the aforementioned policies.

Safe and Appropriate Performance of Invasive Procedures Requires Medical Judgment

The safe and appropriate performance of many invasive procedures requires a physician's medical judgment. Knowing when a certain procedure, invasive or otherwise, is appropriate is part of the art and science of medicine.

Just as defining "the art and science of medicine" has proven elusive for centuries,[23] the same may be true for identifying procedures that may be considered invasive and inappropriate to be performed by non-physician providers. This report will focus on two of the major types of invasive procedures that have caused concern among organized medicine of late, the use of fluoroscopy and interventional chronic pain management.

FLUOROSCOPY

Fluoroscopy is an imaging technique commonly used to obtain real-time moving images of the internal structures of a patient through the use of a fluoroscope. Interventional fluoroscopy uses ionizing radiation to create real time

images that facilitate the accurate placement of small instruments, such as catheters through blood vessels or other pathways in the body.[24] Fluoroscopy is frequently used to assist in a wide variety of medical diagnostic and therapeutic procedures, both within and outside of radiology departments.[25]

Fluoroscopic equipment capabilities have changed dramatically in recent years. So has the development of new devices and procedures.[26] As the complexity and frequency of these procedures has increased, the dose of radiation received by both patients and health care personnel has increased, as well.[27] There have been reports of serious skin injuries in some patients undergoing certain fluoroscopically guided procedures.[28] Moreover, fluoroscopic interventions are used by a rapidly expanding number of health care providers in a wide range of medical specialties, many of which have little training in radiation science or protection measures.

The use of fluoroscopy in medical institutions must be proactively managed to reduce patient radiation exposures to levels that are as low as reasonably achievable consistent with the medical demands of the procedures for which fluoroscopy is used.[29] Management of the use of radiation must also ensure adequate safety of the medical personnel involved in these procedures.[30] Consequently, AMA policy provides for supervision of procedures that involve the provision of fluoroscopy.[31]

Physicians' Highly Specialized Training

Physicians undertake three or more years of residency training to know if, when and how to safely and appropriately perform or delegate–with appropriate supervision–invasive procedures. This is in sharp contrast to the education and training of APRNs, PAs, and other non-physician providers. As discussed above, APRNs state chapters have sought–through independent practice or through delegation–the authority to perform or supervise invasive procedures, including fluoroscopy.

The extensive five or more years of training undertaken by radiologists, for example, prepares them to safely provide interventional, invasive procedures, including fluoroscopy. Your Board believes that these procedures are invasive in nature, requiring–at a minimum–direct and/or personal physician supervision of non-physicians who have received advanced training in the provision of fluoroscopic procedures, following the Code of Federal Regulations' definition of direct and personal supervision. This supervision has been addressed in the courts of at least one state, which invalidated an Iowa Board of Nursing rule that allowed APRNs to directly supervise fluoroscopy.[32]

Regarding non-physician provider education and training in radiology, PAs receive no formal radiology-specific training. [33] For PAs to perform radiography or use fluoroscopy, most states require that PAs undergo additional training or possess some degree of radiographer licensure.[34] The AAPA has developed a standard for this training and licensure, which is discussed below. Like PAs, APRNs receive no formal radiology-specific training. For APRNs to perform radiography or use fluoroscopy, most states require that APRNs undergo additional training or possess some degree of radiographer licensure.[35]

Radiologist assistants (RA) are health professionals certified and registered as a radiographer, credentialed to provide primary radiology health care services under the supervision of a board-certified radiologist.[36] This radiologist-RA team allows patients to receive high quality medical care, as well as the safe application of ionizing radiation for medical procedures.[37] An RA possesses a radiologic technologist credential, which authorizes the RA to administer ionizing radiation. RAs "have undergone education in radiation safety, radiation production and characteristics, radiation biology, imaging equipment, and radiographic procedures during their training as radiologic technologists. Building on this foundation of the safe application of ionization radiation, RAs undergo additional coursework in radiation safety and health physics, fluoroscopic unit safety and operation, radiologic procedures, image evaluation, and post-processing."[38] Currently, there are 29 states with laws that either license or formally recognize RAs.[39]

Existing Standards for Education and Training in Fluoroscopic Procedures

Currently, 27 states[40] have enacted legislation regarding radiation education for operators of fluoroscopic procedures. At least one state[41] mandates that only physicians perform fluoroscopic procedures. Generally, minimum mandatory course requirements for the operation of fluoroscopic procedures are listed, including radiation safety courses. At least four states enacted legislation with hourly course requirements.[42]

In addition to certain educational requirements, most state laws require some type of license to perform, assist, or supervise fluoroscopic procedures.[43] Under the laws of three states, an individual must be a physician in order to perform diagnostic injections with fluoroscopic guidance. To assist state lawmakers with standards for education and training in fluoroscopic procedures, organizations such as the American College of Radiology (ACR), National Cancer Institute (NCI), Society for Interventional Radiology (SIR), the American Academy of Physician Assistants (AAPA), and the American Society of Radiologic Technologists (ASRT) have established standards on the proper level of education and training for physicians and non-physician providers to safely perform fluoroscopy, as well as the appropriate level of supervision for non-physician providers who perform these procedures.

American College of Radiology (ACR)

The ACR "Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures" (ACR Technical Standard) suggests that:

> For fluoroscopic procedures to be performed safely, certain fundamental clinical knowledge and skills are required. In addition to a basic understanding of anatomy, physiology, and pathophysiology, the physician should have sufficient knowledge of the clinical and imaging evaluation of patients to identify those for whom a specific procedure is indicated. The physician should also be able to evaluate a patient's clinical status to anticipate those patients who might be at increased risk, who require additional pre-procedure or post-procedure care, and who have relative contraindications to the procedure. The physician must also have undergone sufficient training in the operation of the equipment to be able to use dose management and image quality features effectively.[44]

Two important points in the ACR Technical Standard are that: (1) "[t]he practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease"; and (2) because of a physician's comprehensive education and training, fluoroscopy may be safely performed by many different physician specialists–provided that they have the requisite training.

Notably, the ACR Technical Standard establishes qualifications and responsibilities of personnel who perform fluoroscopy. These qualifications and responsibilities differ depending on whether they apply to a physician, qualified medical physicist, registered radiologic assistant, radiologic technologist or radiation therapist, or other health care professional.

Society of Interventional Radiology (SIR)

SIR also emphasizes the need for training of physicians and fluoroscopic operators to ensure patient safety. Because of both the increasing use and complexity of fluoroscopy, the SIR and the National Cancer Institute (NCI) have commented that:

> Interventional fluoroscopy is an increasingly important and valuable tool for treating disease, but it is not without risk. It is important for the health care community, manufacturers and regulators to work together to optimize patient radiation dose. Physicians must continuously think about optimizing radiation dose to the patient. Used prudently and optimally, interventional fluoroscopy is one of the valuable treatment modalities for a wide variety of diseases and disorders.[45]

The NCI and SIR conclusion is notable for the fact that it does not limit the use of fluoroscopy to any specific physician specialty. Rather, it highlights the complex nature of this specific invasive procedure, which requires physicians to perform or to directly supervise qualified technicians to ensure patient safety.

American Academy of Physician Assistants (AAPA)/American Society of Radiologic Technologists (ASRT)

A collaboration of the AAPA and ASRT resulted in a fluoroscopy educational framework for the physician assistant.[46] This educational framework provides the professional community with a cognitive base supporting the development of an educational component for PAs who use fluoroscopic guidance in their practice. The educational framework is divided into a didactic component and a clinical component. AAPA and ASRT estimate that the didactic section comprises 40 hours of instruction and the clinical component encompasses an additional 40 hours for a total of 80 hours.[47]

Eight states currently exempt PAs from needing a radiologic technologists (RT) license to use ionizing radiation.[48] Twelve additional states and the District of Columbia do not currently regulate RTs, so PAs are not prohibited by law from using ionizing radiation if delegated to do so by a supervising physician. In 10 states PAs who have had additional training may take x-rays or use fluoroscopy or may do so in specified circumstances. PAs in the remaining 20 states must possess some sort of radiographer license in order to utilize ionizing radiation.

It is clear from the aforementioned standards that fluoroscopy is a highly valuable yet complex science that requires a physician's skill and judgment. While some technical aspects of the provision of fluoroscopy may be taught and safely delegated, your Board believes that the safe and appropriate use of fluoroscopy requires a physician's direct and/or personal supervision, following the Code of Federal Regulations' definition of direct and personal supervision.

INTERVENTIONAL CHRONIC PAIN MANAGEMENT

AMA Policy H-410.958 provides that "interventional pain management of patients suffering from chronic pain constitutes the practice of medicine," and so should be performed only by physicians. Generally, interventional pain management (IPM) includes procedures such as cervical, lumbar, thoracic epidural steroid injections; nerve blocks; facets; discography; sacroiliac joint injections; and trigger point injections.[49]

Treatment and Risks of Interventional Chronic Pain Management

The ability to properly diagnose a patient's pain problem and to develop an appropriate treatment plan is critical in selecting and then providing the appropriate pain management therapy to effectively treat chronic pain.[50] To provide long-term relief from chronic pain, various types of therapies are needed because there is often more than one appropriate therapy. Moreover, the treatment of chronic pain differs from the approach used to treat acute pain.

Proper diagnosis and development of an appropriate plan requires detailed knowledge of the likely pathology, human anatomy, and risks associated with each plan. While IPM primarily involves minimally invasive procedures, these procedures still carry substantial patient risk,[51] some of which must be attended to immediately.[52] In addition, the drugs used for interventional pain procedures vary widely and can be associated with serious complications.[53]

Notably, placement of an epidural for labor pain is not the same as epidural steroid injection for chronic pain.[54] The indications, procedures and management of an epidural catheter placement for obstetrical analgesia are much different than those for chronic pain. As such, the training and experience for one does not equate to being sufficient for the other. Given the serious potential risks of IPM, it is essential that the providers of these procedures perform them appropriately and perform them only when they are indicated. It is also essential for policy- and decision-makers to understand the difference.

Physician Education and Training in Pain Management

Caring for patients with chronic pain requires a broad understanding of diagnostic evaluation, interaction with consultants from many specialties, and familiarity with and use of a wide range of therapies. The practice of pain medicine extends far beyond the application of technical skills. Rather, it requires a detailed foundation in the fundamental knowledge and skills that can only be mastered by physicians who have extensive medical education and training: the ability to elicit a history and perform a detailed physical examination; an understanding of the appropriate use of diagnostic testing and imaging; and selection of appropriate treatment from a broad range of useful modalities, including behavioral management, rehabilitation, pharmacologic therapy, and interventional pain treatment.

Simply performing technical interventions to treat chronic pain exposes patients to unnecessary harm when performed incorrectly or unnecessarily, or without the necessary preliminary planning. Caring for patients with chronic pain requires a physician's comprehensive knowledge of musculoskeletal and nervous system pathology to help determine whether there are underlying medical conditions and whether pharmaceutical, physical, therapeutic, psychiatric, interventional or surgical treatments are the most appropriate course of treatment.

Education on the use of advanced IPM techniques is incorporated into specialty fellowship training programs for pain medicine. Physicians who specialize in pain medicine complete four years of medical school, four years of

anesthesiology residency[55] or residency training in physical medicine and rehabilitation, neurology or psychiatry, as well as a one-year multidisciplinary fellowship in pain medicine and examination for board certification. In fact, pain medicine has become so complicated that fellowship programs are moving to two-year educational experiences in order to ensure an appropriate level of skill and expertise. American Board of Medical Specialties member boards have required that physicians who practice pain medicine have the formal training and have demonstrated the requisite knowledge and skills to practice pain medicine. Specifically, working with their national education associations, they have established ACGME–accredited residency and fellowship training programs. They also have developed board certification processes in pain medicine.

Physicians who are board-certified in pain medicine have thus undergone extensive training and certification in the diagnosis and treatment of patients with chronic as well as acute pain conditions. Contrast this substantial physician education, training, and certification in chronic pain management with the fact that there are no minimum educational requirements, no formal training programs, and no certification for non-physician providers in chronic pain management, as is discussed below.

Interventional pain treatment highlights the education, training and skills that–when combined with a physician's judgment–demonstrate why it is inappropriate for non-physician providers to independently perform such procedures.[56] Many complex IPM procedures require the use of advanced imaging techniques to accurately guide needles to the proper location, evaluate potentially therapeutic or dangerous spread patterns for medications injected via the needles and assist in the intraoperative placement of devices.[57] Proper knowledge of imaging safety considerations and technical interpretation of advanced imaging and management of potential life threatening complications require highly specialized medical training.[58]

Further, ongoing physician supervision is essential for patients with pain. While one treatment may temporarily relieve pain symptoms, effective, ongoing care requires much more. Specifically, effective, ongoing treatment requires a physicians' understanding of best practices and the ability to develop a complete differential diagnosis, as well as oversee the patient's comprehensive medical condition.

Non-physicians Lack the Education and Training to Independently
   Perform Interventional Chronic Pain Management

While APRNs, PAs and other non-physician health care providers play a critical role in the provision of health care in this country, their education and training does not provide the skills needed to coordinate complex diagnostic testing results with patient symptoms and physical examination findings, in order to arrive at an appropriate treatment plan. Non-physicians may gain pieces of knowledge about pain management during their education and training, but they generally lack the clinical knowledge requisite to appropriately diagnose and treat pain conditions. Knowing how or where to place a needle, for example, does not yield an understanding of the potential complications, nor or does it teach one how to properly interpret and manage the test results that lead to appropriate and definitive treatment.

Non-physicians' pain education is mainly limited to the administration of anesthetics and other general techniques and procedures designed as part of a course of treatment prescribed directly by a physician. For example, CRNAs complete a nursing degree, work for a year in an intensive care setting, and participate in a 30-month training program. CRNA educational programs are not required to provide any clinical experience in pain management, though a mere 10 cases of acute and/or chronic pain management are "recommended" as part of the clinical experience.[59]

Further, there is no board or accreditation program for CRNAs who seek to perform chronic IPM techniques. In 2003, the Council on Accreditation of Nurse Anesthesia Educational Programs (COA) began developing standards for pain-management fellowships; however, the COA terminated its effort in 2004 and commented that there was a lack of existing accredited CRNA training programs offering pain management coursework.[60] As a former officer of the AANA has acknowledged in recent court proceedings, "there are no guidelines for assessing the competency, skill set, abilities, or training needed for CRNAs to begin performing interventional pain management procedures."[61]

The AMA remains steadfast in its support for state medical boards and state and national medical specialty societies to adopt advisory opinions, and advance legislation and regulation that define interventional pain management of patients suffering from chronic pain as the practice of medicine. In addition, the AMA will continue to work to

ensure that IPM is defined as the practice of medicine and the treatment rendered to patients by qualified physicians is directed by the best available medical evidence.

Law and Regulation

Oklahoma Interventional Pain Management and Treatment Act

A law enacted in Oklahoma in 2010–the Oklahoma Interventional Pain Management and Treatment Act–defines IPM as "the practice of medicine devoted to the diagnosis and treatment of chronic pain."[62] Specifically, Oklahoma's law defines IPM procedures as: "ablation of targeted nerves; percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, analgesics in targeted areas of the spinal column; and surgical techniques, such as laser or endoscopic diskectomy, intrathecal infusion pumps and spinal cord stimulators."[63] The Oklahoma law further states that only licensed medical doctors or doctors of osteopathic medicine may lawfully "practice or offer to practice interventional pain management" in the state.[64] The Oklahoma law provides exceptions for certain specific procedures, but only "under conditions in which timely on-site consultation by such allopathic or osteopathic physician is available."[65]

Tennessee Legislation Ensured Direct, On-site Physician Supervision

Similarly, laws enacted in Tennessee in 2012 require direct physician supervision when an APRN or PA performs any invasive procedure involving the spine, spinal cord, sympathetic nerves or block of major peripheral nerves in a setting that is not a licensed facility.[66] The supervising physician has to be one who is actively practicing spinal injections and has current privileges to do so at a licensed facility.[67] For the purposes of Tennessee's new law, "direct supervision" is defined as being physically present in the same building as the APRN or PA at the time the invasive procedure is performed.[68]

Missouri Legislation Limited Chronic IPM to Physicians

Missouri also enacted legislation in 2012 that regulates the provision of chronic IPM. The new law provides that no person other than a physician can perform certain interventions in the course of diagnosing or treating chronic pain or pain occurring outside of a surgical, obstetrical, or post-operative course of care.[69] Such techniques limited to licensed physicians are ablation of nerves, placement of drugs in the spinal column under fluoroscopic guidance, laser or endoscopic diskectomy, and placement intrathecal infusion pumps or spinal cord stimulators. The new law does not apply to CRNAs or anesthesiologist assistants providing surgical, obstetrical or post-operative pain control.

Alabama Board of Medicine Proposed Pain Rule Impeded by FTC

In July 2010, the Alabama Board of Medical Examiners (ABME) proposed a rule regulating IPM. The proposed rule stated "interventional pain management of patients suffering from chronic pain constitutes the practice of medicine," and only may be performed by physicians.[70] Physician delegation to non-physicians was expressly prohibited. In November, the Federal Trade Commission (FTC) wrote to the ABME expressing the FTC's concern that the proposed rule would increase costs, hamper patients' access to care and restrict competition.[71] The ABME subsequently tabled the proposed rule.

Iowa Board of Medicine Defines Chronic Interventional Pain Management

In 2010, in order to assist physicians who consider interventional techniques to treat pain, the Iowa Board of Medicine (Iowa Board) promulgated a rule that established standards of practice for interventional chronic pain management.[72] This rule followed a joint commitment of the Iowa Boards of Medicine, Nursing, Pharmacy, and PAs to improve pain management services for all Iowa residents.[73] The rule includes an exhaustive list of procedures that the Iowa Board considers the practice of interventional chronic pain management in detail,[74] and unequivocally states that IPM is the practice of medicine.[75]

Pain management is also the subject of ongoing litigation in Iowa. In 2009, the Iowa Board of Nursing adopted a regulation allowing APRNs to provide direct supervision of fluoroscopy. The board contended that it had the authority to enact the rule under Iowa law, according to court documents. In June 2010, the Iowa Medical Society and the Iowa Society of Anesthesiologists sued the state. The medical societies argued that the regulations violated

state law, which prohibits the expansion of nursing into medicine without official recognition by doctors and others. In addition, the new rules were not in compliance with state standards for radiation health and safety, the societies said. The Litigation Center for the American Medical Association and the State Medical Societies and the SOPP made monetary contributions to the case on behalf of the medical societies.

In an October 2012 opinion, the Fifth Judicial District of Iowa said the fluoroscopy rule did not meet proper state guidelines, and as such, was invalid and illegal. In order for APRNs to "provide 'direct supervision' of fluoroscopy as the term is defined within the Iowa Administrative Code, they must satisfy minimum education and safety standards, including continuing education requirements and an examination established by the Iowa Department of Public Health," the court opinion said. "Even if the expansion of practice by [the nursing board] had been valid, which is not the case, neither the [board nor the department of public health] rules establish a curriculum or minimum criteria and safety standards." The case was appealed to the Iowa Supreme Court; a decision is pending.

Louisiana Board of Medical Examiners Rule Considered Context of IPM Procedures

In 1996, in order to assist Louisiana physicians in the course of their professional practice, the Louisiana State Board of Medical Examiners (Louisiana Board) issued a statement of position that "the injection of local anesthetics, steroids and analgesics, peripheral nerve blocks, epidural injections and spinal facet joint injections, when used for purposes of interventional pain management, constitute the practice of medicine."[76] The statement further provided that these procedures "[were] not delegable by a physician to a non-physician by prescription, direction or supervision." The statement was in response to requests for advisory opinions as to the legality of physician delegation of certain IPM procedures to CRNAs.

The Louisiana Board's rule provides that, while CRNAs remain essential providers of anesthesia for surgery and acute pain associated with surgery,[77] physicians specializing in IPM provide the same procedures[78] as diagnostic tools to assess the cause of a patient's chronic pain, as therapeutic modalities of treatment, and as a basis upon which to recommend additional treatment.[79]

The Louisiana Board's rule explains that, due to "the risk of death, paralysis, cerebral vascular accidents and infection attendant to these procedures," IPM procedures "are typically performed in a hospital or ambulatory surgery setting to afford patients the full range of life-saving measures that may result from an untoward event." The rule also explains that these procedures are also "usually performed in combination with fluoroscopy and x-ray, neither of which CRNAs are formally trained to diagnose and interpret, but both of which are essential to insure proper needle and anesthetic placement for the safety of the patient." When used in this manner by physicians specializing in the treatment of chronic pain, the Louisiana Board noted, these procedures are referred to as 'interventional pain management.' According to the Louisiana Board's rule, when used for IPM purposes such procedures:

> Do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inferences and judgments drawn from patient response to the anesthetic or other agent being administered. In such instances, it is not the procedures–*but the purpose and manner in which such procedures are utilized*–that demand the ongoing application of direct and immediate medical judgment, which constitutes the practice of medicine, and which may only be performed in this state by a Louisiana licensed physician.[80]

As such, the Louisiana Board concluded that, while "a CRNA may utilize these procedures on the order of and under physician direction and supervision for surgical cases and acute pain associated with surgery, for a physician to permit a CRNA, or any non-physician for that matter, to employ CRNAs to diagnose, manage or treat chronic pain patients would necessarily permit the CRNA to exercise independent medical judgment, perform diagnostic testing, render diagnoses, and provide treatment or recommendations for treatment of patients suffering with chronic pain." According to the Louisiana Board, these diagnostic determinations lead to treatment decisions that can have critical implications for the patient.

For these reasons, the Louisiana Board concluded that "the injection of local anesthetics, steroids and analgesics, peripheral nerve blocks, epidural injections and spinal facet joint injections, when used for interventional pain management of patients suffering from chronic pain, constitute the practice of medicine, are not delegable by a

physician to a non-physician by physician prescription, direction or supervision, and may only be performed in [Louisiana] by a physician licensed to practice medicine in Louisiana."[81]

INVASIVE PROCEDURES

With this legislative and regulatory background to provide context, the Board believes that renewed focus should be placed on the provision of invasive procedures with respect to IPM procedures.

AMA policy clearly delineates the types of invasive procedures that may only be performed by a physician and policy clearly defines IPM as the practice of medicine.[82] According to this policy, all of the following surgical procedures, whether performed by a laser, metal knife or scalpel, are considered invasive and should only be performed by a licensed physician:

1. Procedures that structurally alter the human body by the incision or destruction of tissues.
2. Diagnostic or therapeutic treatment of conditions or disease processes by any instruments such as lasers, ultrasound, ionizing radiation, scalpels, probes and needles causing localized alteration or transposition of live tissue.
3. Tissue that is cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means.
4. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system.

Yet, AMA policy also provides clear parameters for physicians to delegate certain procedures to both PAs and APRNs. This policy also clarifies that–within its definition of surgery and invasive procedures–this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous injections when ordered by a physician. The Board believes that this exception also logically extends to PAs, who practice pursuant to a supervision agreement with a physician.[83]

These policies and guidelines have enabled the AMA to work closely with its state and specialty partners to oppose– and successfully defeat–many attempts by non-physician advocacy groups to weaken or eliminate requirements for physician-led, team-based care. In addition, current AMA policy has proven effective in enabling the AMA and its SOPP to analyze and defeat many other attempts by non-physician provider groups to expand their scopes of practice beyond their education and training.

However, to ensure that the AMA is prepared to address all future challenges to the practice of medicine, your Board has accepted the recommendations of the AMA Task Force on Invasive Procedures (Task Force) to modify current AMA Policy H-475.983 "Definition of Surgery." These modifications are intended to clarify existing policy–for example, to include "repair, removal or transplant of an organ or tissue" and invasive procedures assisted by robotics in the definition of surgery. In addition, the proffered modifications seek to offer guidance on those invasive procedures that involve radiologic imaging. Modifications also recognize that invasive procedures include IPM procedures.

In addition, pursuant to the directive of Policy D-35.984, these modifications address the appropriate level of education, training and supervision of non-physician health care professionals who seek to perform invasive procedures, including those employing radiologic imaging. The modifications reaffirm that surgical and invasive procedures require physician level training. However, your Board recognizes that technical aspects of certain invasive procedures may be performed by appropriately trained, licensed or certified, credentialed non-physician providers under direct and/or personal supervision (as defined by the Centers for Medicare & Medicaid Services) of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state and federal regulations. Invasive procedures employing radiologic imaging are the practice of medicine and should be performed only by physicians with appropriate training and credentialing. Finally, to reflect that surgery is just one of many types of invasive procedures, your Board accepts the recommendation of the Task Force to change the name of the policy to "Definition of Surgery and Other Invasive Procedures." Your Board recommends modifications to existing AMA policy to reflect the above considerations.

CENTERS FOR MEDICARE & MEDICAID SERVICES REQUIREMENT
  FOR PHYSICIAN SUPERVISION OF ANESTHESIA

The Type and Complexity of Care Provided by CRNAs in the Opt-out States

The AMA state Advocacy Resource Center (ARC) maintains 50-state surveys that provide detailed information on the state laws and regulations that govern CRNA practice, including but not limited to the following:

1.   CRNA scope of practice;
2.   Requirements for supervision or collaborative practice;
3.   Prescriptive authority;
4.   Workforce information;
5.   Educational requirements;
6.   Educational requirements for certain procedures; and
7.   Continuing education requirements.

The aforementioned surveys are on file with the AMA ARC and available upon request.

Effect of the Opt-out on Access to Care

In November 2001, the Centers for Medicare & Medicaid Services published in the Federal Register a final rule concerning the federal Medicare and Medicaid physician supervision requirement for CRNAs. Prior to publication of the final rule, federal rules required physician supervision of anesthesia services. The final rule amended this requirement, enabling governors to opt-out of this supervision requirement by sending a letter to Centers for Medicare & Medicaid Services, attesting that:

1.   The state's governor has consulted with the state's boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state;
2.   It is in the best interests of the state's citizens to opt-out of the current federal physician supervision requirement; and
3.   The opt-out is consistent with state law.

Since December 2001, 17 states have opted out of the supervision requirement: Alaska, California, Colorado, Idaho, Iowa, Kansas, Kentucky, Minnesota, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oregon, South Dakota, Washington and Wisconsin. (Collectively referred to as the "opt-out states").

AMA Research

In October 2010, the AMA and American Society of Anesthesiologists (ASA) surveyed the opt-out states to determine whether access to care improved as a result of the opt-out. Anecdotal reports suggested that little to no change in access to care occurred as a result of the opt-out.

The AMA again surveyed the opt-out states in September 2012 in search of any new evidence indicating the effect of the opt-out on access to care. Nine medical associations responded to the survey, none of which was able to identify data analyzing the effect of the CRNA opt-out on access to care within their state. In response to the general query "What has been the effect of the opt-out on access to anesthesia care in your state?," six respondents (67%) indicated access was "about the same", one respondent (11%) indicated access was "slightly worse" and two respondents (22%) indicated that they "did not know."

In addition to the survey described above, the AMA also contacted the following organizations in each of the 17 opt-out states seeking available data:

1.   The state board of medicine;
2.   The state board of nursing;
3.   The state anesthesiology society; and
4.   The state department of health

Each organization was asked: (1) whether their organization had undertaken a study or survey analyzing the effect of the CRNA opt-out on access to care within their state; and (2) whether their organization knew of any such study, survey or other available data analyzing such effect on access to care within their state. Each successfully contacted organization indicated that it had not undertaken such a study or survey and was unaware of any other available data on the matter. As such, the AMA was unable to identify any available data to analyze the effects on patients' access to care in the opt-out states to determine whether there has been any increased access to care in those states.

AMA GeoMapping Initiative

The AMA GeoMapping Initiative provides the most comprehensive evidence of CRNA and physician practice locations. The maps produced through this initiative demonstrate 2007-08 data for the practice locations of CRNAs and physician anesthesiologists and pain medicine specialists. (GeoMaps for the states that opted out prior to 2007 are included as Appendix B.) As the maps show, CRNAs and physicians tend to practice in the same large, urban areas. The AMA is currently updating these maps to include more recent data on practice locations of physician and non-physician health care professionals.

Physician supervision of anesthesia services remains a priority for our AMA and its ARC. However, it remains an issue for both those advocating for the opt-out of physician supervision of anesthesia services and those advocating for the preservation of physicians as leaders of the health care team, that there is a lack of empirical data regarding the effect of the opt-out on access to care. The AMA GeoMaps remain the best evidence to indicate the practice locations of anesthesiologists compared to CRNAs.

CONCLUSION

The provision of health care in the United States requires team-based care with physicians, nurses, PAs and other health care professionals all performing at levels commensurate with their education and training. As the nation's health care workforce and patients' demand for services increase, physicians and non-physician providers each will be called upon to increasingly work together in the provision of health care services. To ensure that patients receive optimal care, however, the AMA believes that physicians' education and training put them in the best position to lead the health care team. While physicians may safely delegate some invasive procedures under supervision, not all are appropriate to be delegated to non-physician providers.

The decision about whether or not a certain invasive procedure is appropriate to be delegated is a matter to be decided by a physician's individual judgment and by the best available medical evidence. This evidence is best determined by state medical boards and state and national medical specialty societies adopting advisory opinions, and advancing legislation and regulation to provide further guidance for physicians and non-physicians with respect to specific invasive procedures. These entities also remain the best source for collection of data regarding the practice locations of health care professionals in each state.

With respect to IPM, given its complexity and requirement of a physician's judgment, the AMA is unequivocal in its position that IPM is the practice of medicine. The AMA further believes that state medical boards should be encouraged to adopt policies in opposition to the independent, unsupervised performance of IPM procedures and treatments by non-physician health care professionals.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 218-A-11, and the remainder of the report be filed.

1. That our American Medical Association reaffirm Policies H-160.947, H-160.950, H-360.987, H-410.958, H-475.983, H-475.986, H-475.988, H-475.989, D-35.984 and D-35.990.

2. That our AMA adopt the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:

    Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The

practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications, and collaboration with other health care providers.

Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post-operative course of care. Invasive pain management techniques include:

1. ablation of targeted nerves;
2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and
3. surgical techniques, such as laser or endoscopic diskectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.

At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.

When used for interventional pain management purposes, such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.

Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing.

REFERENCES

[1] Accreditation Council on Graduate Medical Education (ACGME), Web Accreditation Data System Glossary, available at www.acgme.org/adspublic.
[2] ACGME, Program Requirements for Graduate Medical Education in Anesthesiology (July 2011), www.acgme.org/acWebsite/downloads/RRC_progReq/040_anesthesiology_f07012011.pdf. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth. Specifically, the ACGME notes: The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education.
[3] Your Board notes that this not an exhaustive list.
[4] § 60.1 - Incident To Physician's Professional Services, Chapter 15 – Covered Medical and Other Health Services (June 2012). Available at www.cms.gov/manuals/Downloads/bp102c15.pdf.
[5] Id.
[6] Code of Federal Regulations, Title 42, § 410.32.
[7] H-35.988 "Independent Practice of Medicine by 'Nurse Practitioners'"
[8] H-160.949 "Practicing Medicine by Non-Physicians," H-160.947 "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice"
[9] H-160.949 "Practicing Medicine by Non-Physicians"

[10] H-360.987 "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice"

[11] APRNs include nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and certified nurse specialists.

[12] AMA Board of Trustees Report 28-A-09 "Practice Agreements Between Physicians and Advanced Practice Nurses to Advance APRN Supervisory Ratio" contains a checklist of issues for physicians to consider before entering into a collaborative agreement with an APRN.

[13] AAPA, Issue Brief: Physician Assistant Scope of Practice (January 2010), www.aapa.org/uploadedFiles/content/The_PA_Profession/Federal_and_State_Affairs/Resource_Items/PI_PAScopePractice_1 10811_Final.pdf.

[14] AAPA, Six Key Elements of a Modern Physician Assistant Practice Act (March 2011), www.aapa.org/uploadedFiles/content/Common/Files/SL_KeyElements_v3.pdf.

[15] H-360.987 "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice"

[16] H-160.950 "Guidelines for Integrated Practice of Physician and Nurse Practitioner."

[17] American Academy of Nurse Practitioners (AANP), Quality of Nurse Practitioner Practice (2010), www.aanp.org/images/documents/publications/QualityofNPPractice.pdf.

[18] *See*, CNN Money.com, Some nurses paid more than family doctors, Parija Kavilanz, March 11, 2010, http://money.cnn.com/2010/03/11/news/economy/health_care_doctor_incomes/index.htm. According to the American Association of Nurse Anesthetists (AANA), "Once nurses and physicians arrive at anesthesia training, we use the same textbooks and same cases. The training is not too different between the two groups," she said. "We all deliver anesthesia the same way."

[19] *See*, "Administration Puts Politics Before Patients; Implements Cumbersome Anesthesia Care Rule." November 13, 2001. www.aana.com/Advocacy.aspx?id=2575.

[20] Letter from Alexander A. Hannenberg, MD, President, American Society of Anesthesiologists, to Bill Ritter, Jr., Governor of the State of Colorado (August 13, 2010).

[21] *Id*.

[22] *Id*.

[23] In 1900, AMA Chair, George Dock, MD, explained that "[s]o far from growing easier, the art as well as the science of medicine grows daily more difficult. It is more certain, more thorough, more far-seeing and more far-reaching than ever before, but it requires of its votaries more knowledge, more technical dexterity, greater expenditure of time and greater individual judgment than ever before. Address to the Section on Practice of Medicine, June 5-8, 1900.

[24] National Cancer Institute and Society for Interventional Radiology. Interventional Fluoroscopy: Reducing Radiation Risks for Patients and Staff (March 2005), www.cancer.gov/images/Documents/45bae965-697a-4de8-9dae-b77222e0e79d/InterventionalFluor.pdf.

[25] American College of Radiology (ACR) Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures (2008), www.acr.org/~/media/F22C9D1FF46F43AAB001F9ED0466B7E9.pdf.

[26] *Id*. These include endografts for the treatment of abdominal aortic aneurysms, the development of vertebroplasty, kyphoplasty and uterine artery embolization, and increasing use of fluoroscopic guidance during complex endoscopic biliary and upper urinary tract procedures.

[27] *Id*.

[28] *Id*.

[29] *Id*.

[30] *Id*.

[31] D-35.984 "Physician Supervision of Invasive Procedures and the Provision of Fluoroscopy," "D-35.990 "Limiting the Scope of Practice of Specialist Assistants in Radiology."

[32] Iowa Medical Society, et al v. Iowa Dep't of Public Health. Findings of Fact, Conclusions of Law and Ruling. www.iowamedical.org/documents/news/110311_FindingsOfFactConclusionsLawRuling.pdf. The circumstances surrounding this case began in 2006, when the Iowa Board of Nursing (IBN) issued a finding that it is within APRN scope of practice to order, perform, supervise and interpret x-ray tests for the purpose of diagnosis or treatment. This finding included fluoroscopic radiography and CT. Iowa Medical Society (IMS) vigorously opposed the proposed rule change and presented evidence to the IBN and the Iowa Department of Public Health regarding national standards and guidelines and lack of availability of training for APRNs to be qualified to supervise fluoroscopy. The validity of the IBN rule is being litigated.

[33] Nordeck SM, Sanders VL, Killion JB. Comparative Analysis of Physician Extender Curricular Requirements in Radiology: A Detailed View. Journal of the American College of Radiology. 2012;9(4):270-274.

[34] *Id*.

[35] *Id*.

[36] Certification Board for Radiology Practitioner Assistants, Scope of Practice for the Radiology Practitioner Assistant (Nov 1996), www.cbrpa.org/professioninfo/pdf/ScopeofPractice.pdf.

[37] *Supra* note 35.

[38] *Id*.

[39] *Id*.

40 Alaska, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Texas, Vermont, West Virginia, and Wisconsin.

41 Nevada.

42 California, Connecticut, and Georgia; North Dakota has course requirements regarding continuing education.

43 Colorado, Delaware, Louisiana.

44 *Supra* note 27.

45 National Cancer Institute and Society of Interventional Radiology, Interventional Fluoroscopy: Reducing Risks for Patients and Staff (March 2005), www.cancer.gov/images/Documents/45bae965-697a-4de8-9dae-b77222e0e79d/InterventionalFluor.pdf .

46 AAPA and American Society of Radiologic Technologists, Fluoroscopy Educational Framework for the Physician Assistant (December 2009), www.aapa.org/uploadedFiles/content/Common/Files/fluoroscopy_educational_framework_ASRT_AAPA_12-09.pdf.

47 *Id*.

48 AAPA, Summary of State Laws and Regulations Governing the Use of Ionizing Radiation in the Healing Arts, October 2009.

49 American Academy of Physical Medicine and Rehabilitation Coding Manual for 2009.

50 ASA letter to FTC (January 19, 2011), available at www.asahq.org/~/media/For%20Members/Advocacy/ASA%20in%20Washington/ASA%20FTC%20Pain%20letter%201-19-11.ashx.

51 *Id*. These risks include allergic reactions, infections, bleeding, nerve damage, spinal cord injuries (e.g., paraplegia or quadriplegia), brain stem infarctions, and even death. Injuries can result from improper performance of interventional pain procedures, including injection of drugs into vessels or neural tissue. Spinal cord stimulation involves surgically implanting a device in an individual's back to send an electrical current to the patient's spinal cord. A pulse generator sends electrical pulses to the spinal cord in order to interrupt the pain signals from reaching the brain. Risks associated with this type of nerve stimulation include epidural hemorrhage, hematoma, infection, spinal cord compression, paralysis, leakage of spinal fluid, infection, and numbness or pain below the level of implantation. In addition, this procedure has the general risks of surgery.

52 *Id*. Pneumothorax is an example of the need for physicians to rapidly diagnose and treat problems as they occur. This complication is associated with several of the interventional pain procedures. Pneumothorax occurs when a needle improperly damages lung tissue. Air escapes from the damaged tissue into the chest cavity and compresses the lungs. At times, this complication may acutely lead to an inability of a patient to breathe and oxygenate. A person performing interventional pain procedures must be trained to identify this potentially lethal complication and qualified and able to insert a chest tube to allow the air to escape. In the absence of a proper, prompt diagnosis and treatment, the patient may die. CRNAs are not trained to insert chest tubes. Permitting nonqualified individuals to perform these IPM procedures can seriously jeopardize patient safety.

53 *Id*. In addition to commonly used sedative agents and local anesthetics, steroids and neurolytic agents not commonly used for any type of anesthetic care are used to treat chronic pain. Because of their complexity and serious potential side effects, these agents are included in the pharmacology programs of medical schools and anesthesia residency programs. The drugs are not only dangerous because of their specific pharmacology, but also due to the location of the injection and the specific complications associated with the injections. For example, drugs used as part of a neurodestructive treatment plan, such as absolute ethanol and phenol, are injected into the nerve to destroy the nerve or group of nerves that contribute to pain. Complications that have been associated with use of neurolytic agents and particulate steroids include vasospasm and embolic phenomena, which can reduce blood flow and result in devastating complications, such as paraplegia, stroke and death.

54 *Id*. The risks involved with epidural steroid injection include infection, numbness of the bladder, bleeding, nerve damage, and complications from the steroid medication. Complications associated with injectable steroids can include ulcers, immunosuppression, cataracts, and arthritis.

55 Detailed information about anesthesiology residency can be found in the ASA's 2011 letter to the FTC.

56 *Supra* note 51. Specifically, a physician's specialized IPM education and training includes: airway management skills; sedation/analgesia; fluoroscopic imaging and radiation safety; pharmacology of local anesthetics and other injectable medications, including radiographic contrast agents and steroid preparations. This must include treatment of local anesthetic systemic toxicity; trigger point injections; peripheral and cranial nerve blocks and ablation; spinal injections including epidural injections, including interlaminar, transforaminal, nerve root sheath injections, and zygapophysial joint injections; discography and intradiscal/percutaneous disc treatments; joint and bursal injections, including sacroiliac, hip, knee and shoulder joint injections; sympathetic ganglion blocks; epidural and intrathecal medication management; spinal cord stimulation; and intrathecal drug administration systems. In addition to knowing what treatment options are available, physicians are specifically trained to understand, apply and modulate the interactions of pharmaceutical interventions on the peripheral and central nervous systems. Physicians are also uniquely equipped to order diagnostic medical testing and oversee complex interventional procedures such as nerve blocks, electric stimulation, neuromodulation and surgery; psychiatric interventions such as psychopharmacology, psychotherapy, biofeedback and behavior modification; prevent addiction; and safely and effectively prescribe opioids.

57 *Id*.

58 *Id*.

59 Council on Accreditation of Nurse Anesthesia Educational Programs, Standard for Accreditation of Nurse Anesthesia Educational Programs (2012), http://home.coa.us.com/accreditation/Documents/Standards%20for%20Accreditation%20of%20Nurse%20Anesthesia%20Education%20Programs.pdf.

[60] Supra note 51.

[61] Letter from Alexander A. Hannenberg, MD, President, ASA, to Bill Ritter, Jr., Governor of the State of Colorado (August 13, 2010). See also, the decision of two major Medicare carriers (Noridian Administrative Services and Wisconsin Physician Services—to decline to use Medicare funds to pay for CRNAs providing chronic pain services. The carriers concluded that the assessment and skills required for the evaluation of chronic pain and the development of a plan of care were "not part of the CRNA training curriculua."
http://bbnor.noridian.com/Bulletins/Medicare_Part_B/Medicare_B_News/Medicare_B_News_Issue_273_October_6_2011_/CRNA_Practice_and_Chronic_Pain_Management_-_Revised___.htm and
www.wpsmedicare.com/j5macparta/resources/provider_types/crna-pain-management.shtml.

[62] Okla. Stat. tit. 59 §650 (2010). The Oklahoma Society of Anesthesiologists (OSA) and the Oklahoma State Medical Association (OSMA) pursued the legislation because they discovered that certain CRNAs and chiropractors were doing invasive pain procedures, e.g., CRNAs were performing cervical epidural steroids blind without fluoroscopy; a chiropractor was injecting "nutrients" into the spinal column to treat pain. In addition, for several years, according to OSMA and OSA, at least one Oklahoma physician had been seeing referral patients who had received epidural steroid injections by CRNAs without physician involvement. In the interest of patient safety, the OSMA and OSA pursued legislation.

[63] *Id.*

[64] *Id.*

[65] *Id.* The act specifies that "Nothing in this section shall be construed to forbid the administration of lumbar intra-laminar epidural steroid injections or peripheral nerve blocks by a certified registered nurse anesthetist when requested to do so by a physician and under the supervision of an allopathic or osteopathic physician licensed in this state and under conditions in which timely on-site consultation by such allopathic or osteopathic physician is available."

[66] Tennessee House Bill 1846 (Pub. Ch. 961, 107th General Assembly), available at
www.capitol.tn.gov/Bills/107/Bill/HB1896.pdf. The Tennessee Medical Association (TMA) sought this legislation because of concerns that non-physicians were performing pain blocks, facet injections and other procedures at much higher rates than other states. The bill was enacted despite opposition from the Tennessee chiropractic, physician assistant and nursing communities, and the Federal Trade Commission. The state chiropractic association vigorously opposed the legislation since, according to TMA, there were a number of chiropractors in the state who were employing advanced practice nurses in their offices to perform interventional pain management and write prescriptions to those patients for pain medication.

[67] *Id.*

[68] *Id.*

[69] Missouri Revised Statutes 334.153 (eff. August 28, 2012).

[70] Interventional Pain Management, Ala. Admin. Code r. 540-x-15 et seq. (proposed version Oct. 6, 2010).

[71] Letter from the FTC to Patricia E. Shaner, Office of General Counsel, Alabama State Board of Medical Examiners, November 3, 2010, available at www.ftc.gov/os/2010/11/101109alabamabrdme.pdf.

[72] Rules of the Iowa Board of Medicine are found in Iowa Administrative Code Chapter 653. The specific rule at issue is IAC 653-13.9.

[73] Joint Statement on Pain by the Iowa Boards of Medicine, Nursing, Pharmacy, and Physician Assistants (2009), available at
http://medicalboard.iowa.gov/images/pdf/FinalJointPain.pdf.

[74] The rule defines interventional chronic pain management as" the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain. Interventional techniques include percutaneous (through the skin) needle placement to inject drugs in targeted areas. Interventional techniques also include nerve ablation (excision or amputation) and certain surgical procedures. Interventional techniques often involve injection of steroids, analgesics, and anesthetics and include: lumbar, thoracic, and cervical spine injections, intra-articular injections, intrathecal injections, epidural injections (both regular and transforaminal), facet injections, discography, nerve destruction, occipital nerve blocks, lumbar sympathetic blocks and vertebroplasty, and kyphoplasty. Interventional chronic pain management includes the use of fluoroscopy when it is used to assess the cause of a patient's chronic pain or when it is used to identify anatomic landmarks during interventional techniques. Specific interventional techniques include: SI joint injections; spinal punctures; epidural blood patches; epidural injections; epidural/spinal injections; lumbar injections; epidural/subarachnoid catheters; occipital nerve blocks; axillary nerve blocks; intercostals nerve blocks; multiple intercostals nerve blocks; ilioinguinal nerve blocks; peripheral nerve blocks; facet joint injections; cervical/thoracic facet joint injections; lumbar facet injections; multiple lumbar facet injections; transforaminal epidural steroid injections; transforaminal cervical steroid injections; sphenopalatine ganglion blocks; paravertebral sympathetic blocks; neurolysis of the lumbar facet nerve; neurolysis of the cervical facet nerve; and destruction of the peripheral nerve." IAC 653-13.9(1).

[75] IAC 653-13.9(3).

[76] Louisiana State Board of Medical Examiners (LSBME), Statement of Position, Interventional Pain Management Procedures are not Delegable (June 2006),
www.lsbme.louisiana.gov/Statements%20of%20Position/Interventional%20Pain%20Management.pdf.

[77] Including the provision of anesthetics and ancillary services and administration of local anesthetics perineurally, peridurally, epidurally, intrathetically, or intravenously.

[78] Injection of local anesthetics, steroids and analgesics, peripheral nerve blocks, epidural injections and spinal facet joint injections.

[79] LSBME, Statement of Position, IPM Procedures are not Delegable (June 2006).

[80] *Id*. (emphasis added). Louisiana courts have also determined that CRNAs lack the education and training to perform IPM procedures. The Louisiana Court of Appeals has noted the lack of guidelines necessary to assess the competency, skill set, abilities, and training needed for nurse anesthetists to begin performing interventional pain management procedures. During the litigation, the president-elect of the AANA opined that a CRNA should be allowed to perform these procedures once the CRNA has had the "necessary education, training, and feels like they have the necessary skills." The court concluded that the practice of IPM is not within the scope of practice of a CNRA, and is solely the practice of medicine. Spine Diagnostics of Baton Rouge, Inc. vs. Louisiana State Board of Nursing. (4 So.3d 854 (La. App. Ct. 2008).

[81] Id. "No person shall practice medicine as defined herein [the Medical Practice Act] until he possesses a duly recorded license issued under this Part or a permit or registration as provided for herein." La. Rev. Stat. Ann. § 37:1271. The 'practice of medicine' includes: [T]the diagnosing, treating, curing, or relieving of any bodily…disease, condition, infirmity, deformity, defect, ailment, or injury in any human being…whether by the use of any drug, instrument or force…or of what other nature, or any other agency or means…" La. Rev. Stat. Ann. § 37:1261(1)

[82] H-475.983 "Definition of Surgery."

[83] H-475.983 "Definition of Surgery," H-475.986 "Surgical Assistants other than Licensed Physicians;" H-475.988 "Laser Surgery," H-475.989 "Laser Surgery."

Appendix A – Items considered previously

Resolution 216-A-10
At the 2010 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 216-A-10, "Direct Physician Supervision of Non-Physician Providers Performing Invasive Procedures," for report back at 2010 Interim Meeting. In Resolution 216, the Society of Interventional Radiology (SIR) asked our AMA to advocate, in general, that non-physicians should not independently perform invasive procedures, including the use of fluoroscopy. The SIR resolution raised numerous questions, including: Does the performance of such procedures by non-physicians constitute the practice of medicine? If so, under what circumstances, if any, may non-physicians perform such procedures? And if non-physicians may perform certain procedures, what is the appropriate level of physician supervision required to help ensure patient safety?

Resolution 217-A-10
At the 2010 Annual Meeting, the HOD also referred Resolution 217-A-10, "Patient Safety Requiring Direct Physician Supervision for Safe and Effective Pain Management and Care," for decision. In Resolution 217, the SIR asked that our AMA lobby for state and federal legislation and regulation to prohibit the independent unsupervised performance of pain management procedures and treatments by non-physician health care providers. In addition, the SIR asked that this position be communicated to all appropriate state and federal entities, including state boards of medicine and nursing. Although Resolution 217 was referred to the Board of Trustees (the Board) for decision, your Board believed that the issues raised by Resolution 217 overlapped with those raised by Resolution 216 and that the HOD would benefit from their detailed discussion.

Resolution 218-A-11
At the 2011 Annual Meeting, the HOD also referred Resolution 218-A-11, "Physician Extenders," for report back at the 2011 Interim Meeting. In Resolution 218, the New York Delegation asked our AMA to examine programs developed by government or managed care organizations where physician extenders practice independently and insist that there be Level I evidence to demonstrate that there is no diminution in the quality of patient care by programs that use non-physician providers. Resolution 218 was referred for report back on physician-led, team-based care.

Board of Trustees Report 7-I-10
At the 2010 Interim Meeting, the Board prepared Board of Trustees Report 7-I-10 (BOT Report 7), which provided additional background on efforts by non-physicians to expand their scope of practice to include certain invasive procedures and the unsupervised performance of pain management procedures. The Board addressed the issues raised by Resolutions 216-A-10 and 217-A-10 and provided recommendations it believed would help guide the AMA in the larger issue of protecting patient safety by working to distinguish the practice of medicine from non-physician scopes of practice. Specifically, the Board recommended:
- That our AMA encourage state and national medical specialty societies to work with state medical boards to adopt rules and regulations identifying which invasive procedures constitute the practice of medicine and which invasive procedures may be safely performed by non-physicians under physician supervision.
- That, in those states lacking clarity regarding which invasive procedures constitute the practice of medicine, our AMA encourage states to recognize that physicians may, in the exercise of their professional judgment, determine which invasive procedures can be safely delegated to non-physicians, in accordance with applicable state and federal law.
- That our AMA advocate that the provision of fluoroscopy be supervised by a physician trained in radiation safety and radiation management in accordance with the best available medical evidence.
- That our AMA advocate to Congress, state legislatures and regulatory bodies, as appropriate, regarding the need for physician supervision of fluoroscopy.
- That Policy H-410.958 be amended by addition to read as follows to include the statement, "Our AMA will advocate for state and federal legislation and regulation, as appropriate, to prohibit the independent performance of interventional pain management procedures and treatments by non-physician health care providers."

BOT Report 7 was referred following robust testimony from numerous HOD representatives, as well as some non-physician provider organizations. Generally, physician testimony registered strong support for the intent of BOT 7 to provide further clarity regarding non-physicians who may be performing invasive procedures, including the use of fluoroscopy, interventional pain management procedures and other treatments. Testimony suggested, however, that the HOD would benefit from a closer look at how "supervision" is defined.
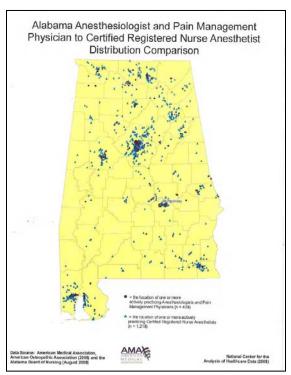
Board of Trustees Report 10-I-11
At the 2011 Interim Meeting, the Board adopted the recommendations of Board of Trustees Report 10-I-11 (BOT Report 10). This report took a closer look at how "supervision" is defined by the Accreditation Council on Graduate Medical Education (ACGME) and agencies such as the Centers for Medicare & Medicaid Services. The Board also looked closely at whether the AMA's interests were best served by adopting a strict definition of "supervision." Specifically, the Board recommended:
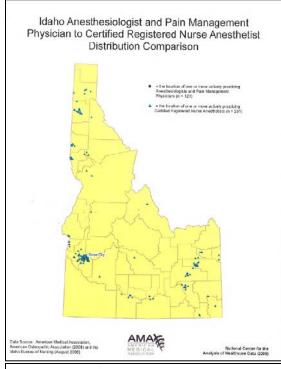
- That our AMA: (1) advocate that interventional chronic pain management including those techniques employing radiation (e.g., fluoroscopy or CT) is within the practice of medicine and should be performed only by physicians; and (2) develop appropriate model state legislation with interested state and medical specialty societies that reflects this policy.

- That our AMA convene a task force of appropriate AMA councils and interested state and medical specialty societies to develop principles to guide advocacy efforts aimed at addressing the appropriate level of supervision, education, training and provision of other invasive procedures by non-physicians including those employing radiologic imaging and report back to our House of Delegates.
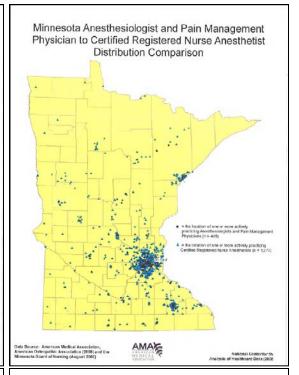
Testimony regarding BOT Report 10 reflected agreement that interventional pain management employing radiation was an invasive surgical procedure to be performed only by physicians. Testimony also identified the need for further study, warranting the creation of a task force. Inasmuch as the AMA works closely with its state and specialty society partners to provide guidance to policymakers regarding scope of practice issues, the Board welcomes the opportunity to provide further clarity to better define concepts and terms such as "invasive procedure" to ensure that any potential new AMA policy complements existing policy on surgery.
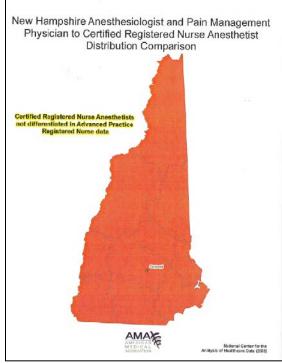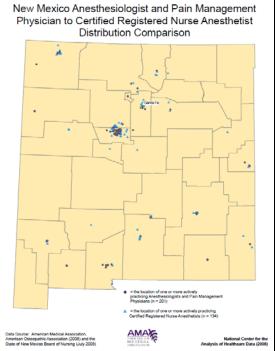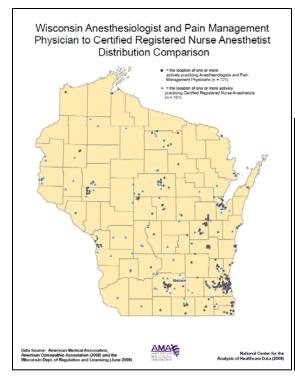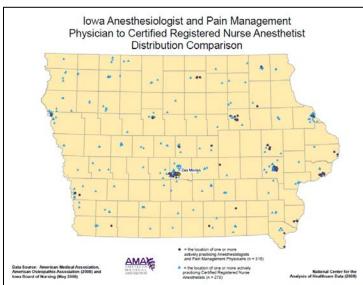
APPENDIX B

Alabama Anesthesiologist and Pain Management Physician to Certified Registered Nurse Anesthetist Distribution Comparison

Arizona Anesthesiologist and Pain Management Physician to Certified Registered Nurse Anesthetist Distribution Comparison

Idaho Anesthesiologist and Pain Management
Physician to Certified Registered Nurse Anesthetist
Distribution Comparison

Minnesota Anesthesiologist and Pain Management
Physician to Certified Registered Nurse Anesthetist
Distribution Comparison

New Hampshire Anesthesiologist and Pain Management
Physician to Certified Registered Nurse Anesthetist
Distribution Comparison

New Mexico Anesthesiologist and Pain Management
Physician to Certified Registered Nurse Anesthetist
Distribution Comparison

Wisconsin Anesthesiologist and Pain Management Physician to Certified Registered Nurse Anesthetist Distribution Comparison

Alaska Anesthesiologist and Pain Management Physician to Certified Registered Nurse Anesthetist Distribution Comparison

Iowa Anesthesiologist and Pain Management Physician to Certified Registered Nurse Anesthetist Distribution Comparison

Kansas Anesthesiologist and Pain Management Physician to Certified Registered Nurse Anesthetist Distribution Comparison

Montana Anesthesiologist and Pain Management Physician to Certified Registered Nurse Anesthetist Distribution Comparison

Nebraska Anesthesiologist and Pain Management Physician to Certified Registered Nurse Anesthetist Distribution Comparison

North Dakota Anesthesiologist and Pain Management
Physician to Certified Registered Nurse Anesthetist
Distribution Comparison

Oregon Anesthesiologist and Pain Management
Physician to Certified Registered Nurse Anesthetist
Distribution Comparison

South Dakota Anesthesiologist and Pain Management
Physician to Certified Registered Nurse Anesthetist
Distribution Comparison

Washington Anesthesiologist and Pain Management Physician to Certified Registered Nurse Anesthetist Distribution Comparison

17. DATA OWNERSHIP AND ACCESS TO CLINICAL DATA IN HEALTH INFORMATION EXCHANGES

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: **RECOMMENDATIONS ADOPTED AND**
                    REMAINDER OF REPORT FILED
                    See Policies H-315.973, H-315.974, H-315.983, H-315.989, H-406.991 and H-478.988

At the 2011 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted as amended Resolution 710-A-11, "Need for AMA Policy and Possible Model Legislation Regarding Data Ownership and Access to Clinical Data by Payers in Health Information Exchanges." This resolution and corresponding Policy D-478.988[2] ask that our AMA "study issues related to how best to protect the legitimate interests of patients and physicians regarding clinical data that is sent to and received from a health information exchange (HIE), particularly in regards to payers and their access to and use of clinical data obtainable via an HIE, and develop policies and standards regarding HIE data, and possible model legislation, with attention to:

a)   who owns the clinical data that is passed to and from an HIE;
b)   what types of parties have a legitimate interest in obtaining clinical data from HIEs, and for what purposes;
c)   who may determine what data is made available to whom;
d)   what constraints should properly be placed on the use of clinical data in an HIE;
e)   ensuring that at a very minimum, no payer would be allowed to obtain identifiable clinical data on individuals who are not currently insured members of a health plan belonging to that payer, with the possible exception of informed consent having been signed by a patient as part of an application for acceptance of that patient by a specified health plan, if such underwriting were once again allowed by law;
f)   how policies and standards for data sharing and access should differentiate between individually identifiable patient data, and de-identified or aggregated patient data;
g)   standards for de-identified and aggregated data to protect against reverse engineering to re-identify clinical data, especially where data relates to rare diseases or comes from rural areas;
h)   policies for data sharing and access that specifically address data use for mandated reporting, 'care management,' research, and proprietary purposes;
i)   informed consent for sharing of data: what such informed consent should include and who should be tasked to obtain it;
j)   possible model state legislation to define accountability for clinical data use in an HIE and to ensure that those policies that are essential to protect patients and physicians can be legally enforceable; and
k)   privacy issues including genetic testing, mental health disorders, and substance use disorders."

BACKGROUND

HIEs are organizations that bring together health care stakeholders, often within a defined geographic area, and supply the connectivity to allow for the electronic sharing of health information among them for the purpose of improving health and medical care in that area. HIEs offer the potential to improve the quality, safety, and efficiency of treatment through the exchange of clinical data at the point of care. HIEs may also enhance quality measurement, reporting, and improvement initiatives, as well as facilitate public health research.

The number of active HIEs has steadily increased over the past few years. For its annual HIE report, the eHealth Initiative surveyed 322 HIE organizations in 2012, an increase from 255 in 2011.[1] Along with the potential gains in health care quality and efficiency, federal funding has driven the recent growth in HIEs. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a subset of the American Recovery and Reinvestment Act (ARRA: Pub. L. 111-5) that was signed into law in February 2009, provided $2 billion to help advance the creation and expansion of HIE infrastructure and services across the United States.[2] These federal funding opportunities for HIEs have significantly increased HIE creation and development. Additionally, the requirement for electronic exchange of health information in Stage 2 Meaningful Use has also played a role in the recent proliferation of HIEs.

The governance, structure, and geographic scope of HIEs vary across the country. Some HIEs may serve a small geographic region, while others serve an entire state or multi-state region. HIEs also differ in technical models, with some acting as conduits of health information and others serving as repositories of health data. There is also wide variance in the types of clinical data exchanged and the services offered by HIEs.

While HIEs offer the opportunity for significant gains in care quality, safety, and coordination, potential risks and harms related to HIE data access have arisen. Issues related to data ownership, security, use, and access within HIEs pose potential ethical, legal, and technical challenges to all entities participating in HIEs, including physicians. As federal funding dwindles and HIEs struggle to develop sustainable business models, HIE data could potentially be sold or marketed as an alternative revenue source. Additionally, the acquisitions of Axolotl and Medicity by Ingenix (now Optum, a business segment of UnitedHealth Group) and Aetna, respectively, have contributed to growing worries regarding HIE data access, security, and use. Policy D-478.988[2] reflects the concerns that have arisen among both physicians and patients regarding the protection of clinical data within HIEs and calls upon the AMA to study these issues and develop policies and standards to ensure appropriate protection of HIE data. It should be noted, however, that the Department of Health and Human Services (HHS) recently released an omnibus final privacy rule which makes changes to the existing Health Insurance Portability and Accountability (HIPAA) Privacy Rule and is expected to help provide further restrictions around HIEs. For instance, HIEs with routine access to protected health information are considered business associates and thus are required to meet HIPAA privacy and security requirements. There are also new, more restrictive requirements around sale and marketing of patient information. These protections will be discussed in more detail in the Federal and State Legislation section.

AMA POLICY

Numerous AMA policies address the protection of data from any potential source, which would include HIEs. The broad nature of AMA policy on data protection is helpful, as it applies to emerging data sources, such as HIEs, as well as other new health data entities that may evolve in the future. Relevant AMA policies for the specific issues raised by Resolution 710-A-11 are itemized below:

Ownership of HIE data: In Policy H-315.974, the AMA advocates for "physician ownership of all claims data, transactional data and de-identified aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, EHRs [electronic health records], or practice management system." Since HIE data originate in the physician's EHR system, this policy would imply physician ownership of data that are submitted to an HIE. Along with asserting physician ownership of data, this policy also states that physicians are to act as "trusted stewards of Protected Health Information." Additionally, AMA Ethics Opinion 7.02 indicates that a physician's notes made during treatment of a patient are for "the physician's own use and constitute his or her personal property." Physician ownership does not negate patients' right to access information in their medical records.

Legitimate users and uses of HIE data: AMA policy expressly advocates for the protection of patient privacy and confidentiality of medical information; however, the AMA does caution against placing "unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities," while noting that de-identified data should be used for these purposes whenever possible (Policy H-315.983). This policy also notes that marketing and commercial uses of a patient's identifiable medical information may violate patient confidentiality and informed consent, and that patients must give permission prior to the disclosure of their identifiable data for these purposes. The disclosure of patient-identifiable data to address public health emergencies or to assist in public reporting associated with disease surveillance is also deemed appropriate by the AMA.

Permission for HIE data access: Policy H-315.973, which addresses entities that warehouse electronic medical records and claims data, states that permission from both the patient and physician must be obtained for any other person or entity to access and disclose individually identifiable clinical data, when the physician is specifically identified. Additionally, AMA Ethics Opinion 5.07 states that the "utmost effort and care must be taken to protect the confidentiality of all medical records, including computerized medical records" and that both patients and physicians should be advised of electronic databases storing patient medical information and the individuals and organizations with access to the data prior to the release of information. Ethical Opinion E-5.07 also limits dissemination of confidential medical data to "only those individuals or agencies with a bona fide use for the data" and limits the disclosure to the specific purpose and time period requested. Disclosures to insurance company representatives require the consent of the patient (Ethical Opinion E-5.08). Again, HIEs are not specifically mentioned in these policies, yet the principles apply broadly to access to patient medical information from all sources.

Constraints on use of HIE data: In Policy H-315.973, the AMA enumerates eight principles for entities that collect and use EHR and claims data: (a) the provision of the minimally necessary information for the intended purpose; (b) compliance with the HIPAA Privacy and Security Rules; (c) physician consent for any analysis undertaken with his/her EHR or claims data; (d) compensation for any additional work required for physician practices; (e) transparency for any analytical methods used; (f) provision of analytical methods/information so that physicians may re-analyze data; (g) appeals process for any adverse determinations; and (h) clinical data collected by a data exchange network may be accessible only for payment and health care operations. The AMA also has policy supporting the use of physician data to improve the quality and efficiency of health care when physician performance is assessed according to certain principles (Policy H-406.991). These principles relate to the release of physician data for profiling purposes and stress the importance of data accuracy and security, methodological transparency, adequate risk adjustment, and the ability of physicians to review and appeal their ranking prior to the public release of their scores.

Health plan access to patient-identifiable information from HIEs for non-members: As indicated above, Policy H-315.973 states that an entity that collects and uses EHR or claims data must comply with the HIPAA Privacy and Security Rules. Health plans are covered entities under HIPAA, and as such, may use or disclose protected information for treatment, payment, and health care operations activities. All other uses of data require authorization from the patient. (See Federal and State Legislation section below for more information on HIPAA and its applicability to HIEs.)

Use of individually identifiable vs. de-identified/aggregated patient HIE data and protection against reverse engineering of patient identity: The AMA advocates for the use of de-identified data whenever possible, including for purposes of utilization review, panel credentialing, quality assurance, peer review, research, quality improvement, and accreditation activities (Policy H-315.983). Ethical Opinion E-5.07 states that patient identifiers should be omitted where appropriate and that patient approval and physician notice are required when identifiable patient information is released outside the medical care environment. The AMA does not have policy that directly speaks to reverse engineering to re-identify clinical data; however, this topic is addressed under HIPAA (see Federal and State Legislation section below).

Use of HIE data for mandated reporting, care management, research, and proprietary purposes: As indicated in (d) above, AMA policy outlines eight broadly applicable principles for any entity that collects and uses EHR and claims data (Policy H-315-973). These principles state that EHR or claims data transmitted "for any given purpose" must be the minimum necessary for the intended purpose and that HIPAA rules must be followed. With specific regard to reporting purposes, the AMA supports the use of physician data "in conjunction with program(s) designed to

improve or maintain the quality of, and access to, medical care for all patients" and when it is used to provide accurate physician performance assessments in concert with the principles listed in Policy H-406.991. Privacy requirements related to research are addressed by the HIPAA omnibus rule (see Federal and State Legislation below). Research involving human participants may raise additional ethical and legal considerations that are distinct from clinical care. These issues may be addressed by mechanisms specific to the research setting, including institutional review board provisions.

Informed consent for sharing of HIE data: The AMA strongly advocates for the protection of patient privacy and confidentiality and affirms that "patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled," with any disclosures being the minimum necessary to fulfill the intended purpose (Policy H-315.983). This policy also states that patients' privacy "should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability." AMA Ethics Opinion 5.07 states that full disclosure regarding computerized databases containing the patient's medical information and the entities with access to this information is required in obtaining the patient's informed consent to treatment.

Model state legislation to define clinical data use within HIEs and protect patients and physicians: The AMA has created a model bill titled, "An Act to protect physician information obtained or released by health information exchanges." This model bill focuses on protecting physician data within HIEs. The bill is deliberately narrow in scope and only addresses safeguards for physician data. As discussed below in the Federal and State Legislation section, HIPAA protects patient information within HIEs.

Privacy for sensitive data within HIEs (genetic testing, mental health and substance abuse treatment records): Broad policy supports AMA leadership in protecting the confidentiality, integrity, and security of patient-specific data (Policies H-315.989 and H-315.983). In addition, AMA Policy H-315.983[7] states that "[g]enetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual." Protection of mental health and substance abuse records is discussed in the Federal and State Legislation section below.

FEDERAL AND STATE LEGISLATION

Health Insurance Portability and Accountability Act

Many of the privacy and data security concerns surrounding HIEs are addressed by HIPAA. Although HIEs are generally not considered to be HIPAA–covered entities, which include health plans, health care clearinghouses, or health care providers, they are considered to be business associates of HIPAA–covered entities. As such, an HIE must enter into contracts or other agreements with participating covered entities—including physicians—that require the HIE, as a business associate, to safeguard and appropriately protect the privacy of protected health information (PHI). Such contracts establish the permitted and required uses and disclosures of PHI by the business associate but do not authorize disclosure of information in a manner that violates HIPAA. Thus, any system used by an HIE must comply with the privacy and security provisions of HIPAA. Additionally, on January 25, 2013, the HHS Office for Civil Rights (OCR) issued a final HIPAA omnibus rule that incorporates new HIPAA requirements, including requirements under the HITECH Act. In the final omnibus rule, it is made clear that HHS will hold business associates directly liable for certain violations of the HIPAA rule including impermissible uses and disclosures of PHI. The final rule also indicates that Health Information Organizations (HIOs), a broad category that covers HIEs, are considered business associates of covered entities if they have routine access to PHI. The final rule provides examples of organizations that would fall under the HIO category including entities that manage the movement of PHI or those that act like a data storage company that maintains PHI on behalf of a covered entity. More stringent state privacy laws and regulations may supersede the national minimum privacy and security standards set by HIPAA.

HIPAA addresses several of the particular concerns raised by Policy D-478.988[2]. With regard to health plan access to non-member clinical data (Item E), HIPAA states that as covered entities, health plans may, without the patient's authorization, use or disclose protected health information for their own treatment, payment, and/or health

care operation activities. For any other uses of or access to patient data, the health plan must first obtain authorization from the patient. Thus, to access or use data for non-members, for which the health plan would have no valid treatment, payment, and/or health care operation purpose, the plan would first have to obtain patient consent.

With regard to identifiable vs. de-identified patient information (Item F), HIPAA only protects individually identifiable patient information. Under HIPAA, a covered entity must develop policies and procedures that limit disclosures of patient data for payment and health care operations to the minimum necessary standard. (The minimum necessary standard does not apply to disclosures for treatment purposes). OCR has developed guidance about methods and approaches to de-identify health information in accordance with the HIPAA Privacy Rule (regarding Item G). OCR cites two methods (Expert Determination and Safe Harbor) that satisfy the HIPAA Privacy Rule's de-identification standard.[3] Once patient information is de-identified according to this guidance, it is no longer considered PHI and, as such, may be used and disclosed by covered entities for any purpose allowable under other applicable laws. If an HIE, as a business associate of a health care provider, re-identifies previously de-identified patient information, the data now related to a specific individual would again be protected by the HIPAA Privacy Rule.

The HIPAA omnibus rule adopts several changes to the privacy requirements governing research (regarding Item H). Many of these changes are based on recommendations made by the HHS Advisory Committee on Human Research Protections and the Institute of Medicine. For example, the final rule allows a HIPAA–covered entity to combine conditioned and unconditioned patient authorizations for research, provided that the authorization clearly differentiates between the conditioned and unconditioned research components and explicitly allows the individual the option to opt in to the unconditioned research activities.

HIPAA also offers protection for sensitive health information, such as genetic information and treatment records related to mental health and substance abuse disorders (regarding Item K). The final HIPAA omnibus rule makes it clear that genetic information is considered health information and is therefore covered by HIPAA privacy protections.[4] The rule prohibits the use and disclosure of genetic information by covered health plans for underwriting purposes, to include eligibility determinations, premium computations, applications of any pre-existing condition exclusions, and any other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. For the release of mental health records, the HIPAA Privacy Rule requires a covered entity to obtain individual authorization prior to a disclosure of psychotherapy notes, even for disclosure to a health care provider other than the originator of the notes, for treatment purposes; there are only a few exceptions to this rule. For substance abuse treatment programs that are subject to HIPAA, information disclosure must comply with HIPAA. Treatment programs that are subject to both HIPAA and federal confidentiality regulations (42 CFR Part 2) must comply with both, unless there is a conflict between them; in such cases, programs usually should follow confidentiality regulations (Part 2).[5] HIPAA thus protects various types of sensitive health information, to include the exchange of this information within an HIE. However, special patient consent may be required to share sensitive health records through an HIE. The more stringent of federal or state laws regarding disclosure of these specially protected types of data will govern the exchange of the information within an HIE.

Other Relevant Federal Legislation

As previously noted, HITECH and ARRA provided significant funding for HIE creation and have driven the rapid growth of HIEs over the past few years. Additionally, federal legislation has also established criteria for meaningful use of health information technology, to include objectives related to the electronic exchange of health information.

State HIE Legislation

In addition to these federal regulations, some states have laws pertaining to HIEs, including laws to create and implement state-sponsored HIEs, establish a certification process for HIEs, and/or protect the privacy of information transmitted by or through an HIE. State HIE laws reflect the heterogeneity of the HIE models being employed across the country. Since HIEs are a relatively new area in health information technology, state legislation on this topic is still evolving. As indicated above, some states also have more stringent privacy laws that supersede HIPAA.

AMA ADVOCACY

In response to Policy D-478.988[2], the AMA has taken several steps, including the development of resources to support physicians in engaging with HIEs. These tools serve to educate physicians regarding both the potential benefits and risks involved in HIE participation, as well as to protect physicians' data and interests in this emerging area of health information technology.

Model Bill

The AMA's Advocacy Resource Center has drafted model state legislation regarding HIEs titled, "An Act to protect physician information obtained or released by health information exchanges." The model bill protects HIE physician data by prohibiting the sale or licensing of physician information obtained or released by an HIE, but it does not limit the use of HIE data for public health or research purposes. The bill also offers liability protection for physicians participating in HIEs by stating that HIE participation in and of itself does not establish a standard of care. The bill prevents physicians from being held liable for any data breaches that occur within an HIE once the physician has released the data to the HIE.

Educational Resources

AMA Private Sector Advocacy has created several educational resources to help physicians become informed consumers before agreeing to participate in an HIE. The document "Physicians' Frequently Asked Questions on Health Information Exchanges" addresses a range of basic topics related to HIE participation, including potential benefits and risks, HIE models and governance structures, HIE services, and potential liability concerns. Because there is so much variation in HIE structure, services, and data exchange models, physicians must have complete information about an HIE and the impact of participation on their practice before signing a contract. To help physicians thoroughly research an HIE before agreeing to participate; the AMA has created another resource titled, "What questions should I ask before I sign a contract to participate in a particular HIE?" An additional helpful resource on this topic is a webinar provided by staff from the AMA and the Healthcare Information and Management Systems Society (HIMSS), which offers a brief overview on HIEs, as well as addresses some of the common issues and concerns being raised by physicians about HIEs, including data ownership, patient consent, and record retention. All of these resources are available at www.ama-assn.org/go/hie.

HIPAA Resources

The AMA offers a variety of resources to help physicians understand and comply with the HIPAA Privacy and Security Rules. The AMA has developed a summary of the new HIPAA requirements and is updating HIPAA website material, which can be accessed free of charge at
www.ama-assn.org/go/hipaa.

In addition, the AMA Bookstore offers a selection of resources to help physicians comply with current HIPAA requirements and those of the new omnibus rule, including:

- HIPAA Plain and Simple: After the Final Rule. This third edition is scheduled for release this summer and provides detailed analysis to help physicians understand the ins and outs of compliance.
- Handbook for HIPAA-HITECH Security. This new release explains practical ways to interpret the new regulations and ensure compliance.
- AMA HIPAA School. These online courses provide the training physicians and their practice staff need to comply with the current HIPAA regulations. Participants can retest and retrain as needed. The course content will be updated with the new requirements by March 26, 2013, the effective date for the HIPAA final omnibus rule.

Healtheway

The AMA is exploring membership in Healtheway, a new non-profit organization that will be composed of both public and private members. Healtheway supports the eHealth Exchange, formerly a federally run initiative to foster the exchange of health care information known as the Nationwide Health Information Exchange (NwHIN). It is AMA's intent to ensure physicians' interests are represented as this initiative grows. Those participating in data

exchange via the eHealth Exchange must comply with a Data Use and Reciprocal Support Agreement (DURSA), which essentially outlines the "rules of the road" for exchanging information in this HIE, so that a level of trust is established among participants.

DISCUSSION

HIEs offer the potential to significantly improve the quality and safety of health care, as well as reduce costs by eliminating, or at least decreasing, redundant services. For example, emergency room physicians with access to patient health records via an HIE can gather valuable information about the patient's current medications, drug allergies, and comorbidities, which could in turn improve the quality of the patient's emergency care. Similarly, the ability to access any recent laboratory results can prevent costly duplication of services in the emergency room and lead to efficiencies in the health care system.

Nonetheless, HIEs carry accompanying risks and concerns for both physicians and patients. Patients are concerned about the privacy and security of their private medical information in this new information source, and they worry about who will be accessing their HIE data, and for what purposes. Additionally, major media attention to security breaches involving electronic medical information has fueled consumer concerns about the security of data being transmitted via HIEs. Along with protecting patient privacy, physicians are also concerned about how their HIE data might be used for public reporting purposes. The numerous concerns about the accuracy and transparency of physician profiling methodologies apply to any performance measurement system that may arise from HIE data. Finally, health plan ownership of HIEs has raised concerns that impact patient and physician acceptance of HIEs. Although HIPAA ensures that health plans may only use a patient's health information for treatment, payment, or health care operations activities, consumers fear that plans may attempt to use HIE data for other purposes, including underwriting. Physicians worry that health plan involvement in HIEs will compound the existing problems with physician profiling programs.

The AMA has created broad policies and advocacy efforts that address appropriate access to and use of health information. These policies are designed to protect health data for both patients and physicians from any potential source and offer sufficient safeguards for the health information transmitted and/or stored in HIEs. Moreover, the final HIPAA omnibus rule makes it clear that HIEs that fall under the business associate definition are now directly liable for violating HIPAA privacy and security requirements. Thus, the concerns regarding HIE data security, protection, and use raised by Policy D-478.988[2] are fully consistent with AMA policy and advocacy and the HIPAA Privacy Rule.

Although the full implications of health plan ownership of HIEs may not be understood at this time, concerns on this topic appear to be addressed by HIPAA and by HIE governance structure. Payer-owned HIEs are required to comply with the same HIPAA business associate requirements as any other HIE. Additionally, HIE governing boards, not health insurers, will make the decisions regarding how a payer-owned HIE's data will be used. Information from Axolotl states that, "… the regional, state organizations and IDNs [integrated delivery networks] that govern their respective HIEs control their data and access to that data … [d]ata will never be used for purposes other than to meet the objectives and requirements defined by and agreed upon with our customers."[6]

Even with these protections and assurances from HIE vendors, it is critical for physicians to thoroughly research and review business associate contracts before agreeing to participate in a particular HIE. The significant variation in HIE business models and offered services means that physicians must have a complete understanding of the benefits and risks of joining a particular HIE prior to signing a contract, as well as the parameters of patient participation. For example, under opt-in HIE models, patients must give consent to have their data included in the HIE, while under opt-out systems, patients' data are automatically included in the HIE, but patients may choose to withdraw from HIE participation. Any HIE contract should clearly enumerate these details of participation, as well as provide complete transparency regarding any secondary uses (i.e., other than direct patient treatment) of patient data. If an HIE contract does not specify what entities have access to the data and all of the intended uses of the HIE's clinical information, physicians should request that these terms be explicitly detailed before any participation agreement is signed. As with any legal document, physicians should consult with their legal counsel before signing an HIE contract.

In addition to carefully studying the HIE contract, physicians should also review and evaluate the governing principles, policies, and procedures of any potential HIE partner. The Colorado Regional Health Information

Organization's (CORHIO's) governing principles[7] offer one example of HIE principles that embody the concepts outlined in AMA policy on access to and use of health information. CORHIO's governing principles include provisions regarding transparency, limitations on data use, privacy and security, information integrity, security breaches, and participant accountability. The operating policies and procedures outlined in the Healtheway DURSA[8] offer another comparative reference for physicians evaluating similar documentation from their local HIE.

As with many areas related to health information technology, the issues surrounding HIE data access, security, and use are continually evolving. In particular, issues pertaining to data ownership are controversial and may ultimately be resolved in the courts. While the AMA advocates for physician ownership of all data created in clinical practice, there may be unintended liability consequences—including those related to data breaches and security issues—of physician ownership of HIE data. Some stakeholders, including an expert panel convened by the American Medical Informatics Association, recommend that the focus be on data access and control instead of data ownership.[9] Given the flux and continual evolution of policy and legislation in this area, the AMA should continue to monitor HIE data issues and develop new policies as needed.

The Board believes this report addresses the intent of Policy D-478.988[2]. In the interest of streamlining the AMA policy database, the House is encouraged to rescind Policy D-478.988.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) continue its efforts to educate physicians on health information exchange (HIE) issues, with particular emphasis placed on alerting physicians to the importance of thoroughly reviewing HIE business associate contracts and clarifying any and all secondary uses of HIE data prior to agreeing to participate in a particular HIE.

2. That our AMA advocate for HIEs to provide an overview of their business models and offered services to physicians who are considering joining the organization.

3. That our AMA advocate for HIE contracts to clearly identify details of participation, including transparency regarding any secondary uses of patient data.

4. That our AMA advocate that HIEs comply with all provisions of HIPAA in handling clinical data.

5. That our AMA encourage physicians who experience problems accessing and using HIE data to inform the AMA about these issues.

6. That our AMA reaffirm AMA Policies H-315.973, H-315.974, H-315.983, H-315.989, and H-406.991 and AMA Ethical Opinions E-5.07, E-5.08, and E-7.02, which ensure protection of the privacy and security of patient and physician data from all sources, including HIEs, and encourage appropriate use of and access to these data.

7. That Policy D-478.988 be rescinded, having been accomplished by this report.

REFERENCES

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http://www.himss.org/content/files/12_04_09_ARRAHITECHHIE_FactSheet.pdf.
[3]Department of Health and Human Services, Office for Civil Rights. "Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule." Available at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/guidance.html.
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Substance Abuse Programs." June 2004. Available at: http://www.samhsa.gov/HealthPrivacy/docs/SAMHSAPart2-HIPAAComparison2004.pdf.

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[8] National eHealth Collaborative. Restatement I of the Data Use and Reciprocal Support Agreement (DURSA). Version Date: May 3, 2011. Available at: http://www.nationalehealth.org/ckfinder/userfiles/files/Restatement%20I__DURSA_5_3_11_FINAL_for%20PARTICIPANT%20SIGNATURE.pdf.

[9] Safran C, Bloomrosen M, Hammond WE, et al, with the Expert Panel. Toward a national framework for the secondary use of health data: an American Medical Informatics Association white paper. *J Am Med Inform Assoc*. 2007; 14:1-9.

APPENDIX

D-478.988 Studying and Supporting Health Information Exchange
1. Our AMA will: (A) study existing health information exchange pilots, create a report for the 2008 Interim Meeting that specifically outlines the ways in which a health information exchange might be used to maximally benefit physicians and their patients and includes ways in which the AMA might apply its resources to assist in the further study and eventual realization of those benefits; and (B) explore ways to help our members have access to and/or share aggregated practice performance data including claims-based and clinical information. 2. Our AMA will study issues related to how best to protect the legitimate interests of patients and physicians regarding clinical data that is sent to and received from a health information exchange (HIE), particularly in regards to payers and their access to and use of clinical data obtainable via an HIE, and develop policies and standards regarding HIE data, and possible model legislation, with attention to: (A) who owns the clinical data that is passed to and from an HIE; (B) what types of parties have a legitimate interest in obtaining clinical data from HIEs, and for what purposes; (C) who may determine what data is made available to whom; (D) what constraints should properly be placed on the use of clinical data in an HIE; (E) ensuring that at a very minimum, no payer would be allowed to obtain identifiable clinical data on individuals who are not currently insured members of a health plan belonging to that payer, with the possible exception of informed consent having been signed by a patient as part of an application for acceptance of that patient by a specified health plan, if such underwriting were once again allowed by law; (F) how policies and standards for data sharing and access should differentiate between individually identifiable patient data and de-identified or aggregated patient data; (G) standards for de-identified and aggregated data to protect against reverse engineering to re-identify clinical data, especially where data relates to rare diseases or comes from rural areas; (H) policies for data sharing and access that specifically address data use for mandated reporting, "care management", research, and proprietary purposes; (I) informed consent for sharing of data: what such informed consent should include and who should be tasked to obtain it; (J) possible model state legislation to define accountability for clinical data use in an HIE and to ensure that those policies that are essential to protect patients and physicians can be legally enforceable; and (K) privacy issues including genetic testing, mental health disorders and substance use disorders. (Res. 722, A-08; Appended: Res. 710, A-11; Reaffirmed in lieu of Res. 705, A-12)

H-315.973 Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data
1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles: a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose. b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules. c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used. d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims, eligibility) must be compensated by the entity requesting the data. e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities. f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed. g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data. h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations. 2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles: a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information. b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research. c. Physician and patient permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified. d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed. (CMS Rep. 6, I-06)

H-315.974 Guiding Principles, Collection and Warehousing of Electronic Medical Record Information
Our AMA expressly advocates for physician ownership of all claims data, transactional data and de-identified aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information. (Res. 802, I-05; Reaffirmed: BOT Rep. 19, I-06)

H-315.983 Patient Privacy and Confidentiality
(1) Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure. (2) Our AMA affirms: (a) that physicians who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law. (3) Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients and physicians should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. (4) Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. (5) The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. (6) Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. (7) Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. (8) When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. (9) Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. (10) Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. (11) Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures (12) Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. (13) Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. (14) Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. (15) In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business

transactions when ownership or control of medical records changes hands. (16) The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. (17) Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. (18) Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. (19) Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. (20) Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes. (BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12)

H-315.989 Confidentiality of Computerized Patient Records
The AMA will continue its leadership in protecting the confidentiality, integrity, and security of patient-specific data; and will continue working to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data. (BOT Rep. F, A-93; Reaffirmation I-99; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmation I-08; Reaffirmation A-10)

H-406.991 Work of the Task Force on the Release of Physician Data
Principles for the Public Release and Accurate Use of Physician Data - *The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients and is used to provide accurate physician performance assessments in concert with the following Principles:*
1. Patient Privacy Safeguards - All entities involved in the collection, use and release of claims data comply with the HIPAA Privacy and Security Rules (H-315.972, H-315.973, H-315.983, H-315.984, H-315.989, H-450.947). - Disclosures made without patient authorization are generally limited to claims data, as that is generally the only information necessary to accomplish the intended purpose of the task (H-315.973, H-315.975, H-315.983). 2. Data Accuracy and Security Safeguards - Effective safeguards are established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data (H-406.996, H-450.947, H-450.961). - Reliable administrative, technical, and physical safeguards provide security to prevent the unauthorized use or disclosure of patient or physician-specific health care data and physician profiles (H-406.996, H-450.947, H-450.961). - Physician-specific medical practice data, and all analyses, proceedings, records and minutes from quality review activities are not subject to discovery or admittance into evidence in any judicial or administrative proceeding without the physician's consent (H-406.996, H-450.947, H-450.961). 3. Transparency Requirements - When data are collected and analyzed for the purpose of creating physician profiles, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure (H-315.973, H-406.993, H-406.994, H-406.998, H-450.947, H-450.961). - The limitations of the data sources used to create physician profiles are clearly identified and acknowledged in terms understandable to consumers (H-406.994, H-450.947). - The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers (H-315.973, H-406.994, H-406.997, H-450.947, H-450.961). - Case-matched, risk-adjusted resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients (H-285.931). 4. Review and Appeal Requirements - Physicians are provided with an adequate and timely opportunity to review, respond and appeal the results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release (H-315.973, H-406.996, H-406.998, H-450.941, H-450.947, H-450.961). - When the physician and the rater cannot reach agreement, physician comments are appended to the report at the physician's request (H-450.947). 5. Physician Profiling Requirements - The data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians (H-406.994, H-406.997, H-450.947, H-450.961). - Data reporting programs only use accurate and balanced data sources to create physician profiles and do not use these profiles to create tiered or narrow network programs that are used to steer patients towards certain physicians primarily on cost of care factors (450.951). - When a single set of claims data includes a sample of patients that are skewed or not representative of the physicians' entire patient population, multiple sources of claims data are used (no current policy exists). - Physician efficiency of care ratings use physician data for services, procedures, tests and prescriptions that are based on physicians' patient utilization of resources so that the focus is on comparative physicians' patient utilization and not on the actual charges for services (no current policy exists). - Physician-profiling programs may rank individual physician members of a medical group but do not use those individual rankings for placement in a network or for reimbursement purposes (no current policy exists). 6. Quality Measurement Requirements - The data are used to profile physicians based on quality of care provided - never on utilization of resources alone -- and the degree to which profiling is based on utilization of resources is clearly identified (H-450.947). - Data are measured against evidence-based

quality of care measures, created by physicians across appropriate specialties, such as the Physician Consortium for Performance Improvement. (H-406.994, H-406.998, H-450.947, H-450.961). - These evidence-based measures are endorsed by the National Quality Forum (NQF) and/or the AQA and HQA, when available. When unavailable, scientifically valid measures developed in conjunction with appropriate medical specialty societies and practicing physicians are used to evaluate the data (no current policy exists). 7. Patient Satisfaction Measurement Requirements - Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians to better meet patient needs particularly as they relate to favorable patient outcomes and other criteria of high quality care (H-450.982). - Because of the difficulty in determining whether responses to patient satisfaction surveys are a result of the performance of a physician or physician office, or the result of the demands or restrictions of health insurers or other factors out of the control of the physician, the use of patient satisfaction data is not appropriate for incentive or tiering mechanisms (no current policy exists). - As in physician profiling programs, it is important that programs that publicly rate physicians on patient satisfaction notify physicians of their rating and provide a chance for the physician to appeal that rating prior to its publication (no current policy exists). (BOT Rep. 18, A-09; Reaffirmation A-10; Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 808, I-10; Reaffirmed in lieu of Res. 824, I-10; Reaffirmation A-11)

E-5.07 Confidentiality: Computers
The utmost effort and care must be taken to protect the confidentiality of all medical records, including computerized medical records. The guidelines below are offered to assist physicians and computer service organizations in maintaining the confidentiality of information in medical records when that information is stored in computerized data bases: (1) Confidential medical information should be entered into the computer-based patient record only by authorized personnel. Additions to the record should be time and date stamped, and the person making the additions should be identified in the record. (2) The patient and physician should be advised about the existence of computerized data bases in which medical information concerning the patient is stored. Such information should be communicated to the physician and patient prior to the physician's release of the medical information to the entity or entities maintaining the computer data bases. All individuals and organizations with some form of access to the computerized data bases, and the level of access permitted, should be specifically identified in advance. Full disclosure of this information to the patient is necessary in obtaining informed consent to treatment. Patient data should be assigned a security level appropriate for the data's degree of sensitivity, which should be used to control who has access to the information. (3) The physician and patient should be notified of the distribution of all reports reflecting identifiable patient data prior to distribution of the reports by the computer facility. There should be approval by the patient and notification of the physician prior to the release of patient-identifiable clinical and administrative data to individuals or organizations external to the medical care environment. Such information should not be released without the express permission of the patient. (4) The dissemination of confidential medical data should be limited to only those individuals or agencies with a bona fide use for the data. Only the data necessary for the bona fide use should be released. Patient identifiers should be omitted when appropriate. Release of confidential medical information from the data base should be confined to the specific purpose for which the information is requested and limited to the specific time frame requested. All such organizations or individuals should be advised that authorized release of data to them does not authorize their further release of the data to additional individuals or organizations, or subsequent use of the data for other purposes. (5) Procedures for adding to or changing data on the computerized data base should indicate individuals authorized to make changes, time periods in which changes take place, and those individuals who will be informed about changes in the data from the medical records. (6) Procedures for purging the computerized data base of archaic or inaccurate data should be established and the patient and physician should be notified before and after the data has been purged. There should be no mixing of a physician's computerized patient records with those of other computer service bureau clients. In addition, procedures should be developed to protect against inadvertent mixing of individual reports or segments thereof. (7) The computerized medical data base should be online to the computer terminal only when authorized computer programs requiring the medical data are being used. Individuals and organizations external to the clinical facility should not be provided online access to a computerized data base containing identifiable data from medical records concerning patients. Access to the computerized data base should be controlled through security measures such as passwords, encryption (encoding) of information, and scannable badges or other user identification. (8) Back-up systems and other mechanisms should be in place to prevent data loss and downtime as a result of hardware or software failure. (9) Security: (a) Stringent security procedures should be in place to prevent unauthorized access to computer-based patient records. Personnel audit procedures should be developed to establish a record in the event of unauthorized disclosure of medical data. Terminated or former employees in the data processing environment should have no access to data from the medical records concerning patients. (b) Upon termination of computer services for a physician, those computer files maintained for the physician should be physically turned over to the physician. They may be destroyed (erased) only if it is established that the physician has another copy (in some form). In the event of file erasure, the computer service bureau should verify in writing to the physician that the erasure has taken place. (IV) Issued prior to April 1977; Updated June 1994 and June 1998.

E-5.08 Confidentiality: Insurance Company Representative
History, diagnosis, prognosis, and the like acquired during the physician-patient relationship may be disclosed to an insurance company representative only if the patient or a lawful representative has consented to the disclosure. A physician's responsibilities to patients are not limited to the actual practice of medicine. They also include the performance of some services ancillary to the practice of medicine. These services might include certification that the patient was under the physician's care and comment on the diagnosis and therapy in the particular case. See also Opinion 2.135, "Insurance Companies and Genetic Information." (IV) Issued prior to April 1977.

E-7.02 Records of Physicians: Information and Patients

Notes made in treating a patient are primarily for the physician's own use and constitute his or her personal property. However, on request of the patient, a physician should provide a copy or a summary of the record to the patient or to another physician, an attorney, or other person designated by the patient. Most states have enacted statutes that authorize patient access to medical records. These statutes vary in scope and mechanism for permitting patients to review or copy medical records. Access to mental health records, particularly, may be limited by statute or regulation. A physician should become familiar with the applicable laws, rules, or regulations on patient access to medical records. The record is a confidential document involving the patient-physician relationship and should not be communicated to a third party without the patient's prior written consent, unless required by law or to protect the welfare of the individual or the community. Medical reports should not be withheld because of an unpaid bill for medical services. Physicians may charge a reasonable fee for copying medical records. (IV) Issued prior to April 1977; Updated June 1994.

18. ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2012 THROUGH FEBRUARY 2013

Reference committee hearing: see report of <u>Reference Committee D</u>.

HOUSE ACTION: FILED

This report summarizes American Medical Association (AMA) activities and progress in tobacco control from March 2012 through February 2013 and is written in response to AMA Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE IN THE UNITED STATES

Tobacco use remains the leading preventable cause of death in the U.S. It is responsible for about one in five deaths annually (i.e., about 443,000 deaths per year, and an estimated 49,000 of these smoking-related deaths are the result of secondhand smoke exposure). Tobacco use is also the leading cause of preventable deaths worldwide. According to the May 25, 2012 issue of the Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR) that looked at tobacco deaths worldwide, approximately 6 million tobacco-related deaths occur each year, including 600,000 from secondhand smoke.

If current trends continue, the World Health Organization (WHO) estimates that by 2030 approximately 8 million persons will die each year from tobacco use. The May 2012 issue of the MMWR was released in recognition of World No Tobacco Day on May 31, 2012. By achieving a modest decline in smoking prevalence worldwide (from 25 percent to 20 percent) through further use of tobacco control measures, 100 million deaths can be prevented by 2020 (Frieden T, Bloomberg M. "How to prevent 100 million deaths from tobacco". Lancet 2007;369:1758–61).

CDC Morbidity and Mortality Weekly Reports (MMWR)

The CDC released nine additional MMWRs in 2012-13 related to tobacco use. Among the topics were smoking rates, quit line usage, physician screening practices, and advertising awareness. Two of these reports with particular salience for physician practices are highlighted in this report.

The June 2012 issue of the MMWR included the report, *Tobacco Use Screening and Counseling during Physician Office Visits among Adults,* which analyzed data from the National Ambulatory Medical Care Survey and the National Health Interview Survey. The report indicates that although tobacco use screening occurred during the majority of adult visits to outpatient physician offices during 2005–2008 (62.7 percent), among patients who were identified as current tobacco users, only 20.9 percent received tobacco cessation counseling, and 7.6 percent received tobacco cessation medication. Screening and intervention rates varied by race and ethnicity of the patients. For example, Hispanic patients were less likely to be screened for tobacco use than non-whites. The report discussed barriers most often cited by physicians – lack of time, knowledge and institutional support.

The August 2012 CDC report, *Consumption of Cigarettes and Combustible Tobacco – United States, 2000-2011*, noted a disturbing trend away from cigarettes to other forms of tobacco use. From 2000-2011, cigarette-consumption declined while non-cigarette combustible tobacco-consumption cigars and loose tobacco for roll-your-own cigarettes, or for use in other devices like hookahs, increased. According to the report, total cigarette-consumption declined 32 percent while total consumption of non-cigarette combustible products increased 123 percent. This

increase is attributed to the 2009 federal tobacco excise tax increase that resulted in lower taxes on cigars and loose tobacco. A switch from cigarettes to other, lower-taxed, combustible tobacco products blunts the effect of increasing prices, one of the most effective ways to reduce smoking and prevent youth smoking initiation. It also has practical implications for clinicians screening for tobacco use – asking only about cigarette usage will miss an increasing number of cigar and loose tobacco users.

CDC Launches Media Campaign

CDC's Office on Smoking and Health (OSH) launched a tobacco education media campaign in March 2012 to raise awareness of the human suffering caused by smoking and to encourage smokers to quit. The campaign, called "Tips From Former Smokers" (Tips), profiled people who are living with the significant adverse health effects due to smoking. The campaign featured people who experienced smoking-related diseases before they were 40 years old. "Tips" proved effective in educating the public as well as smokers about available resources. The overall quit line call volume more than doubled during the "Tips" campaign, and visitors to the website (www.smokefree.gov) were more than five times the levels measured during the same 12-week period in 2011. In spring 2013, the campaign will include a Talk with Your Doctor component, and the AMA is partnering with CDC in this initiative. A full page ad will appear in *JAMA* alerting doctors to the campaign and resources. The AMA is also working with CDC to develop a companion webinar.

NATIONAL REPORTS

In December the American Lung Association issued its annual report on smoking cessation, "Helping Smokers Quit: Tobacco Cessation Coverage 2012." The report looks at each state's tobacco cessation coverage and provides an up-to-date review of federal coverage and requirements under the Affordable Care Act. Major findings of the report indicate that the federal government has missed several opportunities to provide better cessation coverage and that state coverage varies widely.

In its comments on the report, the AMA urged states to extend Medicaid coverage of smoking cessation to all recipients so that every single smoker in America, regardless of their state of residence or economic status, will have access to the help they need to quit.

"Broken Promises to Our Children: The 1998 State Tobacco Settlement 14 years later," was also released in December by the Campaign for Tobacco-Free Kids. The report shows that states have inadequately funded tobacco prevention and treatment programs resulting in a slower than expected decline in youth smoking rates. The AMA commented on the report, pointing out that funding for tobacco cessation and prevention programs helps reduce the $96 billion in annual tobacco-related health care costs.

A study conducted by researchers from Georgetown University examined how the tobacco cessation benefit mandated by the Affordable Care Act is being implemented by insurers. The findings identified that insurers either do not understand the new provision or purposely are misleading consumers to avoid coverage. According to an article about the study in *AMNews*, 36 insurance contracts studied included language indicating that preventive services would be paid for in full, but 26 of those contracts also said smoking cessation was not covered. Four contracts excluded individual counseling, and 10 did not include telephone counseling. Seven covered counseling for tobacco cessation but required patients to pay a portion. Other contracts limited access to tobacco cessation by requiring that a related health condition be present before coverage would begin. The insurance companies in the study were not identified.

The study authors recommended that federal and state regulators issue further guidance to address problems in insurance contracts affecting coverage for tobacco cessation treatment, and federal regulators should provide model contract language for this benefit, which would help address ambiguities.

AMA TOBACCO CONTROL ACTIVITIES

Collaborations

The AMA is a member of a national tobacco control partnership that includes public health and advocacy organizations, as well as medical specialty societies. Among the activities this partnership engaged in during 2012

was support of multi-unit smoke-free housing. Addressing multi-unit housing is the next step in protecting everyone where they live, work, and play from the health risks associated with secondhand smoke exposure. The AMA was a co-author on a response to a request for information from the Department of Housing and Urban Development on implementation posted in the Federal Register.

The AMA is also a member of the North American Quit Line Consortium and provided background information on standards for electronic health records for use with referrals to the tobacco quit lines.

Legislation

Legislation introduced in the previous Congress (S. 1461/H.R. 1639) would have prohibited FDA from promulgating any regulations involving certain types of cigars. The AMA and other health, medical, and advocacy organizations are concerned about the wide range of cigar products that would likely have been exempted from any regulation under that bill, including Swisher Sweets Sweet Chocolate Blunts, Phillies Sugarillos Cigarillos (described on the box as "when sweet isn't enough!"), White Owl Grape Blunts Xtra, and Optimo Peach Blunts. These candy-flavored tobacco products are among the most popular with youth. The bill language is still being discussed in Congress. AMA co-signed on a letter to the House urging opposition to any legislation exempting certain types of cigars from oversight.

R.J. Reynolds and American Snuff submitted a Citizen Petition to the FDA Center for Tobacco Products seeking a rule-making proceeding to change the warning labels on smokeless tobacco products. The AMA was a co-signer on comments arguing against the tobacco companies' petition. The tobacco companies claimed that the current warning label ("This product is not a safe alternative to cigarettes.") is misleading and that the label should state that smokeless tobacco is less harmful than cigarettes. The comments submitted by the AMA and others countered this assertion stating that the information on the current label is supported by scientific evidence. In addition, the comments emphasized that such claims of reducing harm would need to be considered by the FDA under Section 911, which addresses modified risk ("harm reduction") claims. FDA review is an avenue that R.J. Reynolds is most likely unwilling to pursue.

AMA/State Medical Society Litigation Center

Since the passage in June 2009 of the Family Smoking Prevention and Tobacco Control Act (Act), which granted regulatory rights to the FDA over tobacco, the tobacco industry has aggressively sought to halt regulations authorized by the Act. The industry has filed a number of lawsuits to challenge the FDA's authority, and the AMA has joined in amicus briefs to bolster the FDA's arguments.

One provision of the Act called for the implementation of graphic warning labels on cigarette packs. In their lawsuits, the tobacco companies assert that the provision violates their First Amendment rights, as the proposed images go beyond illustrating factual information. They further contend that the images convey an anti-smoking agenda, which the tobacco companies should not be forced to have on their products. The AMA has submitted several amicus briefs in these cases, arguing that the FDA regulations are a reasonable effort to curtail cigarette smoking, and that most smokers have become insensitive to non-graphic warnings. Although much of the Act has been upheld, in August 2012, a federal court of appeals ruled that the requirement of having graphic warning labels was unconstitutional.

The AMA signed on to an amicus brief with the Ohio State Medical Association, Ohio Osteopathic Association, Cleveland Clinic, and 12 other health and medical groups in August 2011. The issue in this case, *Bartec v. Wymsylo*, is whether businesses and their owners can be held liable for violations of the Ohio Smoke-Free Workplace Act and the regulations that implement it. In May 2012, the court upheld the authority of the Ohio Department of Health to administer the state's smoke-free law.

The AMA, along with several other anti-smoking organizations, filed amicus briefs to support a New York City ordinance requiring that retail outlets selling tobacco products post city-provided graphic warning signs. A number of retailers brought suit to challenge the validity of the ordinance under the First Amendment. The court ruled in favor of the retailers and the city appealed. In July 2012, the court affirmed the ruling; the city ordinance was preempted by the 1965 Federal Cigarette Labeling and Advertising Act.

Evans v. Lorillard Tobacco Co. is pending before the Supreme Judicial Court in Massachusetts. Lorillard is appealing a judgment of $126 million, based on its marketing of mentholated cigarettes in the 1950s and 1960s to African-American children in a housing project. The AMA signed on to an amicus brief to emphasize the addictive nature of menthol cigarettes and their propensity for causing cancer and other diseases.

Tobacco Control Activities Related to AMA Focus on Improving Health Outcomes

The AMA's Improving Health Outcomes strategic focus seeks to improve outcomes for cardiovascular disease and type 2 diabetes. Given the strong link between tobacco exposure and cardiovascular outcomes, the AMA will continue its work with federal agencies and medical specialty societies to develop resources for clinicians on evidence-based interventions for treating tobacco dependence and continue its work with advocacy partners on policies supporting tobacco control.

19. UPDATE ON CORPORATE RELATIONSHIPS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 – December 31, 2012. Corporate activities that associate the AMA name or logo with a company, non-Federation association, or foundation, or include commercial support, must undergo review and recommendations by the Corporate Review Team (CRT) Policy G-630.040 (Appendix A).

BACKGROUND

At the 2002 Annual Meeting, the HOD approved revised principles to govern the American Medical Association's (AMA) corporate relationships. These "Guidelines for American Medical Association Corporate Relationships" were incorporated into the corporate review process, are reviewed regularly, and were reaffirmed at the 2012 Annual Meeting. AMA managers are responsible for reviewing these projects to ensure they fit within these guidelines.

YEAR 2012 RESULTS

In 2012, 33 activities were considered and approved through the Corporate Review Process, and 27 were implemented. Of the 27 implemented projects, nine were conferences or events, 10 were education or content materials, five were business arrangements, and three were member service provider programs. Six projects were not implemented for reasons unrelated to CRT, such as timing, contract terms, etc. (Appendix B).

CONCLUSION

The BOT continues to evaluate the review process to balance risk assessment with the need for external collaborations that advance the AMA's strategic focus.

APPENDIX A – Corporate Review Process Overview

The Corporate Review Team (CRT) includes senior managers from the following areas: Finance, Business, Advocacy, Federation Relations, Office of the General Counsel, Medical Education, Ethics, Enterprise Communications and Marketing (ECM) and Membership.

The CRT evaluates each project with the following criteria:

- Type, purpose and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);

- Source of external funding;
- Use of the AMA logo;
- Fit or conflict with AMA Corporate Guidelines;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.
- Independent and company-sponsored foundation supported projects.
- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database licensing.)
- Member service provider programs such as new affinity or insurance programs and member benefits.
- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.
- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions only if there is corporate sponsorship.
- Vendor requests for usage of AMA name beyond a client listing.

For the above specified activities, if the CRT recommends approval, the project proceeds. In addition, the Executive Committee of the Board reviews and must approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees. The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

APPENDIX B – Summary of Corporate Review Recommendations for 2012

Project No.	Project Description	Corporations	Approval Date
	CONFERENCES/EVENTS		
1101-0023	International Conference on Physician Health - AMA sponsorship of 2012 Conference.	Quebec Medical Association Quebec Physician Health Group British Medical Association Canadian Medical Association	2/10/2012
1101-0433	AMA Co-Sponsorship of the Eighth Annual Integrated Healthcare Association (IHA) Pay for Performance Summit - Co-sponsorship of summit on value based performance and payment.	California Healthcare Association California Association of Physician Groups Center for Healthcare Quality and Payment Reform Network for Regional Healthcare Improvement The Leapfrog Group Healthcare Incentives Improvement Institute National Committee for Quality Assurance (NCQA) Pacific Business Group on Health (PBGH) Premier, Inc. Integrated Healthcare Association	12/13/2012

Project No.	Project Description	Corporations	Approval Date
1104-0486	Co-Sponsored CME with Yale University - CME titled "Health Equity in Cancer: Creating an Action Plan Addressing Clinical, Research, Education and Community Perspectives".	Genentech, Inc. Lilly, USA, LLC Onyx Pharmaceuticals Sanofi-Aventis U.S., LLC. Yale University	12/13/2012
2201-0042	AMA Co-Developed Forum with National Journal - National Journal forum on payment and delivery reform.	National Journal Group, Inc.	9/25/2012
2203-0406	AMA/WEDI/MGMA Vendor Engagement Meeting – Vendor conference to assist physicians with adoption of electronic transactions.	Medical Group Management Association Workgroup for Electronic Data Interchange	5/22/2012
2203-0407	Co-Sponsorship of Accountable Care Organization (ACO) Congress – Seminar on effective ACO implementation.	California Hospital Association California Medical Association California Association of Physician Groups Integrated Healthcare Association	7/10/2012
4401-0143	International Medical Graduate (IMG) Section 15th Anniversary Summit - Interactive meeting on future international medical graduates and of globalization.	Kaplan Medical Educational Commission for Foreign Medical Graduates Federation of State Medical Boards The Josiah Macy Jr. Foundation Pfizer, Inc. American Association of Physicians of Indian Origin (AAPI) Association of Pakistani Physicians of North America (APPNA) Prometric National Board of Osteopathic Medical Examiners Nixon Peabody LLP American Board of Internal Medicine American Board of Medical Specialties (ABMS) Internet Testing Systems Pearson VUE Von Tauber Institute Pritzker Medical School Northwestern Medical School The College of Canadian Family Physicians Ross Medical School St. Georges Medical School National Association of Public Hospitals & Hospital Systems	1/20/2012
4401-0145	AMA Group Practice Career Fair - Career Fair connecting medical students and young physicians with large medical group practices.	Mayo Clinic Cleveland Clinic Henry Ford Health System Aurora Health System Scott & White Healthcare Wenatchee Valley Medical Center Kaiser Permanente McFarland Clinic, PC	2/7/2012
5503-0079	AMA Collaboration with Annual HIMSS Conference - 2013 HIMSS Conference and Exhibition. AMA collaboration acknowledged on conference materials.	HIMSS	11/1/2012

Project No.	Project Description	Corporations	Approval Date
	EDUCATION		
1100-0202	AMA Board Chair Quote - Dr. Stack, Chair of the AMA Board of Trustees, quote for "Medical Licensing and Discipline in America: A History of the Federation of State Medical Boards" written by David Johnson and Humayun Chaudhry.	Federation of State Medical Boards Lexington Books	6/13/2012
1101-0427	Communication Climate Assessment Toolkit (C-CAT) - Ethical Force Training Program.	Compass Consulting Services, LLC Cross Cultural Health Program Global Health Care Associates, LLC Literacy Coalition of Central Texas CULTURELink, Inc. Wilson Stronks, LLC Critical Measures, Inc. Health Communication Research Institute, Inc.	9/5/2012
1104-0478	Patient Preventative Services Brochure Walgreens/AARP strategic alliance for Preventative Services Brochure.	AARP Walgreens Co.	3/2/2012
1104-0480	Education Transportation Guide - Guide titled, "Getting Around After Your Medical Procedure/Illness: A Guide to Plan for Transportation" with Easter Seals.	Easter Seals	2/3/2012
1104-0483	Practical Steps to Resilience Module - CME credit companion piece to "AMA Healthier Life Steps: A Physician's Guide to Personal Health."	Renew	3/15/2012
1104-0485	Co-Sponsored Genetics Webinar - An AMA/Nova/Hastings Center co-sponsored webinar regarding genetic technologies in clinical practice.	NOVA (PBS) The Hastings Center	7/25/2012
2203-0408	AMA/Federation/UHC Whitepaper - Created by AMA, UHC and the Federation to document successful interactions, streamline procedures and improve the relationship between UHC and the physician community.	UnitedHealth Group United Healthcare	10/17/2012
4401-0144	AMA Education Session on Contracting - An educational event on physician contracting to support member engagement and recruitment.	Healthcare Incentives Improvement Institute National Committee for Quality Assurance Pacific Business Group on Health Premier, Inc. Integrated Healthcare Association	1/20/2012
6601-0424	i-Human Project - AMA support for creation of new patient case studies by leading academic medical institutions for i-Human.	Summit Performance, LLC	11/5/2012
6606-0407	Advancement of Women in Medicine Fund - Support for a fund created by the AMA Foundation and Women Physicians Congress to advance the progress of women in the medical profession.	Pfizer, Inc.	1/20/2012
	BUSINESS		
5505-0036	AMA Insurance Agency (AMAIA) Business Owner's Policy - To provide physicians with commercial insurance for their practice.	The Hartford Insurance Group	5/22/2012

Project No.	Project Description	Corporations	Approval Date
5505-0472	AT&T Healthcare Online and AMAGINE - Transfer of the AMAGINE business platform to AT&T.	AT&T (Healthcare Online)	2/7/2012
5505-4063	National Master Business Agreement with Blue Cross Blue Shield Association (BCBSA) - To facilitate the licensing of the AMA printed and online suite of coding products by BCBSA member plans and affiliated companies.	Blue Cross Blue Shield Association	10/8/2012
5505-4064	Z Codes for CPT Code Map - Licensing relationship to offer a consistent tracking and reporting on Molecular Diagnostic (MDx) testing.	McKesson Corporation	10/8/2012
5505-0473	AMA Relationship with AmericanEHR Partners - Participation in program on electronic health records including logo association.	AmericanEHR Partners 3/23/2012	
	MEMBER SERVICE PROVIDER PROGRAMS		
5505-0347	AMA Member Value Program (MVP) - Mercedes-Benz Pilot Program - Adding Mercedes-Benz USA as a preferred provider within the AMA MVP.	Mercedes-Benz USA	6/13/2012
5505-0435	AMA Member Value Program (MVP) - Wells Fargo - AMA Sponsored Commercial Lending Program with Matsco - Wells Fargo and other associations.	Wells Fargo American Dental Association American Optometric Association American Animal Hospital Association	9/5/2012
5505-0471	AMA-Sponsored Kaplan Discount Update – Member discount on Kaplan USMLE/COMLEX online test question banks.	Kaplan Medical	9/5/2012

20. PHYSICIANS' RESPONSE TO VICTIMS OF HUMAN TRAFFICKING
(RESOLUTIONS 4-A-12, 8-A-12)

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTIONS 4-A-12 AND 8-A-12 AND
REMAINDER OF REPORT FILED**
See Policy H-65.966

At the 2012 Annual Meeting, the American Medical Association (AMA) House of Delegates referred to the Board of Trustees Resolutions 4-A-12, "Educating Medical Providers as First-Line Responders to Stop Human Trafficking" (Illinois Delegation) and 8-A-12, "The Recognition and Protection of Human Trafficking Victims" (Michigan Delegation).

Resolution 4 asked our AMA to encourage physicians to act as first responders in addressing human trafficking, including creating a curriculum to screen for victims and developing guidelines to educate health care professionals on how to intervene in cases of human trafficking.

Resolution 8 asked our AMA to work with the Department of Health and Human Services to develop guidelines for identifying victims of human trafficking and to encourage editors and publishers to include screening information on human trafficking in medical training literature.

THE PROBLEM OF HUMAN TRAFFICKING

The United Nations defines human trafficking as "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs"[1].

It is difficult to determine the extent of human trafficking with any precision. However, drawing on data from the U.S. Department of Health and Human Services and the U.S. Department of Justice, the nonprofit organization Force4Compassion estimates that between 14,500 and 17,500 individuals are trafficked in the United States each year, 50 percent of whom are children [2]. Force4Compassion estimates that some 800,000 individuals are trafficked worldwide. The Polaris Project, a nonprofit anti-trafficking organization, has noted that although the number of trafficking victims in the U.S. is not known with certainty, "hundreds of thousands" of children may be at risk of commercial sexual exploitation [3].

As of January 2013, all 50 states had enacted laws criminalizing human trafficking [4].

AMA POLICY

Current AMA policy does not address human trafficking directly, but rather broader issues of violence and abuse, particularly with respect to children:

- E-2.02 Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse, issued in 2008, calls on physicians to routinely inquire about abuse as part of the medical history, familiarize themselves with signs of violence and abuse, and clarifies physician responsibility to address abuse.
- H-60.992 Missing and Exploited Children, reaffirmed in 2006, supports cooperating with the American Academy of Pediatrics and other professional associations to develop and disseminate information about the health care needs of missing children.
- H-515.960 Identifying and Reporting Suspected Child Abuse, adopted in 2009, supports development of a "comprehensive educational strategy" to improve detection, reporting, and treatment of child abuse.
- D-515.993 Support for Legislative Action and Improved Research on the Health Response to Violence and Abuse, adopted in 2004, called for a Federation-wide task force to review and promote best practices for identifying, managing, and preventing family violence, which resulted in a report to the House of Delegates in 2005 (CSA 7-A-05, Diagnosis and Management of Family Violence).

RESOURCES FOR PHYSICIANS

Recognizing the important role that physicians and other health care providers can play in addressing the problem of human trafficking, the U.S. Department of Health and Human Services (HHS) has developed extensive resources to aid physicians through the Rescue & Restore campaign under the Administration for Children & Families. Resources include screening questions to help physicians identify victims, a review of health problems seen in victims, guidance to help physicians understand the mindset of a trafficking victim, and messages for communicating with victims. (Companion resources are available for social service organizations and for law enforcement officers.)

The Polaris Project, through its National Human Trafficking Resource Center (the NHTRC), likewise offers tools for health care professionals and other service providers and law enforcement personnel, including an online training program in recognizing and responding to human trafficking in health care contexts. In addition, the NHTRC provides speakers and training materials through its technical assistance program, as well as links to local resources in all 50 states and the U.S. territories.

FOCUSING AMA IMPACT

As Isaac and colleagues note "[h]ealthcare providers are one of the few groups of professionals likely to interact with victims of human trafficking while [the victims] are still in the control of the criminals who are manipulating

and profiting from them"[5]. However, in light of the wide range of resources already available to physicians through The Polaris Project and the HHS Rescue and Restore campaign, it is unlikely that AMA efforts to develop guidelines and educational materials for physicians would have significant additional impact in this area. AMA could more meaningfully address human trafficking by making physicians aware of the existing resources available to them.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 4-A-12 and 8-A-12 and the remainder of this report be filed:

That our American Medical Association (AMA) encourage its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

- The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and children.

- The Polaris Project
  In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:

  o Operates a 24-hour National Human Trafficking Hotline
  o Maintains the National Human Trafficking Resource Center, which provides
    ▪ An assessment tool for health care professionals
    ▪ Online training in recognizing and responding to human trafficking in a health care context
    ▪ Speakers and materials for in-person training
    ▪ Links to local resources across the country

- The Rescue & Restore Campaign
  The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

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21. EXAM ROOM COMPUTING & PATIENT-PHYSICIAN INTERACTIONS
(RESOLUTION 701-A-12)

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 701-A-12 AND
REMAINDER OF REPORT FILED
See Policy D-478.977

At the 2012 Annual Meeting, the American Medical Association (AMA) House of Delegates referred to the Board of Trustees Resolution 701-A-12, "Effect of Computers in the Exam Room on Patient-Physician Communication" (Medical Student Section). Resolution 701-A-12 asked:

That our American Medical Association study the effect of electronic devices, including but not limited to computers and tablets, in the exam room on doctor-patient communication with an emphasis on alternatives and modifications that might improve the physician-patient relationship.

COMPUTERS IN THE EXAMINATION ROOM

Anticipated Benefits & Undesired Consequences

Electronic health records are expected to improve the quality and efficiency of care delivery [1,2,3]. It is argued that real-time access to health information at the point of care could give physicians more time to explain diagnoses and treatments and address patient concerns, while greater access to the patient's medical information could support more productive discussions with patients [1]. And indeed, studies have indicated that health information technology can improve adherence to preventive care guidelines, reduce inpatient medication errors, and reduce cost of care [1].

At the same time, concerns have been raised that the presence of computers in the examination room could have negative effects on patient-physician interactions. These include shifting physicians' attention away from engaging with the patient, encouraging clinicians to focus on clinical over psychosocial issues [1,3,4], and disrupting clinical workflow [4] and increasing physicians' workload [3].

Patient Satisfaction Before & After Implementation of Exam Room Computing

These concerns have been explored in several studies of patient satisfaction. Over the past two decades, research has consistently indicated that patient satisfaction does not appear to be adversely affected by the introduction of computers into the examination room [5,6]. In one longitudinal study, for example, Hsu and colleagues found that despite initial concerns on the part of patients, "overall visit satisfaction, satisfaction with the physician's level of familiarity, communication about medical issues, and the degree of comprehension with decisions made during the visit all improved significantly" following implementation of exam room computing [1].
A study among adult psychiatric outpatients found no change in patient satisfaction, even in this setting, despite concerns that implementing an EHR could disrupt the dynamics of communication that are central to the patient-psychiatrist relationship and disproportionately influence these patients [5].

Responses by family medicine patients surveyed by Lelievre and Schultz indicated that the factor which most affected patients' perceptions of exam room computing was in fact their physicians' attitude toward the computer: "The more positive they perceived their doctors' attitudes toward the computer to be, the more likely respondents were to indicate a preference for computer use" [7]. Indeed, some patients appear to take physicians' use of EHRs as an indicator that patients are receiving better care [3].

Computers & Patient-Physician Interactions

Observational studies and interviews with clinicians have explored how the presence of computers in the examination room affects patient-physician interactions. These studies have found that, although the introduction of computers does influence the encounter, for the most part the feared negative effects of exam room computing have not materialized [2,3,4,8,9,10,11].

These various studies have identified several factors that influence patient-physician interactions, including the positioning of the computer monitor in the examination room relative to patient and physician, which could either include or exclude the patient during physicians' use of the computer [4,8,10,11]. Physicians' proficiency in using computers, including typing ability and comfort in navigating EHRs, also affects interactions [2,3,8], as do features of the technology itself, for example, how an EHR structures information and data input processes (e.g., through templates) [8, 4], and the nature and frequency of clinical reminders and "pop-ups" [9,12].

Whether physicians treat the EHR as simply an updated version of paper charts or perceive it in other ways, as a tool for educating patients or even a party to the interaction, also influences how exam room computing affects encounters with patients [2,8,11]. In addition, the culture of the health care organization can affect implementation and use of EHRs in patient-physician interactions. How accepting or skeptical an organization is of exam room computing, as well as individual physicians' levels of enthusiasm in adopting EHRs, can carry over into encounters with patients, with positive or negative effects [3,8].

Among the most important factors, however, are physicians' communication skills and their individual style of interacting with patients [2,4,8,11,13]. In one video-based longitudinal study with primary care physicians, Frankel and colleagues observed that physicians who skillfully integrated collecting data through patient interviews and recording it in the paper chart before the introduction of computers into the exam room "were also able to seamlessly integrate the computer into their visits" [2]. Physicians who performed less well at baseline (before the implementation of exam room computing) "also had additional difficulties using the computer as an interpersonal communication tool" [2].

Another video-based study among primary care physicians found that physicians who exhibited an "informationally based" style focused on their computer monitors and used computer guided questions to elicit "problem-oriented" details from patients, while physicians who exhibited an "interpersonal" style, "were led by patient narratives" and engaged their patients, taking advantage of the mobility of their computers when available. Physicians with a "managerial" style alternated attention between the patient and the computer [8]. Other research has described exam room layouts along a range of "inclusiveness," reflecting the ease with which patients were able to view the computer screen. At one extreme, inclusive layouts allowed patients to see the monitor "without unnatural body movement"; at the other, exclusive layouts placed the monitor so as to make it impossible for patients to view the screen [4,10].

Patient-Physician-Computer Interactions

Researchers increasingly describe a triadic relationship among patient, physician, and computer in which the computer, or more properly, the EHR, is to greater or lesser degree an active participant in clinical encounters [8,10,11]. For example, Ventres and colleagues observed that "the EHR has its separate identity in the encounter, and both physicians and patients project their perceptions onto this identity. They pattern their behaviors accordingly as they go about the shared work of medical care." [8]

In this context one recent study among primary care practices in Australia is of particular interest. In this study, in-depth analysis of videotaped interactions indicates that while some patients engage primarily in dyadic relationships with the physician that tend to exclude the exam room computer, other patients actively negotiate triadic relationships in which both physician and computer are parties along with the patient [11]. For these latter patients, the authors suggest, "computers allow power in the consultation to be shared in ways it has not been before." They conclude that exam room computing "democratizes" and "commoditizes" information flow and authority in new ways, setting the stage for more truly patient-centered medicine.

MAXIMIZING BENEFITS, MINIMIZING DISRUPTION

While the use of computers in the examination room clearly does affect clinical encounters, then, it equally clearly does not inevitably disrupt or undermine patient-physician interactions. Technical improvements in EHRs that focus required computer tasks on activities that meaningfully influence patient outcomes [4], or that streamline data input and reduce the time needed to complete common tasks in clinical work and decrease the potential for distraction [4,9], will help minimize the possibility for disruption.

Removing spatial barriers, such as installing mobile monitors or configuring examination rooms to enable physicians to maintain eye contact while using the computer and allow patients to view the computer screen easily [1,10,11] can help promote "inclusive" use of computers in clinical encounters.

Experienced users have recommended engaging patients in viewing their medical records [9, 8,10], and using the computer to seek out medical information online and foster shared decision making [3]. Further, better educating physicians to integrate the use of computers in their interactions can also help maximize benefits and minimize undesired consequences. As yet, however, there is no consensus about when or how best to do so [8]. Approaches that have been suggested include using video observations of a physician's own practice [4].

However, the accumulating evidence suggests that whether exam room computing has a positive or negative effect depends in significant measure on the perspective and skills physicians bring to using computers in encounters with patients. As Ventres and Frankel observe, "Physicians with good baseline communication skills tend to integrate exam room computing into their relationship with patients whereas physicians with poor baseline skills tend to create communication barriers when using computers in the exam room" [13].

Kaiser Permanente's Interregional Clinician-Patient Communication Leaders identified five communication behaviors that foster effective integration of computers into patient-physician interactions, captured in the acronym *LEVEL* [6]:

Let the patient look on – move the computer screen so the patient can see it, invite the patient to view information, ask the patient to verify information as it is entered

Eye contact – greet the patient, maintain eye contact

Value the computer as a tool – acknowledge the computer, let the patient know how it improves care

Explain what you are doing – inform the patient about actions and decisions, tell the patient what you are doing, such as ordering lab tests

Log off and say you are doing so – tell the patient you are logging off to safeguard his or her information

Family Practice Management also published tips for patient-centered care using EHRs [14]:

- Use a mobile monitor
- Learn to type
- Integrate typing around your patient's needs
- Separate routine data entry from patient encounters
- Start with patients' concerns
- Tell patients what you're doing
- Point to the screen
- Encourage patients' participation
- Look at your patients

The data suggest that incorporating such relatively simple behaviors may be as effective as any other response to the challenges of integrating computers and EHRs into interactions with patients.

RECOMMENDATION

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

1. That our American Medical Association (AMA) make physicians aware of tips and resources for effectively using computers and electronic health records (EHRs) in patient-physician interactions through AMA publication vehicles.

2. That our AMA encourage physicians to incorporate questions regarding use of computers and EHRs in patient-satisfaction surveys to provide feedback on how their own patients experience the use of computers in the examination room.

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22. PROFESSIONALISM IN TELEMEDICINE & TELEHEALTH (RESOLUTION 711-A-12)

Reference committee hearing: see report of Reference Committee G.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 711-A-12
REMAINDER OF REPORT FILED AND**
See Policies H-225.962, H-480.968, H-480.969, H-480.974 and D-480.974

At its 2012 Annual Meeting, the American Medical Association (AMA) House of Delegates referred to the Board of Trustees Resolution 711-A-12, "Web-Based Tele-Health Initiatives and Possible Interference with the Traditional Physician-Patient Relationship" (New York Delegation). Citing concerns that telemedicine or telehealth may adversely affect the patient-physician relationship, Resolution 711-A-12 asked:

1. That our American Medical Association urge the Department of Health and Human Services (DHHS) to review telehealth initiatives being implemented by major health insurance carriers (i.e., United Healthcare, Blue Cross Blue Shield) and others to assure that appropriate standards of care are maintained, that such initiatives and the physicians who work with them are adherent to professional practice standards and federal public health laws and regulations; and to take appropriate actions to eliminate such initiatives that do not meet acceptable standards and regulations; and

2. That our AMA seek regulatory guidance from DHHS regarding the essential requirements of web-based telehealth technology and health care initiatives and the requirements of physicians and healthcare providers who engage in delivery of such services.

BACKGROUND

Defining Telemedicine & Telehealth

The terms "telemedicine" and "telehealth" are used to refer to a variety of applications of information technologies in health care, from telephone or email communication between patient and physician, to remote monitoring of patient health status, to online programs for patient self-management, to two-way real time interactive communication between patient and physician.

Under definitions adopted by the Centers for Medicare & Medicaid Services (CMS), *telemedicine* comprises the provision of service through two-way, real time interactive communication between a patient and a physician or practitioner at a distant site using interactive telecommunications equipment that includes (at minimum) audio and video equipment [1]. It is thus a subset of telehealth. *Telehealth* involves a broader range of devices, including telephones, facsimile machines, electronic mail, or remote patient monitoring devices to collect and transmit patient data for monitoring and interpretation in real time or through store and forward technologies [2]. The goal of both telemedicine and telehealth is to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance.

Telemedicine/telehealth services may be available through health care facilities, such as rural hospitals or outpatient clinics that link local patients with services at remote facilities, such as VHA telehealth services [3]; and through Web portals maintained by physician practices, health care organizations, insurers, or others that enable patients to access health information and services online, such as Mayo Clinic, Partners Healthcare, or Web MD [4,5,6].

Oversight of Telemedicine & Telehealth

Oversight of telemedicine/telehealth is fragmented and remains piecemeal. At the federal level, the U.S. Food and Drug Administration (FDA) requires online pharmacies to comply with licensure rules of the states in which the pharmacy operates [7]. FDA regulates medical device data systems, i.e., devices "intended to transfer, store, convert from one format to another according to preset specifications, or display medical device data" [8]. In addition, it has issued draft guidance on mobile medical applications, applications that are "used as an accessory to a regulated medical device" or "transform a mobile platform into a regulated medical device" [9].

Other federal oversight focuses on the use of telemedicine/telehealth in federal health care systems, such as the Veterans Health Administration and Indian Health Service and to issues of reimbursement and credentialing under Medicare and Medicaid.

Medicare reimburses physicians and certain other health care professionals for a limited set of telemedicine services provided to beneficiaries in rural and critical access areas. Conditions of reimbursement include that the physician be licensed under state law to provide the service and credentialed by the facility at which he or she otherwise provides face-to-face services [2].

Medicaid permits states to determine whether to cover telemedicine and telehealth services, what types of services to cover and how much to reimburse for telemedicine services, as well as to set other conditions for provision of these services [1]. As of February 2013, 44 state Medicaid programs reimburse for a variety of telemedicine and telehealth services [10]. Like Medicare, Medicaid requires that a physician or other health care professional be licensed to provide the service under his or her state practice act [1].

At the state level, licensure requirements established by state medical boards vary considerably with respect to telemedicine [11], with most requiring that physicians providing telemedicine services be licensed in the state in which the patient receives services. With the support of U.S. Health Resources and Services Administration, the Federation of State Medical Boards continues to pursue initiatives to facilitate license portability and reduce regulatory barriers to telemedicine, [12] including exploring mechanisms to expedite multi-state licensing [13]. The majority of states (41) require that the physician examine the patient in person before prescribing [14].

Standards of care for telemedicine/telehealth services are a work in progress. Under the auspices of the Agency for Healthcare Research & Quality's Innovations Exchange, the American Telemedicine Association has developed

both practice guidelines and technical standards in a variety of areas, including, for example, telemental health and telerehabilitation [15,16]; that work is ongoing.

In addition, professional specialty societies continue to develop clinical guidelines or position statements relating to telemedicine and telehealth. These include the American College of Radiology, American Academy of Dermatology, American Psychological Association, and Society of American Gastrointestinal and Endoscopic Surgeons [17]. Some have also developed educational programs for physicians involved in telemedicine/telehealth [18]. The Veterans Health Administration (VHA), an early adopter and leader in telemedicine/telehealth, also continues to evolve standards and training for health care professionals across the VHA system [3].

THE PATIENT-PHYSICIAN RELATIONSHIP IN TELEMEDICINE/TELEHEALTH

The relationship of trust between patient and physician has long been understood as foundational to ethical practice in medicine. AMA policy stresses that such relationships must be predicated on

open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in his or her care; commitment of the physician to be an advocate for the patient and for what is best for the patient, without regard to the physician's personal interests; provision by the physician of that care which is necessary and appropriate for the condition of the patient and neither more nor less; and avoidance of any conflict of interest or inappropriate relationships outside the therapeutic relationship [H-275.937 Patient/Physician Relationship and Medical Licensing Boards].

The AMA *Code of Medical Ethics* holds that physicians who provide advice to users of health-related websites, including users with whom the physician does not have an existing patient-physician relationship, should uphold general standards of truthfulness, privacy and confidentiality, informed consent, and transparency with respect to the limitations of the technology. It further provides that physicians who establish or are involved in health-related online sites must minimize conflicts of interest and commercial biases, e.g., through disclosure of funding and honesty in advertising [Opinion E-5.027 Use of Health-Related Online Sites]. Opinion E-5.025 Physician Advisory or Referral Services by Telecommunication, issued in 1994, prohibits physicians from providing any clinical services via telecommunications. This stricture may no longer be consistent with best ethical analysis or strong practice in the rapidly evolving area of telemedicine/telehealth and merits review by the Council on Ethical and Judicial Affairs.

The same core values are underscored in various codes of ethics for the health Internet [19] and the World Medical Association's Statement on the Ethics of Telemedicine [20].

There have been few empirical studies of the impact of telemedicine/telehealth on patient-physician interactions. A 2010 Cochrane Collaboration review found that a majority of telemedicine studies have focused on establishing diagnostic accuracy rather than assessing impact on patient outcomes or communication between patients and health care professionals [21]. The authors conclude that "the use of telemedicine technologies may require different clinical skills such as, for example, the use of specific communication skills, and approaches to information giving, and may indeed significantly alter the nature of the clinical encounter and the relationship between the professional and the patient" [21]. However, they draw no conclusions as to whether the effect of change would ultimately be positive or negative.

That patients desire access to online medical information and at least some clinical services seems clearly indicated by widespread use of online health sites, increasingly through health-related applications for smartphones and other mobile devices [22]. Moreover, some studies have suggested that patients may have different expectations for telemedicine than do health care professionals or policy analysts; for patients, the convenience of telemedicine and enhanced access to specialist care may be key considerations, for which some trade-offs in other areas, such as communication, are acceptable [23].

RELEVANT HOD POLICY

AMA has long-standing policy dealing with various aspects of telemedicine/telehealth, including licensure and credentialing of health care professionals who provide telemedicine/telehealth services, development of practice parameters/guidelines by medical specialty societies, coding and reimbursement, and quality of care:[*]

- H-120.956 Internet Prescribing (1999, reaffirmed 2004, 2005)
- H-480.974 Evolving Impact of Telemedicine (1994, reaffirmed 2001, 2011)
- H-480.968 Telemedicine (1996, reaffirmed 2006)
- H-480.969 The Promotion of Quality Telemedicine (1996, amended 1999, reaffirmed 2009, 2010, 2012)
- H-225.962 Medical Staff Membership Category for Physicians Providing Telemedicine (1997, reaffirmed 2007)
- H-478.999 An International Code of Ethics for Health Internet Sites (2000, reaffirmed 2010)

AMA policy discourages government intrusion into interactions between patients and physicians in H-100.971 Preserving the Patient-Physician Relationship (1995, reaffirmed 2005) (in the specific context of medication prescribing).

RECOMMENDATION

In view of these considerations, and recognizing that telemedicine/telehealth hold out promise for improving access to care and health outcomes, the Board of Trustees recommends that in lieu of Resolution 711-A-12 the following recommendations be adopted and the remainder of this report be filed:

1.   That policies H-480.968 Telemedicine, H-480.969 The Promotion of Quality Telemedicine, H-225.962 Medical Staff Membership Category for Physicians Providing Telemedicine be reaffirmed; and

2.   That H-480.974 Evolving Impact of Telemedicine be amended by addition and deletion to read as follows:

Our AMA:
(1) will evaluate relevant federal legislation related to telemedicine;

(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;

(3) urges professional organizations that serve medical ~~specialty societies~~ specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;

(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;

(45) encourages ~~the CPT Editorial Board to develop CPT codes or modifiers for telemedical services~~ development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;

(56) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;

(67) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine; and

_____
[*] See also the following Directives of the House of Delegates: D-120.960 Internet Prescriptions; D-120.986 Guidance for Physicians on Internet Prescribing, D-275.996 Creation of AMA Data Bank on Interstate Practice of Medicine, D-480.999 State Authority and Flexibility in Medical Licensure for Telemedicine.

(~~7~~8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries.

3.   That the Council on Ethical and Judicial Affairs be asked to review Opinions relating to telemedicine/telehealth and update the *Code of Medical Ethics* as appropriate.

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23. INNOVATION TO IMPROVE USABILITY AND DECREASE COSTS OF ELECTRONIC HEALTH RECORD (EHR) SYSTEMS FOR PHYSICIANS

Reference committee hearing: see report of Reference Committee G.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AND
                    REMAINDER OF REPORT FILED**
               See Policy D-478.976

INTRODUCTION

At the 2012 Interim Meeting, the House of Delegates amended Policy H-478-992, "Innovation to Improve Usability and Decrease Costs of Electronic Health Record (EHR) Systems for Physicians," to call for our American Medical Association (AMA) to:

> Submit a report at the 2013 Annual Meeting on what steps our AMA has taken to implement AMA Policy H-478.992, as well as a strategic plan for further implementation of this policy.

This report provides background on the current state of open source vs. proprietary electronic health record (EHR) technology that meaningfully represents the interests of physicians and their patients, and supports diverse substitutable software applications based on open or proprietary code.

BACKGROUND

AMA Policy H-478.992 was the result of a resolution adopted by the House of Delegates at A-09 and reads as follows:

> Our AMA supports law and public policy that would provide an open source electronic health record that meaningfully represents the interests of physicians and their patients, that embodies an open standards platform that is both interoperable at large and supports diverse substitutable software applications based on open or proprietary code, and will work with the Department of Health and Human Services and other agencies to implement this policy. Our AMA will report at our 2013 Annual Meeting on what steps our AMA has taken to implement HOD Policy H-478.992, as well as on a strategic plan for further implementation of this policy.

Physicians use electronic health record (EHR) software applications to document, monitor and manage patient health information for the delivery of care. The use of EHRs allows prompt access to notes, laboratory results and other patient data. The intent is to improve the quality, safety, and efficiency of health care.

There are two varieties of EHR software: proprietary and open source. The latter emerged as a model for EHR software between 2000 and 2002,[1] due largely to the success of an open-source operating system (Linux®[2]) and in response to the then high cost of proprietary systems especially for smaller practices. Open-source software was thought to offer lower acquisition and maintenance costs, greater opportunity for customization and enhancement, shared development costs, decreased barriers to interoperability and less vulnerability to vendor failure.[3]

An open-source EHR installation can cut the cost for a typical inpatient EHR in half. EHR implementation costs for smaller practices and organizations vary greatly and are more difficult to project. While pricing is more transparent than in the past, the factors that influence total implementation cost and time (e.g., practice readiness, training time, degrees of customization, etc.) vary dramatically. In the ambulatory space, estimates for the cost of open-source EHRs range between $5,000 and $15,000 per full-time physician.[4] A California Healthcare Foundation study from 2008 found open-source EHR costs to be "very low (even zero, if no commercial add-on modules are purchased),"[5] noting that the bulk of monetary costs stem from hardware purchases, installation/support services and software customization. The cost of purchasing and installing a proprietary EHR technology at that time ranged from $15,000 to $70,000 per provider.[6]

However, the commercial EHR market is now offering "free" or very low cost EHRs, especially so-called software as a service (SaaS) models. PracticeFusion, a company offering such a free software option, reports having 150,000 medical practitioner users.[7] An EHR developed exclusively for the iPad, drchrono, garnering recent press from The

New York Times, Wall Street Journal, USA Today and Forbes also offers a free version. The company recently announced the infusion of $2.8 million from the investment community and reported 15,000 registered providers.[8] Other SaaS EHRs can cost as little as $5,000 per full-time physician.

The Veterans Health Information Systems and Technology Architecture (VistA) is an enterprise-wide, open source information system built around an EHR that is used by the United States Department of Veterans Affairs (VA) medical system. It consists of nearly 160 integrated software modules for clinical care, financial functions, and infrastructure. VistA is the oldest and most well-known open source EHR. It is also regarded as one of the most reliable EHRs and is in use throughout the VA hospital and clinic system. It was developed at VA hospitals in the 1970s and perhaps surprisingly shares the same programming language[9] (i.e., MUMPS) as Epic Systems—one of the largest and highest priced EHR vendors. The VistA system is available through the Freedom of Information Act directly from the VA website or through a growing network of distributors.

WorldVistA EHR is the iteration for use by organizations outside the VA. Also a fully open-source EHR, WorldVistA has developed software modules (such as pediatrics, obstetrics and other functions) not used in the veterans' healthcare setting. WorldVistA EHR achieved meaningful use (MU) certification in 2011 and was used by other companies to create open-source EHRs for the ambulatory market.[10] An Office of the National Coordinator (ONC) certified version of the VistA system developed by Medsphere Systems Corp., Carlsbad, Calif., has been used by seven hospitals and one physician to achieve MU. In addition, an open-source VistA version from the not-for-profit organization WorldVistA has been used to achieve MU by one hospital, federal records show.[11]

The VA recently formed the Open Source Electronic Health Record Agent (OSEHRA), an independent, nonprofit, to take an active role in upgrading and standardizing the VistA EHR. The group is dedicated to facilitating, through the use of best practices in open source software development, the improvement and maintenance of EHR information systems.[12] They welcome the contributions of developers from all backgrounds and organizations.

In addition to the VA, there are other companies offering ONC-certified, open-source EHRs. At least six other certified open-source EHRs received certification for either the inpatient or outpatient setting or a combination. As of December 2012, one open-source company, OpenEMR, reported 5,000 installations in physician offices and other small healthcare facilities across the U.S.[13] Other MU certified open-source EHRs include ClearHealth and Tolven.

The EHR marketplace remains diverse and is expected to grow significantly over the next several years. The U.S. market value for inpatient and outpatient EHR software was nearly $1.98 billion in 2009 and will steadily increase to $3.8 billion in 2015, according to a 2011 report from research firm IDC Health Insights.[14]

This steady growth is largely attributable to recent government support. The American Recovery and Reinvestment Act of 2009 (ARRA) included $30 billion to support new Medicare and Medicaid incentives to adopt EHRs based on the belief that widespread adoption of health information technology (HIT) could transform health care delivery. The bill also allotted $500 million for states to develop HIT and included the provision of a government-led process for certification of EHRs. The purpose of certification is to assure purchasers that all certified EHRs, whether used in ambulatory or hospital settings, will have certain baseline capabilities.

MU is still an early stage program. Up to the date of this report, there is only preliminary financial incentive data to assess the impact of the program. Recent data from the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics survey, however, indicates that in 2012, 72% of office-based physicians used an EHR.[15] This marks a 26% increase over 2011, the first year eligible professionals could qualify for EHR MU incentives, and a 41% increase over 2010, the year before MU incentives. Additional estimates from the CDC survey showed that the percentage of office based physicians using all or partial EHR systems by state ranged from 22% to 71%.[16]

ARRA also stipulates provisions for the development of uniform standards to facilitate more interoperable exchange of health information. The Heath Information Technology Standards Committee has defined a number of interoperability specifications that, when executed, make the exchange and integration of data among different systems easier. Despite these efforts and significant growth, the EHR market remains immature.

DISCUSSION

Physicians have historically listed the cost of EHR systems, concerns about technical support and the usability of systems as top barriers to EHR adoption.[17] Cost is especially important among smaller physician practices where most patients seek care.[18] Thus, the success of the VA's open-source EHR software made it appear a popular and widely available option to resolve cost and other issues.

EHR products–including proprietary ones–have continued to evolve, improving in functionality and design to support the needs of users to capture, navigate and retrieve important patient information. The advent of SaaS and cloud computing have significantly reduced the cost and have also minimized the need for practice-based technical resources for maintenance of EHR software.[19] Hosting software at a central location and making it accessible via a secure network or Internet connection has made it easier for developers and programmers to improve and enhance EHRs.

When proprietary EHR software was higher in cost and required onsite installation and hosting, open-source software provided an important alternative for practices and hospitals with appropriate technical resources. It also mitigated some risks such as obsolescence, costly upgrades and customization. But open-source development has its limitations. Relying on a loosely structured development community that depends, primarily, on volunteer efforts, open source EHRs can fail to keep pace with innovation. Unlike commercial EHRs which offer implementation services, practices must turn to third-party support for implementation and, if required, customization.

Implementation of any EHR requires a tremendous amount of work that is not within the typical physician's skillset. Opting to use open-source software does not reduce the difficulty or duration of the implementation process. A 2006 Centers for Medicare and Medicaid Services (CMS) pilot of WorldVistA EHR beta software in 10 small practices uncovered implementation issues also commonly experienced by practices implementing proprietary EHRs. The practices relied extensively on third-party firms to implement the EHR. The California Healthcare Foundation's assessment of the open-source EHR market determined a need to assist practices in finding third-party support firms. The practices also documented issues with support and training, practice management system integration, insufficient templates for specialties and general difficulty with customization.[20]

Open-source EHRs are only as strong as the developer community and the "know-how" they provide to end-users. It is easy for open-source software to fall victim to what has been called the "museum" model, meaning developers write beautiful code and make it available, but there are no support documents or testing routines, so they are difficult to use and the new users have to experiment to find the proper or best way to implement the software's capabilities. Open-source projects typically struggle with generating and maintaining usable and high-quality documentation which can be used and distributed by third parties to their clients.[21]

In its own day-to-day work, the VA is now experiencing challenges that are similar to those experienced by many proprietary EHR vendors as they attempt to help physicians use their systems to exchange data. The integrated EHR (iEHR) project that will combine the Department of Defense (DoD) and VA EHRs was announced back in 2011; however, the VA and DoD recently announced they were abandoning the project citing problems with integrating these open-source EHRs, instead focusing on interoperability.

VistA plans to leverage OSEHRA and its group of hundreds of programmers willing to devote some of their time to enhance VistA and to tailor it to non-VA hospitals and clinics. However, many of these programmers do not adhere to typical corporate behavior, meaning it is not their full-time job to support and improve the EHR.[22] Although they have zest for the project, the lack of discipline, standards and reliability must be considered and mitigated by organizations planning to implement open-source EHRs.

Remaining Issues

A recent report from KLASResearch found that more than half of EHR purchasers are not first-time buyers, indicating the difficulty of finding appropriate EHR software.[23] Keeping up with the MU requirements and lagging customer service were noted as reasons why practices were entering the market again. These reasons have also been validated by AmericanEHR Partners' survey data (AMA has recently entered into a partnership with AmericanEHR Partners). Regardless of EHR type—open or proprietary—there is no disputing that the work is not done. There are still physicians without EHRs, and there are those that are unhappy with their choices, with good reason.[24]

Specialists in pediatrics, obstetrics, oncology, nephrology and ophthalmology have gone on record about how existing EHRs fail to meet their needs.[25][26] It is clear that one size does not fit all, and that the best EHR software is not yet here.

In turn, much of the current dialogue has moved away from purely driving adoption to the need to improve usability. Issues such as poor interface design, older legacy systems, users not knowing what they need, overcrowded screens packed with data, alert and reminder fatigue causing users to switch off or ignore functions in the EHR and others are now the focus.[27] A recent paper written by a group convened by the Institute of Medicine, "Comparative User Experiences of Health IT Products: How User Experiences Would Be Reported and Used" echoed these concerns and called for more transparency and public review of EHRs.[28] They addressed the closed nature of the EHR industry, where vendors still prohibit users from sharing screenshots or otherwise publicly discussing EHR problems.

The authors noted that even "after a decade of development and experience, EHRs and other health IT products have not advanced sufficiently; nor have they been adopted widely and enthusiastically, in step with other consumer products such as smartphones and iPads."[29] They addressed the disadvantage of EHRs, unlike other consumer product areas, where there is little opportunity for cross-vendor comparison. They argue it has stifled the evolution of this technology.

It is clear that the healthcare industry is still struggling toward best practices in EHR design and widespread integration. With increased demand for statewide and eventually nationwide health information exchange, physicians, health insurers and vendors all recognize the need for greater standardization to support data exchange among EHRs.[30] Addressing financial and strategic barriers will be necessary to successfully achieve interoperability among systems and throughout the healthcare system.

A properly designed, implemented and utilized EHR should help physicians not only document and get paid more appropriately for services rendered,[31] it should also enhance information accessed at the point of care to improve care decisions. The challenge for EHR developers today–whether open-source or proprietary–is to rethink EHR design based on a more complete understanding of the patient care process. With this understanding, the developer will be able to create EHR software that better fulfills those needs.

AMA Advocacy Activity

The AMA supports advancement of health IT and the use of EHRs as crucial to improving quality of care and patient safety. The AMA has advocated vigorously for affordable health IT solutions, including those based on open-source technology. The AMA has worked aggressively to promote workable criteria that define what makes a physician a "meaningful user" of EHRs. The AMA has also contributed significantly to the growing body of knowledge on EHR usability, workflow and patient safety issues through comment letters to the Office of the National Coordinator for Health Information Technology and CMS. These positions apply equally to open-source and proprietary EHRs.

CONCLUSION

The intent of AMA Policy H-478.992 was to make open source EHRs available to the physician community. This intent has been realized. Open source EHRs are readily available and several have been certified for the meaningful use program. Underlying this intent is the assumption that open source EHRs are less costly and more useable. It has also been suggested that open source can lead to greater innovation. Yet, advancements in technology have blurred the distinction between proprietary and open-source EHR systems to a point where the AMA should not be focused on one type over the other. There is no clear advantage of one system over another in terms of cost, implementation, usability or meeting the objectives of improved patient care. It is possible that open-source EHR software may offer more flexibility in terms of customization, but that assumes a physician has the technical resources, or can find adequate resources, to support those efforts and customization can have a downside as well.

In a highly competitive marketplace, EHR vendors should be motivated by their customers to continuously improve their products and provide better solutions over time. While user interface design, integration with other information systems and customization are important attributes of EHRs and all other forms of health IT, subscribing solely to one technology over others can stifle innovation. More open dialogue across the EHR industry will advance best

practices, adoption, and interoperability and ultimately help physicians improve the quality of care more quickly than focusing on any one type of technology.

Progress in interoperability will ultimately be driven by the development of system interfaces and, more importantly, by policies that necessitate the appropriate exchange and sharing of patient health information among health care institutions and ancillary service providers. With EHR adoption approaching critical mass, it is most important to continue refining products according to industry best practices, supporting national standards adoption and ensuring that payment policies reflect the open interchange of data flow required to provide the best medical care, and to support new and innovative care organizations now being established. It is important for the AMA to promote more transparency in the vendor marketplace, and continue to focus on its current advocacy around usability, workflow, patient safety and interoperability.

RECOMMENDATIONS

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

1.   That American Medical Association (AMA) Policy H-478.992, "Open Source Code Electronic Medical Records" be rescinded.

2.   That our AMA advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace.

3.   That our AMA continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status.

4.   That our AMA, through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs—open source and proprietary—to create more transparency and support more informed decision making in the selection of EHRs.

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APPENDIX – Current AMA Policy

H-405.971 Use of Physician Time on Computerized Information Systems
(1) The AMA supports the need for cooperation among all sectors of the health care industry to design, carry out, and analyze the results of scientifically rigorous studies to measure the benefits (in effectiveness and quality of care, and in efficiency and costs of its provision) and the costs (in time use, behavioral, and organizational change, as well as in monetary costs) of physician use of computers in all health care settings. (2) The AMA urges health care facilities designing, selecting, and/or implementing clinical information systems for physician use to: (a) establish an oversight committee of clinically respected physicians who can act as internal advocates, provide input into all phases of system design and selection, and can make and enforce necessary decisions; (b) select technologies for data entry and retrieval that are easily and rapidly mastered and are acceptable to the physician users; and (c) design and/or select systems that are flexible and provide users with multiple options for display formats and navigation paths that can be stored and rapidly retrieved by individual users. (3) The AMA will instruct representatives to inter-professional groups working on computerized medical records to work vigorously for design features that reduce the physician time requirements for information entry, data retrieval and display, and to make appropriate reports to the House on progress in that direction. (BOT Rep. R, A-93; Reaffirmed: CSA Rep. 8, A-03)

H-480.971 The Computer-Based Patient Record
The following steps will allow the AMA to act as a source of physician input to the revolutionary developments in computer-based medical information applications, as a coordinator, and as an educational resource for physicians. The AMA will: (1) Provide leadership on these absolutely critical and rapidly accelerating issues and activities. (2) Work, in cooperation with state and specialty associations, to bring computer education and information to physicians. (3) Work to define the characteristics of an optimal medical record system; the goal being to define the content, format and functionality of medical record systems, and aid physicians in evaluating systems for office practice computerization. (4) Focus on the CPR aspect of human-computer interaction (the physician data input step) and work with software venders on the design of facile interfaces. (5) Provide guidance on the use of computer diagnosis and therapeutic support systems. (6) Continue to be involved in national forums on issues of electronic

medical data control, access, security, and confidentiality. (7) Continue to work to ensure that issues of patient confidentiality and security of data are continually addressed with implementation resolved prior to the implementation and use of a computer-based patient record. (BOT Rep. 29, A-96; Reaffirmation A-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08)

D-478.995 National Health Information Technology
Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. (Reaffirmed A-08)

D-478.996 Information Technology Standards and Costs
Our AMA will: (1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems; (4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems. (Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08)

24. COST AND BENEFIT ANALYSIS FOR ELECTRONIC HEALTH RECORD IMPLEMENTATION, UNDERSTANDING THE PITFALLS OF EHRS AND PROVIDING STRATEGIES FOR SUCCESS (RESOLUTIONS 722-A-12 AND 725-A-12)

Reference committee hearing: see report of Reference Committee G.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
                  IN LIEU OF RESOLUTIONS 722-A-12 AND 725-A-12 AND
                  REMAINDER OF REPORT FILED**
                  See Policies D-478.976 and D-478.995

INTRODUCTION

At the 2012 Annual Meeting, the House of Delegates referred Resolutions 722-A-12 and 725-A-12, "Cost and Benefit Analysis for Electronic Health Record Implementation" and "Understanding the Pitfalls of EHRs and Providing Strategies for Success." The resolutions were introduced by the Texas Delegation and the Organized Medical Staff Section (OMSS), respectively, and Resolution 722 asked that our American Medical Association:

Conduct a comprehensive literature review and/or study to analyze the current cost and/or benefit of implementing an electronic health record (EHR) for physicians in the ambulatory setting to determine if practices are able to realize financial return on investment and an increase in quality of care from their EHR; and

Advocate for the position that the parties benefiting most financially from the implementation of EHRs must share fairly in the cost.

Resolution 725 asked that our American Medical Association:

Survey a large number of physicians in private practice representing primary care physicians and a broad cross section of specialists; and

Survey experienced EHR users with regard to strategies that have been effective in addressing the potential pitfalls of EHRs; and

Survey physicians who have used EHR scribes as a way of improving the use of the EHR, improving office efficiency, and more accurately and completely documenting patient visits; and

Make available the results of its surveys on physician experiences with EHRs, including a thorough report of various strategies including the use of scribes that have brought physicians closer to optimal use of an EHR with respect to quality, efficiency and reimbursement, and report back at the 2013 Annual Meeting.

This report provides a brief overview of current cost and benefit information for EHRs in the ambulatory space and addresses how the AMA is currently involved in surveying EHR users to learn about the costs of ownership, issues preventing greater office efficiency and more accurate documentation of patient visits and overall improvement to quality of care.

BACKGROUND

Over the last decade most industries have invested heavily in computerization.[1] And while health care has embraced many specific medical technologies (e.g., ultrasound imaging, mammography, etc.), EHRs, the technology that is thought to hold great promise in improving the quality of care and reducing costs in the health care system, have only recently established a foothold.

Cost has long been the preeminent barrier cited for lagging EHR adoption. Large upfront costs, maintenance fees and uncertain return on investment have specifically inhibited small practices from undergoing the transition. Costs are so variable that the Office of the National Coordinator for Health Information Technology (ONC) lists a range of $15,000 to $70,000 per physician.[2] While some studies have attempted to evaluate the financial benefits to individual practices, many still focus on health system benefits. The following studies are among the most often cited.

- *The American Journal of Medicine*, 2003.[3]
  The seminal paper, "A Cost-Benefit Analysis of Electronic Medical Records in Primary Care," estimated the net benefit from using an EHR for a 5-year period to be $86,400 per provider. The paper showed benefits accruing primarily from savings in drug expenditures, improved utilization of radiology tests (both system benefits that can also be a benefit to individual practices under certain value-based reimbursement schemes), better capture of charges and decreased billing errors. In one-way sensitivity analyses, the model was most sensitive to the proportion of patients whose care was capitated; the net benefit varied from a low of $8,400 to a high of $140,100.

- Commonwealth Fund, 2005.[4]
  This study looked at case studies of fourteen solo or small-group primary care practices using EHR software from two vendors. Initial EHR costs averaged $44,000 per full-time-equivalent (FTE) provider, and ongoing costs averaged $8,500 per provider per year. The average practice paid for its EHR costs in 2.5 years and profited after that (about $23,000 in net benefits per FTE/year); however, some practices did not cover costs as quickly. Most providers spent more time at work initially, and some practices experienced substantial financial risks. Financial benefits resulted primarily from increased coding levels and efficiency-related savings or revenue gains. Increased coding levels accounted for an average of $16,929 per FTE/year. Efficiency-related gains, including transcription, transaction and paper supplies, plus revenue gains from increased visits, accounted for 48.3%, or an average of $15,808 per FTE/year, of financial benefits. This did not include pay-for-performance rewards from health plans for quality improvement.

- Medical Group Management Association, 2010.[5]
  According to a 2009 survey of 1,324 primary care and specialty practice members using EHRs, efficiency gains from eliminating paper chart pulls, transcription savings, better charge capture and reduced billing errors resulted in a median of $49,916 more revenue after operating costs per FTE physician than paper-based practices. After five years of EHR use, practices reported a median operating margin of 10.1% higher than practices in their first year of using an EHR.

- Agency for Healthcare Research and Quality, 2011.[6]
  This study found the total cost of planning, buying, implementing and operating an EHR system for the first year in a five-physician primary-care practice averaged $46,659 per physician. Hard costs from one-time

infrastructure purchases totaled $25,000 per practice. Practices also paid around $7,000 per physician for personal computers, printers and scanners. Maintenance costs, including software licensing fees, hosting costs, technical support through a third-party vendor, networking and networking support costs, totaled about $17,100 per physician for the first year. The study also reported that "end-users"—physicians, other clinical staff, and nonclinical staff—in this particular network needed 134 hours, on average, to prepare for use of the record system in clinical encounters.

- *Journal of the Medical Informatics Association*, 2013[7]
  This study evaluated 42 papers that examined costs for health information systems. Of those studies, 33 met the researchers' criteria and were deemed "high quality." In their review, 23 of 33 or 69.7% of the papers reported positive findings demonstrating value for certain HIS types. Specifically, five of seven papers, or 71.4%, on primary care EHR use had positive economic results over different time periods that ranged from 6 months to 8 years. Of the seven papers reviewed, six were pre/post or with/without EHR implementation comparisons. One study looked at the impact of an EHR on combination drug cost savings—a notable healthcare system benefit, not necessarily a benefit to the physician/practice. However, an ambulatory surgery clinic, reported an average cost-saving of $3.09 per encounter that translated to $184,627 per provider over 4 years given a startup EMR cost of $10,329 per provider.

In these studies, and in many others, it is generally accepted that benefits of EHR adoption accrue to others in addition to physicians, yet physicians are required to make the upfront investment. Historically, the misalignment of incentives and high upfront costs has been an obstacle to adoption. Given these considerations, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, which is part of the American Recovery and Reinvestment Act (ARRA), was signed into law with the explicit purpose of incenting physicians to adopt the technology.

HITECH includes, among other things, $30 billion to support new Medicare and Medicaid incentives to adopt EHRs (up to $44,000 under Medicare and $63,750 under Medicaid), $500 million for states to develop health information exchange and the provision of a government-led process for certification of EHRs.

DISCUSSION

Much has been written about return on investment (ROI) for EHR adoption. For the most part, however, the EHR space has been too immature to accurately calculate ROI at the system and individual physician practice level. One landmark study from Rand in 2005 tried to project system level savings but has been challenged by a more recent Rand study. The early report predicted that the potential efficiency and safety improvements made possible by health information technology—primarily EHRs in both the inpatient and outpatient settings—could save the U.S. healthcare system $81 billion a year.[8] In the new Rand report, the organization puts forth a much more conservative outlook, stating "health IT's failure to quickly deliver on its promise is not due to its lack of potential but to shortcomings in the design and implementation of health IT systems." [9]

The consensus is that ROI is difficult to capture and may vary significantly. There are, of course, tangible factors (hardware, software, training, implementation assistance and maintenance fees), but there are also intangible factors. For example, a California Healthcare Foundation study[10] observed five different EHR user types—viewers, basic users, strivers, arrivers and system changers. The different user types had varying experiences and reported different levels of benefit—many while using the same EHR software. The study acknowledges differences in EHR software but argues that technology differences only explain some of the variation in benefits. The tie between user type and benefits appears to be the more important indicator of overall benefits to the physician and practice.

- Viewers: Minimally interacted with the computer and EHR software, obtained few benefits and invested little time in making complimentary changes to increase benefits. Viewers used the EHR primarily to view data. Viewers dictated or hand-wrote the progress note and prescriptions and spent little extra time at work.
- Basic Users: Entered a limited amount of data into the EHR, obtained few benefits, invested limited time in customizing forms, entering past data and making other changes to complement EHR. Basic users viewed EHR data, maintained some electronic lists and ordered prescriptions but elected to dictate visit notes while viewing visit- or disease-specific templates. Transcription costs remained high. The practice also added costs of scanning tests and consultant reports into EHR. Spent the same or more time at work.

- Strivers: Invested substantial time in creating changes that complemented the EHR with hope of generating financial benefits and reducing their time costs. Reaped only modest financial benefits.
- Arrivers: Were "strivers" for some period of time. They invested substantial additional time in activities that complement the EHR implementation—entered past patient data, customized templates, created interfaces, developed stable technical support structures. The 10 arriver interviewees reaped sizeable benefits and spent the same or less time at work than before EHR. Most arrivers reorganized their exam rooms and office workflows.
- System Changers: Are similar to arrivers, but were characterized by even more benefits and time savings per patient, use of numerous customized electronic forms (templates) and changes in workflow. They delegated tasks to other clinical staff. They also attempted to change the external environment by encouraging health plans to reward practices for producing high quality of care due to the EHR.

The research suggests that physicians will probably always have different experiences with EHR technology, and thus report variable ROI. There is no question that some EHRs will deliver better customer service, for example, and some are just easier to use.[11] But the general preparedness of the practice, how much outside support is needed and how smoothly physicians and staff take to using the technology probably matter more.

Despite mixed data, EHR adoption continues to near critical mass. And the extent to which physicians are happy with their choice, again, varies. Recent evidence suggests as many as 17% of practices may be back on the EHR market by the end of the year.[12] Specialists such as pediatricians, urology, ophthalmology and gastroenterology reported high rates of discontent. Somewhat surprisingly, 54% of small practices say they are happy with their EHR.[13]

While the EHR industry remains immature, there is no question that EHR products have continued to evolve, improving in functionality and design. There is also no disputing that EHRs are more cost effective and accessible due to the advent of cloud computing versions that have minimized the need for extensive on-site technical support.[14] Still, the healthcare industry is struggling toward best practices in EHR design and widespread integration.

Survey Data

There is a growing body of data that can help the industry and physicians specifically, to make better decisions when it comes to EHRs. AmericanEHR Partners is a widely acknowledged and reputable source of such data. AmericanEHR Partners mission is to create an online community of clinicians who use information technology to deliver care to Americans. Through education, social media and the collection of peer contributed data, AmericanEHR Partners organizes information to facilitate optimal decision making.

The AMA recently entered into a relationship with AmericanEHR and, together with 16 other participating physician associations and societies has already surveyed its member and non-member physicians with opt-in email addresses. This relationship is timely given the Organized Medical Staff Section's interest (Resolution 725-A-12) in understanding physicians' experience with EHRs. The AMA now has access to the information to answer nearly all of OMSS's inquiries. More important is the recognition that it is only from historical data—year-over-year—that the AMA will be able to observe physicians' experiences with EHR technology.

The OMSS areas of inquiry and corresponding areas of the AmericanEHR Partners survey follows:

1. The amount of time per patient it takes to complete the EHR.
   Physicians reported that it is "Very easy" (32%) or "Easy" (32%) to document a progress note for each encounter after just three months of use. About one-quarter responded that it is either "Difficult" or "Very difficult." Three quarters (76%) of physicians who had used an EHR for several years or more found documentation of a progress note to be easy.

   As far as performing related activities such as maintaining an up-to-date problem list of current and active diagnoses, generating a patient referral letter and documenting care plans, a majority of physicians reported being "Very satisfied" or "Satisfied." Nearly three-quarters found it at least "Easy" to maintain an active medication allergy list, and half said it is at least "Easy" to manage drug interaction alerts.

2. Reimbursement before and after the EHR.

When asked about satisfaction with the billing function of their EHRs, 40% of physicians said they were "Satisfied" or "Very satisfied" compared to 7% who signaled they were "Very dissatisfied."

3. Quality of life before and after EHR adoption.
    Nearly half (46%) of physicians indicated that their EHR improved their efficiency (e.g., easier to access lab results and historical information). Yet, when responding to a question about workload, 46% indicated that they are "Disappointed" or "Very disappointed" that using an EHR has not decreased their workload. About one-quarter of physicians say they are not yet back to pre-EHR productivity levels. About 15% indicated that it took more than 6 months to return to pre-EHR productivity; one-third said it took three to six months. Interestingly, nearly half (46%) of physicians reported that they were pleased with their vendor's customer support. A majority (66%) were "Very satisfied" or "Satisfied" that they could access their EHR remotely.

4. Confidence in coding within an EHR.
    Nearly half of physicians (44%) indicated that it is either "Very easy" or "Easy" to use E/M coding support when charting a patient visit. Another 17 percent said it is "Neither easy nor difficult;" only 7% reported it to be "Very difficult."

5. Use of templates.
    With respect to creating templates for specific clinical conditions, about one-third indicated that it is "Very easy" or "Easy." 12% said it is "Very difficult."

More information about certain areas and topics such as specific reimbursement levels before and after EHR implementation and the use of scribes would make good additions to future iterations of the user satisfaction survey. Many physicians commented about the use of scribes, but the information was qualitative in nature. The AMA, in collaboration with AmericanEHR Partners, could modify the survey to ask about the use of scribes and also potentially survey those who have indicated high user satisfaction over the years to learn more about their experience. Those results could be used to help educate the broader physician community.

CONCLUSION

The AMA has long supported the advancement of health IT and the use of EHRs to improve quality of care and patient safety. However, it is well documented that cost–upfront and ongoing, in addition to usability and design issues–remains a barrier to EHR adoption and intended use. The immaturity of the EHR market and the challenge it presents to physicians in terms of workflow disruption and productivity remains an issue and a significant obstacle to achieving the promise of HIT and EHRs.

It is important that the AMA continue to take a leadership role, in collaboration with other physician associations and industry leaders and deliver information about physicians' EHR use and experiences. Through continued collaboration with AmericanEHR Partners, AMA can support efforts that will lead to the refinement of EHRs according to industry best practices and subsequently promote more transparency in the vendor marketplace. AMA should also continue to focus on its current advocacy around usability, workflow and patient safety through comment letters and relationships with the ONC.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 722-A-12 and 725-A-12 and the remainder of the report be filed:

1. That American Medical Association Policy D-478.995, "National Health Information Technology," be reaffirmed.

2. That our AMA, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs—open source and proprietary—to create more transparency and formulate more formal decision making in the selection of EHRs and that our AMA work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes.

3.   That our AMA make available the findings of the AmericanEHR Partners' survey and report back to the House
     of Delegates.

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APPENDIX – Current AMA Policy

H-405.971 Use of Physician Time on Computerized Information Systems
(1) The AMA supports the need for cooperation among all sectors of the health care industry to design, carry out, and analyze the
results of scientifically rigorous studies to measure the benefits (in effectiveness and quality of care, and in efficiency and costs
of its provision) and the costs (in time use, behavioral, and organizational change, as well as in monetary costs) of physician use
of computers in all health care settings. (2) The AMA urges health care facilities designing, selecting, and/or implementing
clinical information systems for physician use to: (a) establish an oversight committee of clinically respected physicians who can
act as internal advocates, provide input into all phases of system design and selection, and can make and enforce necessary
decisions; (b) select technologies for data entry and retrieval that are easily and rapidly mastered and are acceptable to the
physician users; and (c) design and/or select systems that are flexible and provide users with multiple options for display formats
and navigation paths that can be stored and rapidly retrieved by individual users. (3) The AMA will instruct representatives to
interprofessional groups working on computerized medical records to work vigorously for design features that reduce the
physician time requirements for information entry, data retrieval and display, and to make appropriate reports to the House on
progress in that direction. (BOT Rep. R, A-93; Reaffirmed: CSA Rep. 8, A-03)

H-480.971 The Computer-Based Patient Record
The following steps will allow the AMA to act as a source of physician input to the revolutionary developments in computer-
based medical information applications, as a coordinator, and as an educational resource for physicians. The AMA will: (1)
Provide leadership on these absolutely critical and rapidly accelerating issues and activities. (2) Work, in cooperation with state
and specialty associations, to bring computer education and information to physicians. (3) Work to define the characteristics of an
optimal medical record system; the goal being to define the content, format and functionality of medical record systems, and aid
physicians in evaluating systems for office practice computerization. (4) Focus on the CPR aspect of human-computer interaction
(the physician data input step) and work with software venders on the design of facile interfaces. (5) Provide guidance on the use
of computer diagnosis and therapeutic support systems. (6) Continue to be involved in national forums on issues of electronic

medical data control, access, security, and confidentiality. (7) Continue to work to ensure that issues of patient confidentiality and security of data are continually addressed with implementation resolved prior to the implementation and use of a computer-based patient record. (BOT Rep. 29, A-96; Reaffirmation A-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08)

D-478.995 National Health Information Technology
Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. (Reaffirmed A-08)

D-478.996 Information Technology Standards and Costs
Our AMA will: (1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems; (4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems. (Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08)

D-455.994 Standardizing Portable Medical Imaging Formats to Enhance Safe, Timely, Efficient Care
1. Our American Medical Association will participate in efforts to ensure implementation of the recommendations for imaging standards developed by the AMA-convened imaging safety and standards Panel, that the Radiological Society of North American (RSNA) endorsed and Integrating the Healthcare Enterprise (IHE) adopted and wrote into the portable data initiative standards. 2. Our AMA will develop a strategy to inform the health care and imaging communities of the AMA's work to improve Imaging Safety and Standards that includes the following: a. Disseminate (widely) the AMA-convened Panel's statement, "All medical imaging data distributed should be a complete set of images of diagnostic quality in compliance with those found in the IHE PDI (Portable Data for Imaging) Integration Profile;" b. Publish the Panel's work; c. Increase hospital group, deeming organization, medical group, and survey certification group awareness of the AMA's work; determine their role in developing infrastructure support for medical imaging safety per AMA recommendations and IHE-PDI standards; d. Expose the AMA's work to the Office of the National Coordinator; e. Encourage industry to view physicians as developers rather than solely as adopters of technology and to include physicians, as end users, in the development and implementation of technology solutions; and, f. Encourage physicians, as end users of technology, to participate in development and implementation of technology to ensure its appropriate use and application at the point of care. (BOT Rep. 1, I-09)

25. EVALUATION OF ICD-11 AS A NEW DIAGNOSTIC CODING SYSTEM

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

HOUSE ACTION: REFERRED

INTRODUCTION

At its 2012 Annual Meeting, the House of Delegates adopted Policy D-70.952 "Stop the Implementation of ICD-10." It asks that our American Medical Association (AMA) evaluate the feasibility of moving from ICD-9 to ICD-11 as an alternative to moving to ICD-10 and report back to the House of Delegates.

This Board of Trustees informational report will provide an overview of what is known today about ICD-11. Additionally, this report will include an overview of the development of ICD-11, a comparison of the implementation of ICD-10 versus ICD-11, and advantages and disadvantages of moving from ICD-9 to ICD-11.

ADVOCACY

The AMA has worked vigorously to stop the implementation of ICD-10, since the passage of Policy D-70.952 in November 2011 and amended in June 2012 and November 2012. Following letters to Congress and the Secretary of Health and Human Services (HHS), HHS initiated a regulatory change to delay the ICD-10 implementation date

until October 1, 2014. This recent delay followed years of previously successful advocacy resulting in the Centers for Medicare & Medicaid Services (CMS) holding back on the implementation of ICD-10 for over a decade.

The implementation of ICD-10 is a divisive issue for the industry. While many physicians have concerns about the costs and burden of ICD-10, there are many other stakeholders, including government agencies, researchers, large payers, large health system providers, and public health entities, that support the conversion. Stakeholders have already invested millions towards the adoption of ICD-10. Several physician state and specialty societies supported the one-year delay as a good compromise. At the urging of the AMA, HHS has stated it will engage stakeholders on a wide variety of ICD-10 implementation issues, including reduction of the burden on physician practices. The AMA will work constructively with the administration on this effort.

DEVELOPMENT OF ICD-11

ICD-11 is currently being developed by the World Health Organization (WHO). To develop ICD-11, the WHO is using a collaborative process calling on experts and users to participate in the revision process through a web-based platform. The anticipated outcome will be a classification that is based on user input and needs.

The WHO development work has included the development of an Alpha Browser that was available in 2011 for public viewing and comment. In May 2012, the Beta Browser was made available to the public. During the Beta period, the WHO is encouraging stakeholders to participate in the ICD-11 revision process. Individuals are able to make comments, make proposals to change ICD categories, participate in field trials, and assist in translating.

ICD-11 is scheduled at this time to be brought to the World Health Assembly, the decision-making body of the WHO, for consideration in May 2015. Once approved by the WHO, the U.S. will need to develop its clinical modification of the code set; just as it has done for ICD-9 and ICD-10.

Some have speculated that the health care industry will have to wait more than 20 years to have a U.S. version of ICD-11 implemented, based on the experience of when the WHO ICD-10 version was available and the final implementation date for ICD-10 in the U.S. Much of the delay, however, with implementing ICD-10 has been related to the implementation timeline and not because the development of the U.S. version (known as "Clinical Modification" or "CM") of ICD-10 took so long. The implementation of ICD-11 could take less than 20 years if there is a strong commitment, along with adequate resources, to develop the U.S. version, finalize regulation adopting it, and complete the work to implement it. While it is hard to pinpoint the specific timeframe for doing this work, it is expected to take at least several years.

FEATURES OF ICD-11

While ICD-11 is not yet finalized, the WHO has provided some information on what the features of it will be. In ICD-11, each disease category will have definitions, a standard definition template, and further features in what will be a "Content Model." The Content Model will allow for more computerization, with links to the Systemized Nomenclature of Medicine – Clinical Terms (SNOMED CT) and other terminologies. ICD-11 will have a multi-axial framework with linkages among the diagnostic concepts, which is in contrast to the hierarchical structure of ICD-10.

COMPARING ICD-10 AND ICD-11

With the WHO approval of ICD-11 expected in May 2015, just eight months after the U.S. compliance requirement for ICD-10, questions have been raised about the value of implementing ICD-10 versus waiting to implement an expected ICD-11. Since ICD-11 is not yet complete, an evaluation of both options is limited.

From a code structure standpoint, ICD-10 differs from ICD-9 by having more characters and being alphanumeric and these changes will require updates to computer systems and documents that are currently using ICD-9. A large difficulty with implementing ICD-10 involves the use of outdated practice management and other electronic systems that cannot accommodate the ICD-10 structure change and need to be updated/replaced. With the other terminology underpinnings, e.g., SNOMED CT, in ICD-11, more computerization will be needed to support data exchange. The electronic system changes to implement ICD-11 will be more significant, but they will be significant from either ICD-10 or ICD-9.

Training to understand and code using ICD-10 will be significant due to the changes in coding concepts and coding guidelines. Training will also go beyond the traditional billing staff, since ICD-10 will have a greater impact on clinical work, quality measurement, disease management, and public health reporting. While it is too early to understand what the needs for training will be for ICD-11, it can be anticipated that most staff, as with ICD-10, will be using ICD-11 and will need training.

The act of coding in ICD-10 will remain largely consistent with ICD-9, in that coding can be done manually using code books or electronically using code selection software. ICD-11 is expected to allow for both manual coding and computerized coding, but more computerization may be necessary for the coding. The multi-axial structure of ICD-11 will allow for more linkages of code concepts, which will require greater electronic collection and storage of the codes. ICD-11 is also expected to support better natural language coding and data exchange.

The costs to implement ICD-10 will be significant based on the nature of how and where ICD-10 is used, the need for widespread system changes, and the need for training of clinical and administrative staff. With ICD-11, these same costs will exist in its implementation. In addition, the development of the Content Model for ICD-11, the multi-axial format, and need for more computerization have the potential to add to its implementation costs.

DISCUSSION

This report is an early evaluation of ICD-11 and a preliminary assessment of the feasibility of moving from ICD-9 to ICD-11 without implementing ICD-10. The assessment of feasibility is based on the advantages and disadvantages of moving directly from ICD-9 to ICD-11.

The following are advantages for moving from ICD-9 to ICD-11 (skipping ICD-10):

- Implementation efforts for ICD-11 will be significant and costly regardless of whether or not ICD-10 is implemented.
- Waiting to implement ICD-11 will give physicians and the health care industry more time to implement electronic health records (EHRs) and develop the electronic systems infrastructure for health information exchange, since resources will not be stretched between the two major implementation activities of ICD-10 and EHRs.
- Physicians will only have to go through one implementation period, instead of two to go from ICD-9 to ICD-10 to ICD-11.

The following are disadvantages of moving from ICD-9 to ICD-11 (skipping ICD-10):

- ICD-9 is outdated today and continuing to use the outdated codes limits the ability to use diagnosis codes to advance the understanding of diseases and treatments, identify quality care, drive better treatments for populations of patients, and develop new payment delivery models.
- The market will miss out on the improvements in the ICD-10 codes that align with today's diagnosis coding needs, including the addition of laterality, updated medical terminology, greater specificity of the information in a single code, and flexibility to add more codes.
- Skipping ICD-10 will impede the ability of the industry to build on their knowledge and experience of ICD-10, which is expected to be needed for ICD-11. Learning the medical concepts, training efforts, and overall implementation efforts for ICD-11 will be more challenging if ICD-10 is not implemented first.
- Focusing solely on moving from ICD-9 to ICD-11 risks missing the opportunity to educate physicians and leaving them unprepared for the anticipated transition to ICD-10, which could result in significant cash flow disruptions.
- Implementing ICD-10 is expected to reduce payers' reliance on requesting additional information, known as "attachments", which could reduce burdens on physicians, but this opportunity will be delayed until ICD-11 is implemented.
- The timeframe to have ICD-11 fully implemented could be as many as 20 years, unless there is a strong commitment by the industry to implement it faster.

CONCLUSION

Our AMA harbors serious concerns and reservations with the significant burden of the ICD-10 mandate and will continue to convey these points to policymakers in Washington. However, given the even greater complexities and uncertainties with moving directly from ICD-9 to ICD-11, the Board of Trustees believes skipping ICD-10 and moving directly to ICD-11 is fraught with its own pitfalls and therefore, based on current information available, is not recommended.

The AMA will continue to advocate for physicians on this issue and monitor the situation as new information becomes available.

26. SECURITY OF TELEMEDICINE COMMUNICATION

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND
**   REMAINDER OF REPORT FILED**
See Policy H-480.974

INTRODUCTION

At the 2012 Interim Meeting, the House of Delegates adopted Policy D-480.976, "Security of Telemedicine Communication." It asked that our American Medical Association (AMA):

1. Develop appropriate warnings and guidance for physicians for the use of various common telemedicine modalities; and

2. Provide physicians useable information and warnings that can be given to patients about the security of common telemedicine modalities if they choose to use such technologies.

This report provides an overview of the advancements in telemedicine, factors influencing adoption, including technology advancements and reimbursement, concerns, relevant AMA policy and recommendations.

BACKGROUND

The terms "telemedicine" and "telehealth" are used to refer to a variety of applications of information technologies in health care, from telephone or email communication between patient and physician, to remote monitoring of patient health status, to online programs for patient self-management, to two-way real time interactive communication between patient and physician.

Three categories: store-and-forward, remote monitoring and (real-time) interactive services have been described:

•   Store-and-forward telemedicine involves acquiring medical data (like medical images, bio signals etc.) and then transmitting this data to a doctor or medical specialist at a convenient time for assessment offline.[1] It does not require the presence of both parties at the same time and has thus become popular with specialties such as dermatology, radiology and pathology which are conducive to asynchronous telemedicine.

•   Remote monitoring, or self-monitoring or testing, enables medical professionals to monitor a patient remotely using various technological devices. This method works well for managing chronic diseases or specific conditions (e.g., heart disease, diabetes mellitus, or asthma).

•   Interactive telemedicine services provide real-time interactions between patient and provider (e.g., phone conversations and online communications). History review, physical examination, psychiatric evaluations, ophthalmology assessments and other activities can be conducted comparably to those done in a traditional patient encounter. Telemedicine, where the patient and provider are connected through real-time audio and video technology (generally a requirement for reimbursement) offers an alternative to the traditional method of

care delivery, and can be leveraged to deliver such care as the diagnosis, consultation, treatment, education, care management and self-management of patients.

Telemedicine is a product of 20th century telecommunication and information technologies. With near ubiquitous use of computers, the Internet and cell phones to communicate with others and to seek and exchange information, physicians and patients now have more ways to access health care in the United States. Effective use of telemedicine can address issues of access, equity, quality and cost effectiveness[2] in health care. Telemedicine has proven particularly efficacious for providing care in rural and underserved areas by enabling better communication between care providers, improving access to specialists, reducing transportation expenses and increasing cost efficiency as well as improving quality of care. There also is growing evidence that telemedicine could be used to save lives in critical care and emergency situations.[3]

Technological advances such as fiber optics, satellite communications, methods of data compression, and real-time video transmission, have minimized many of the technological barriers that previously slowed the growth of telemedicine. The continued decrease in technology cost has also made telemedicine capabilities accessible to more physicians and patients. The most prevalent applications of video telemedicine are for rural health services, remote specialty and subspecialty consultation, correctional facility health care, and military health care. Telemedicine, particularly videoconferencing, is used by a growing number of medical specialties, including cardiology, dermatology, home health care, oncology, psychiatry and radiology.[4]

DISCUSSION

Although telemedicine is generally considered to be a viable means of delivering health care remotely and has quickly become well established, technology and policy issues still challenge effective implementation. Top among them are licensure, privacy and reimbursement.

Licensure

State licensure, credentialing and privileging requirements vary, and this is particularly true when it comes to telemedicine. Some states require a full medical license to provide telemedicine within the state. Other states allow providers to obtain a temporary, special training, special volunteer or full medical license to practice telemedicine. An up-to-date matrix of state licensure rules can be found on the American Telemedicine Association website.[5] As the regulatory landscape evolves, it will continue to be imperative that physicians understand the rules for telemedicine in their state and in any other state where they may employ this technology to deliver care.

Questions about telemedicine fitting into standard medical liability insurance are a related topic causing some concern for physicians seeking to offer telemedicine services. Physicians performing telemedicine services will want to obtain written assurances that their medical liability insurance policy covers telemedicine services. Additionally, if the physician will be providing services across state lines, they must ensure that their medical liability insurance extends coverage to multiple states. Physicians also may choose to seek an additional and specific policy for telemedicine.[6]

Reimbursement

Reimbursement issues also pose a significant barrier to widespread implementation. Only recently have formal reimbursement mechanisms been established, but inconsistencies continue to prohibit further adoption of telemedicine. The passage of the Balanced Budget Act of 1997 and the Telemedicine Communications Act of 1996 enabled payment for professional telemedicine consultation in 1999, but it was limited to those providing services to Medicare beneficiaries residing in rural counties designated as health professional shortage areas (HPSA) and to real-time audio and visual communications. As many as thirty-six states include some telemedicine coverage in their Medicaid plans and twelve states prohibit health plans offered in their states from discriminating against telemedicine-provided covered services.[7] Although their policies vary, some of the leading private insurers provide coverage and reimbursement for telemedicine. The policies are also geared toward real-time communication between the physician and patient. In many cases, the patient must be located at an approved health care facility and the services must be provided by certain practitioners.

Privacy

Protecting the privacy of patients and securing protected health information (PHI) are of paramount concern for physicians. The advent of widespread technology use—while enabling unprecedented opportunities to improve quality of care and patient safety through access to more complete data at the point of care—has also introduced new partners in health care and greater potential for data breaches. Physicians, as "covered entities" under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, are familiar with the policies and procedures required to secure and protect PHI. These same rules apply for covered entities regardless of care setting—even when conducting a remote encounter or service using information and communication technologies.

Telemedicine is a service delivery model. Thus, any services rendered must comply with the same rules, regulations (federal, state, institutional) and practice stipulations that apply to services delivered in-person.[8] In addition to complying with the HIPAA Privacy and Security Rule provisions, physicians should become familiar with the HIPAA Breach Notification Rules and technology encryption requirements. The aforementioned discrepancies between state licensure requirements for telemedicine also come into play when it comes to privacy and security. In instances where states have differing requirements for privacy, security and informed consent, physicians are encouraged to follow the most restrictive laws and regulations.

There also continues to be much debate and confusion about the liability of technology partners like telemedicine companies. A company may become subject to HIPAA as a business associate by assisting a covered entity in the performance of a function involving the use or disclosure of medical information. It is worth noting that not every company that uses or discloses medical information will necessarily fall under the definition.[9] Some companies are considered mere "conduits" of PHI. These companies, like the US Postal Service and telephone companies, may act as conduits of PHI, but they do not have to assume business associate status because they do not sell or provide services specifically intended or designed for use by covered entities.[10]

The Health Information Technology for Economic and Clinical Health Act in 2009, and more recently the Department of Health and Human Services final regulations containing modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules (Omnibus Rule), created strict rules and liability for covered entities and business associates. For example, the rule narrowed the definition of a "conduit" to companies who only transmit data. Any company in the business of storing PHI, even those who do not access it (e.g., cloud computing companies), is now a business associate. The business associate distinction is important for physicians to understand, especially now that HIPAA is actively enforced and steeper penalties are more commonly issued.

With the growing popularity of unencrypted web-based communication platforms (e.g., Skype), it is not surprising that physicians and patients would gravitate toward them. Many are free, familiar and widely used. But such free, unencrypted web-based communication platforms do not meet the standards noted above, so physicians and patients must understand the risks and their potential exposure if they elect to deploy them. More importantly, commonly available technologies such as telephone, unencrypted and unsecured email and Skype are generally not accepted as media for reimbursable telemedicine services.

Physicians still opting to use unencrypted web-based communication platforms should:

- Request audit, breach notification, and other information from web vendors.
- Have patients sign HIPAA authorization and separate informed consent as part of intake procedures when using web-based platforms.
- Develop specific procedures regarding the use of Skype and similar platforms (interrupted transmissions, backups, etc.).
- Train workforce regarding the privacy and security risks associated with these platforms
- Exclude the use of these platforms for vulnerable populations (i.e., severely mentally ill, minors, those with protected conditions such as HIV).
- Limit to certain clinical uses (i.e., only intake or follow up).

Physicians pursuing telemedicine should also keep in mind that there are a growing number of HIPAA compliant technologies available to them. Just as physicians and other health care organizations develop intricate policies, procedures and systems aimed at ensuring the privacy and security of patients' PHI in the ordinary course of providing health care services so should they for telemedicine.

Expert Telemedicine Resources

Telemedicine leaders, including the American Telemedicine Association and the Telehealth Resource Center, have compiled extensive materials for physicians interested in offering telemedicine services.* Complete standards and guidelines cover topics ranging from teledermatology and telerehabilitation to telepathology and many others.[11] The practice guidelines cover the fundamental requirements to be followed in providing remote medical services, interactive patient encounters and any other electronic communications between patients and practitioners for the purposes of health care delivery. They also provide workflows, equipment requirements and best practices from the administrative, technical and clinical perspective for the different telemedicine modalities.

Physician-Patient Relationship

The growing interest in telemedicine extends to patients. A PwC study found that nearly three-fourths of U.S. consumers say they would use telemedicine, defined as remote monitoring to track their condition and vital signs.[12] Before beginning to offer any telemedicine services, physicians should understand and comply with the American Telemedicine Association's core guidelines for telemedicine. A few important provisions include:

1. Health professionals providing telemedicine services shall be fully licensed and registered with their respective regulatory/licensing bodies and with respect to the site where the patient is located.

2. The organization and health professionals shall be satisfied that health professionals providing care via telemedicine are aware of their own professional discipline standards and those standards shall be upheld in the telemedicine encounter, considering the specific context, location and timing, and services delivered to the patient.

3. Health professionals shall be guided by professional discipline and existing clinical practice guidelines when practicing via telemedicine, and any modifications to specialty-specific clinical practice standards for the telemedicine setting shall ensure that clinical requirements specific to the discipline are maintained.

4. Health professionals using telemedicine shall be cognizant of when a provider-patient relationship has been established within the context of a telemedicine encounter between the health care provider and the patient, whether interactive or store-and-forward, and proceed accordingly with an evidence-based, best possible standard of care.

5. Health professionals providing telemedicine services shall have the necessary education, training/orientation, and ongoing continuing education/professional development to ensure they possess the necessary competencies for the safe provision of quality health services in their specialty area.

6. The entity or health professional shall have a mechanism in place for assuring that patients are aware of their rights and responsibilities with respect to accessing health care via telemedicine technologies, including the process for communicating complaints.[13]

Patients also play an important part in their care and in ensuring their health care communications are safe and secure. A study published in the International Journal of Telerehabilitation[14] on Free Voice over Internet Protocol (VoIP) technologies recommends patients:

•   Advocate for a readable, clear privacy and security policy either within the system consent/agreement of use or as part of the system policies.
•   Ask questions about privacy and security when using any videoconferencing system.
•   Know their privacy rights as they pertain to HIPAA and other US Office of Civil Rights requirements.

If approached by patients about offering telemedicine services, it is important that physicians inform patients about unsecured and unencrypted media that do not conform to best practices and federal and/or state guidelines.

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* See the American Telemedicine Association website at www.americantelemed.org/practice/standards/ata-standards-guidelines and the Telehealth Resource Center at www.telehealthresourcecenter.org/.

CONCLUSION

There is growing evidence that telemedicine has the potential to provide comparable health outcomes to traditional in-person patient encounters, supply greater satisfaction to patients and may be more cost-effective. Telemedicine will be an important tool given the projected provider shortages and growing transportation costs that will present barriers to access of health services.[15]

Telemedicine has the potential to remove barriers of distance and time, reduce health disparities and drive efficiencies in the delivery system. Broad adoption of telemedicine offers physicians the opportunity to more efficiently connect to consumers and to provide patients with the care they need, thereby reducing total health care costs. In fact, physicians should expect the value of telemedicine to become more evident with the shift to value-based payment and service innovations, such as medical homes and accountable care organizations (ACOs).[16] Telemedicine has been linked to reducing hospital emergency room visits and ambulance use–exactly the type of events ACOs are tasked with limiting.

The most recent and comprehensive assessment of telemedicine's economic value was conducted for California and its Medicaid program, Medi-Cal. It concluded that telemedicine used for "home monitoring for chronic diseases [such as] heart failure and diabetes ... has the potential to produce savings to the Medi-Cal program of as much as several hundred million dollars annually."[17] It reported a 42 percent reduction in costs related to heart failure care and a 9 percent reduction in costs related to diabetes care.

Along with continuing to support the adoption of certified health information technology and publishing good scientific data demonstrating the benefits of telemedicine, it is critical that there be more consistent licensure requirements among the states, adequate reimbursement and resources to help physicians and health care organizations ensure the security of the telemedicine—whether it be real-time, asynchronous or within and across state boundaries. At this point it seems clear that telemedicine could be an effective tool for physicians to meet new demands to improve the quality and cost of health care. However, physicians need to be reminded and encouraged to consult the extensive and expert resources available through such organizations as the American Telemedicine Association.

RECOMMENDATIONS

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

1. That American Medical Association Policy D-480.976, "Security of Telemedicine Communication" be reaffirmed.

2. That our American Medical Association leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services–encrypted and unencrypted.

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APPENDIX – Current AMA Policy

D- 480.976 Security of Telemedicine Communication
Our AMA will: (1) develop appropriate warnings and guidance for physicians for the use of various common telemedicine modalities; and (2) provide physicians useable information and warnings that can be given to patients about the security of common telemedicine modalities if they choose to use such technologies. (Res. 804, I-12)

H-160.937 The Promotion of Quality Telemedicine
(1) The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used: (a) The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine. (b) Physician supervision (e.g. regarding protocols, conferencing, and medical record review) is required when nonphysician providers or technicians deliver services via telemedicine in all settings and circumstances. (c) Physicians should visit the sites where patients receive services from nonphysician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the nonphysician providers utilized. (d) The supervising physician should have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting. (e) Nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services. (f) The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services. (g) Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, nonphysician providers, and technicians. (h) The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving nonphysician providers or technicians. (2) The AMA urges those who design or utilize telemedicine systems to make prudent and reasonable use of those technologies necessary to apply current or future confidentiality and privacy principles and requirements to telemedicine interactions. (3) The AMA emphasizes to physicians their responsibility to ensure that their legal and ethical requirements with respect to patient confidentiality and data integrity are not compromised by the use of any particular telemedicine modality. (4) The AMA advocates that continuing medical education conducted using telemedicine adhere to the standards of the AMA's Physician Recognition Award and the Essentials and Standards of the Accreditation Council for Continuing Medical Education. (CME/CMS Rep., I-96; Reaffirmed: CMS Rep. 8, A-06)

H-480.974 Evolving Impact of Telemedicine
Our AMA: (1) will evaluate relevant federal legislation related to telemedicine; (2) urges CMS and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship; (3) urges medical specialty societies involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine; (Reaffirmed by CME/CMS Rep. A-96) (4) encourages the CPT Editorial Board to develop CPT codes or modifiers for telemedical services; (5) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms; (6) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine; and (7) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries. (CMS/CME Rep., A-94; Reaffirmation A-01)

H-480.969 The Promotion of Quality Telemedicine
(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles: (a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state; (b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation; (c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions. (3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12)

H-480.968 Telemedicine
The AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery. (Res. 117, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

27. WORK-RELATED ABUSES OF IMG PHYSICIANS WORKING UNDER
THE CONRAD-30 PROGRAM
(RESOLUTION 222-A-12)

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
                    IN LIEU OF RESOLUTION 222-A-12 AND
                    REMAINDER OF REPORT FILED**
                    See Policy D-255.985

INTRODUCTION

At the 2012 American Medical Association (AMA) Annual Meeting, Resolution 222-A-12, "Work-Related Abuses of IMG Physicians Working Under the Conrad 30 Program," was referred by the House of Delegates (HOD). Resolution 222, introduced by the American College of Physicians and the International Medical Graduates (IMG) Section, called for the AMA to:

(1) develop a mechanism by which physicians working under the Conrad 30 program who encounter work-related abuses may report this information directly to the AMA without fear of retribution for purposes of data collection for advocacy support; (2) aggressively investigate reports of possible work-related abuses encountered by IMG physicians under the Conrad 30 program; and (3) advocate for legislative and regulatory changes to the Conrad 30 program if deemed necessary to prevent work-related abuses of IMG physicians.

Reference committee testimony on Resolution 222 revealed that many IMGs with Conrad 30 Visa waivers suffer from work-related abuses and have no mechanism to report such abuses. While the reference committee shared these concerns and believed that a mechanism for reporting abuses and seeking a remedy was necessary, there was agreement that the complexity of these work-related abuses warranted further exploration before the AMA could take any action. Testimony also suggested that it would be inappropriate for the AMA to investigate and address instances of IMG work-related abuse.

BACKGROUND

International medical graduates play an integral role in providing medical care in the U.S. It is estimated that IMGs represent 25% of the physician population and provide over 30% of primary care services in the U.S.

Many IMGs complete their residency or fellowship training in the U.S. while on J-1 Visas. After the completion of their training, IMGs on J-1 Visas are required to return to their home countries for a minimum of two years before they may return to the U.S. This two-year return-home requirement may be waived for IMGs who agree to work for at least three years in a U.S. Department of Health and Human Services (HHS)-designated health professional shortage area (HPSA), medically underserved area (MUA), or medically underserved population (MUP). This J-1 Visa waiver program (also known as the Conrad 30 program) is a key mechanism for alleviating primary care and other U.S. physician workforce shortages.

While each state administers its own J-1 Visa waiver program and establishes its own program application and guidelines, all J-1 Visa waiver physicians must adhere to the following criteria:

- Be employed full-time at a health care facility located in an HHS-designated HPSA, MUA, or MUP;
- Obtain a contract from the health care facility located in an area designated by HHS;
- Obtain a "no objection" letter from his or her home country if the home government funded his or her exchange program; and
- Agree to begin employment at the health care facility within 90 days of receipt of the J-1 Visa waiver.

DISCUSSION

IMGs participating in the J-1 Visa waiver program report that they are abused by their employers. These abuses are wide-ranging and may include, for example, non-payment, unreasonable work hours, contract modification, and so forth. IMGs participating in the J-1 Visa waiver program are particularly vulnerable to such abuse because the physician's immigration status is connected to continued employment. For example, J-1 Visa waiver physicians cannot leave their jobs without first finding another employer willing to sponsor their J-1 Visa waiver. If the physician does not find another employer sponsor, they must leave the country. Additionally, switching employers restarts the clock on the three- to five-year work requirement. Some employers use these requirements as leverage to force IMGs to accept less-than-optimal working conditions. Consequently, regardless of how poorly they are treated, J-1 Visa waiver program physicians often have no option but to remain in their positions or be forced to leave the U.S.

Information on the abuse of J-1 Visa waiver program participants is largely anecdotal. One exception is data collected by the state of Nevada, which conducted a comprehensive study of its J-1 Visa waiver program that examined, among other issues, abuse of physicians. The study identified a variety of abuses of program participants such as those listed above. The study also revealed a sharp decrease (67%) since 2003 in the number of physicians participating in Nevada's J-1 Visa waiver program. This decline was attributed in part to IMGs avoiding Nevada after hearing stories and reading news articles about employers' poor treatment of IMGs.

In response to the study findings, the state of Nevada established a Primary Care Advisory Council to provide guidance to the administrators of the J-1 Visa waiver program as they sought to address the many identified problems with the Nevada program. The state also created a website to facilitate the anonymous filing of complaints and established policies for addressing these complaints. Additionally, the Nevada legislature passed legislation to provide uniform regulations for the Nevada J-1 Visa waiver program and to improve oversight of participating employers and physicians. Nevada's approach to this issue has been successful and may be a model for other states.

Legislation was introduced in the 112th Congress to enhance the Conrad-30 state program. The "Conrad State 30 Improvement Act" would have permanently reauthorized the J-1 Visa waiver program and made improvements to the program, including employment contract terms. This federal bill would have provided protection by requiring employment agreements between employers and physicians to specify certain information, e.g., maximum weekly on-call hours and work locations. However, this legislation was not passed. Instead the Conrad 30 state program was extended through September 2015. The AMA continues to advocate and support improvements to the J-1 Visa waiver program.

Given its lack of jurisdiction and its capabilities in this area, the AMA does not investigate reports of work-related abuses encountered by IMG physicians participating in state J-1 Visa waiver programs. However, the AMA does on occasion receive complaints of abuse. The AMA maintains two resources that may be helpful to IMGs currently participating or considering participating in J-1 Visa waiver programs that are listed below:

- AMA Physician Assistance Program (www.ama-assn.org/go/assistance): As a benefit of membership, the AMA provides assistance to individual physicians in matters pertaining to their relationships with hospitals, health systems, and other similar entities. While the AMA cannot provide legal opinions or representation, the AMA is dedicated to answering physician questions and providing advice on physician-hospital issues such as employment and contracting, medical staff bylaws, credentialing, peer review, due process, medical staff self governance, and more.

- AMA Model Annotated Physician Employment Agreements (www.ama-assn.org/go/employmentagreement): These model contracts address the specific needs of physicians who are preparing to negotiate employment contracts with hospitals or related entities or with small group practices, multispecialty group practices, or similar entities. (Note: AMA Policy H-255.975 "supports a model employment contract specific to J-1 Visa Waiver physicians.")

CONCLUSION

With the current physician workforce shortage, IMGs are critical to the U.S. physician workforce, especially in underserved areas. While anecdotal evidence suggests that some IMGs participating in J-1 Visa waiver programs are subjected to abuse by their employers, comprehensive data about such abuse is not readily available. Some states, such as Nevada, have already taken steps to curb such abuses and otherwise improve their J-1 Visa waiver programs to the mutual benefit of patients, physicians and employers.

The AMA does not have the jurisdiction or the capabilities to investigate and address reports of work-related IMG abuse. The AMA will continue to proactively monitor this issue and any complaints received and will support legislation and regulation that strengthens workplace protections for IMGs participating in J-1 Visa waiver programs.

RECOMMENDATION

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 222-A-12 and the remainder of the report be filed:

1. That our American Medical Association continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.

2. That our AMA continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.

3. That as a benefit of membership, our AMA provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.

4. That our AMA encourage IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.

28. COUNCIL ON LEGISLATION SUNSET REVIEW OF 2003 HOUSE POLICIES

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

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

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies Policy G-600.110. Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the AMA policy database is current, coherent and relevant. By eliminating outmoded, duplicative and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Using the areas of expertise of the AMA Councils as a guide, the staffs of the AMA Councils determine which policies should be reviewed by which Councils.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
- The Speakers assign the policy sunset reports for consideration by the appropriate reference committees.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process. In this report, the Board of Trustees presents the Council on Legislation's recommendations on the disposition of the House policies that were assigned to it. The Council on Legislation's recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX 1 – Recommended Actions on 2003 House Policies

Policy Number	Title	Text	Recommendation
H-260.973	Cost and Benefits of CLIA '88 and Other Health Regulations	The AMA demands from the government any proven evidence, research, study or any data concerning CLIA '88: (a) showing that this law was actually necessary; and (b) indicating in a quantitative way how any potential benefits of this law outweigh this addition to the already overburdened cost of health care. (Res. 245, I-92; Reaffirmed: BOT Rep. 28, A-03)	Retain – this policy remains relevant.
H-260.975	Repeal of CLIA	The AMA (1) will work through appropriate regulatory, legislative or judicial channels for changes in CLIA '88 or elimination of those portions of the CLIA '88 regulations that do not improve patient care; and (2) will continue to work to achieve changes that markedly reduce or eliminate the obstacles experienced by physicians under CLIA '88, with the understanding that should this not be successful, the Association shall move	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		to seek legislative repeal of CLIA '88. (Sub. Res. 237, I-92; Reaffirmed: BOT Rep. 28, A-03)	
H-260.977	Commission on Office Laboratory Accreditation	The AMA, with state medical and national medical specialty societies, will (1) take immediate action to cause CMS to publish the "deeming" regulations under CLIA '88; (2) take immediate action to assure that applications for deemed status under CLIA '88 are processed expeditiously and that potential accrediting organizations capable of complying with the regulations are granted deemed status as quickly as possible; (3) take immediate action to cause CMS to delay sending bills for laboratory certification fees until at least 60 days have passed from the time that at least one alternative private sector accrediting body has been granted deemed status; and (4) publicize information about the Commission on Office Laboratory Accreditation (COLA) and encourage that all physicians seek clinical laboratory accreditation through COLA in lieu of federal or other government certification. (Sub. Res. 264, A-92; Reaffirmation I-99; Reaffirmed: BOT Rep. 28, A-03)	Retain – this policy remains relevant.
H-330.897	Quality Cancer Care Preservation Act	Our AMA continues to support existing policy principles in evaluating legislative language on matters relating to Medicare reimbursement for physician acquisition and administration of prescription drugs. (BOT Action in response to referred for decision Res. 129, A-03)	Retain – this policy remains relevant.
H-330.922	Waiver of Copayments of Certain Medicare Patients	Our AMA seek legislative and/or regulatory action that permits physicians in the exercise of their judgment to provide free medical services and/or waive deductibles and co-payments for patients with Medicare, Medicaid, and other health insurance. (Res. 254, A-98; Reaffirmation I-98; Modified: BOT Rep. 12, A-03)	Retain – this policy remains relevant.
H-330.951	Non-Routine Waiver of Copayments and Deductibles Under Medicare Part B for Indigent Patients	The AMA will seek promulgation of a safe harbor provision by the Office of Inspector General, U.S. Department of Health and Human Services, for the non-routine waiver of Medicare Part B copayments and deductibles for indigent patients. (Res. 210, I-93; Reaffirmed: BOT Rep. 28, A-03)	Retain – this policy remains relevant.
H-365.983	Occupational Safety and Health Administration Regulations	The AMA (1) will work to modify the Occupational Safety and Health Administration regulations on Occupational Exposure to Bloodborne Pathogens to address its practicality and to make physician compliance possible; and (2) in conjunction with other national health provider groups, will work with Congress and other government regulatory agencies to ensure that all decisions regarding the regulation of medical practices be based upon scientific principles and/or fact. (Res. 242, I-92; Reaffirmed: BOT Rep. 28, A-03)	Retain – this policy remains relevant.
H-390.885	Advance Payments During Medicare Slow-Downs	The AMA will continue to seek legislation requiring CMS to make interim payments available to physicians when disruptions in Medicare claims processing result in undue delays in the normal flow of Medicare payments. (Sub. Res. 242, A-92; Reaffirmed: BOT Rep. 28, A-03)	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-390.962	Notification to Patients of Charge Amounts Prior to Service as Per Omnibus Reconciliation Act of 1986	(1) The AMA opposes efforts by commercial carriers or the federal government which would require physicians to predict reimbursement for services rendered. (2) The AMA supports the repeal of the provision of OBRA 1986 regarding notification of patients receiving elective surgery of the physician charge, the expected amount of Medicare reimbursement, and the balance that the patient would be responsible for paying when the charge for the service is $500 or more and the claim is not accepted on an assigned basis. (3) The AMA supports repeal of those provisions of OBRA that require physicians to refund payments associated with Medicare services that are deemed medically unnecessary by CMS after the fact. (4) The AMA believes that increases in Medicare reimbursement need to be universal, that current reimbursement should be adjusted and that there should be no discrimination in schedules between participating and nonparticipating physicians. (Sub. Res. 13, I-87; Reaffirmed: Res. 237, A-93; Reaffirmed: BOT Rep. 28, A-03)	Retain – this policy remains relevant.
H-40.976	Recruitment and Retention of Reserve Military Medical Personnel	(1) The AMA will (a) work with all appropriate parties in developing and proposing a multi-faceted approach toward rejuvenation and improvement in recruitment and retention in the military reserves; (b) work to assure that retired military medical personnel become eligible for reserve status; (c) support enactment of federal laws to assist physicians in the transition from medical practice to active military service; (d) promote use of existing laws for selective service and retirement credits as models for development of practical equitable criteria to be applied; and (e) support improvements in professional utilization of military medical personnel during both active duty periods and "weekend drill." (2) The AMA supports the development of a statutory system of limitations on call-up, retention and recall of reservists in order to provide stability and predictability to reserve status and duty, with the basis for such a system to be defined statutorily using credits or "points" to prioritize options available to individual reservists as to call-up, retention, rotation and recall. (Sub. Res. 234, I-92; Reaffirmed: BOT Rep. 28, A-03)	Retain – this policy remains relevant.
H-40.993	Support of the Civilian-Military Contingency Hospital System	The AMA supports the CMCHS and urges U.S. civilian hospitals, when requested, to provide all possible support to the Department of Defense CMCHS in this important effort which will enable the U.S. to prepare for the treatment of casualties from any future conventional military conflict. (Sub. Res. 17, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CMS Rep. 10, A-03)	Retain – this policy remains relevant.
H-435.964	Federal Preemption of State Professional Liability Laws	The AMA supports professional liability reform on the federal level that will preempt state constitutional, statutory, regulatory and common laws that prohibit a cap on liability awards; and such federal legislation shall not preempt state constitutional, statutory, regulatory and common laws that set caps or other restrictions on liability awards which are lower or more comprehensive than the caps on liability awards established by such federal legislation. (Res. 237, A-95; Reaffirmed: Sub. Res. 910, I-03)	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-435.966	Prohibit Third Party Payers from Requiring Professional Liability Coverage Beyond Mandated Limits	The AMA finds unreasonable the demand by any hospital or third party payer that their providers carry professional liability coverage in excess of the minimum mandated of physicians by state law; and will design and distribute model legislation that prevents any health care institution or third party payer from requiring their physicians to carry professional liability coverage in excess of the minimum mandated by law. (Res. 203, I-93; Reaffirmed: BOT Rep. 28, A-03)	Retain – this policy remains relevant.
H-435.975	Bush Administration Professional Liability Proposal	Our AMA commends the Bush Administration for its legislative efforts designated to achieve medical liability reform and supports the elements of legislative proposals introduced in the 102nd Congress which are consistent with Association policy, including (1) limitations of $250,000 or lower on recovery of non-economic damages; (2) the mandatory offset of collateral sources of plaintiff compensation; (3) a decreasing, sliding scale regulation of attorney contingency fees; (4) periodic payment of future awards of damages; and (5) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. (Sub. Res. 158, A-91; BOT Rep. I-93-53; Reaffirmation A-00; Reaffirmation I-03)	Retain – this policy remains relevant.
H-440.926	United States Surgeon General	The AMA, in order to best protect the health care needs of the American people, will seek changes in federal law to require that the Surgeon General of the United States be an MD/DO, whether the Surgeon General is confirmed by the U.S. Senate or appointed to serve on an acting or interim basis. (Sub. Res. 211, I-93; Reaffirmed: BOT Rep. 28, A-03)	Retain – this policy remains relevant.
H-60.959	Uniformity of State Adoption and Child Custody Laws	The AMA urges: (1) state medical societies to support the adoption of a Uniform Adoption Act that places the best interest of the child as the most important criteria; (2) the National Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform Adoption Act; and (3) state medical societies to support adoption of child custody statutes that place the "best interest of the child" as the most important criterion determining custody, placement, and adoption of children. (Sub. Res. 219, I-93; Reaffirmed: BOT Rep. 28, A-03)	Retain – this policy remains relevant.
D-120.982	Illegal Online Prescribing Operations	Our AMA will: (1) support further legislative and regulatory efforts that require establishing a physician/patient relationship, as defined by the individual state boards of medicine and US governmental agencies, before prescribing medications online; and (2) in conjunction with state and specialty societies, lobby representatives of the state and federal governments to enforce existing laws and regulations that make certain online pharmaceutical practices illegal and to prosecute these companies to the full extent of the law in order to ensure these operations are effectively shut down. (Res. 921, I-03)	Retain – this policy remains relevant.
D-175.986	Physician Persecution	Our American Medical Association will consider and take action at the national level on Medicaid fraud prosecutions and related issues. (Res. 212, A-03)	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
D-190.982	HIPAA Extension	Our AMA will: (1) support necessary legislative and/or regulatory changes to mandate that health plans continue to accept non-standard electronic claims from physicians during a reasonable transition period following October 16, 2003, when the HIPAA transaction rule takes effect, and (2) take steps to assure that Medicare continues to support free software for filing claims to Medicare and that payers continue to accept paper claims from physicians who choose to submit claims on paper. (Res. 224, A-03)	Retain – this policy remains relevant.
D-190.983	Protection of Health Care Providers from Unintended Legal Consequences of HIPAA	Our AMA will: (1) take appropriate legislative, regulatory, and/or legal action to assure that the unanticipated negative consequences of the Health Insurance Portability and Accountability Act privacy regulations, affecting the patient/doctor relationship and exposing health care providers to legal action, are corrected; and (2) initiate necessary legislative, regulatory, and/or legal action to assure that HIPAA violations that are not malicious in intent and are not directly related to any alleged act of medical negligence may not be attached to such litigation. (Res. 204, A-03)	Retain – this policy remains relevant.
D-195.997	Time to Revisit Health Maintenance Organization Act	Our AMA will provide an update on the impact of the Health Maintenance Organization Act of 1973. (Res. 214, A-03)	Rescind – this directive has been completed. See CMS Report 4 – A-04 at www.ama-assn.org/resources/doc/cms/cmsreport4-a04.pdf.
D-195.998	HMO Excesses	Our AMA will update, reorganize and consolidate information on the current status of litigation, regulations and laws controlling HMO practices, which exists currently on public portions of our AMA Internet site, into a new user-friendly site for AMA members only. (Res. 719, A-03)	Rescind – this directive has been completed. See PSA website on managed care at www.ama-assn.org/ama/pub/physician-resources/practice-management-center/claims-revenue-cycle/managed-care-contracting.page?, and OGC's site at www.ama-assn.org/ama/pub/physician-resources/legal-topics/litigation-center/case-summaries-topic/managed-care-payments.
D-200.994	Appropriations for Increasing Number of Primary Care Physicians	Our AMA will encourage members to communicate with their US Senators and Representatives to support Public Health Service Act, Title VII, Section 747. Res. 814, I-03)	Retain – this policy remains relevant.
D-270.992	Support for Inflammatory Bowel Disease Bill (HR 290/S. 491)	The AMA does not support H.R. 290/S. 491, the "Inflammatory Bowel Disease Act," at this time. (BOT Action in response to referred for decision Res. 914, I-03)	Rescind – reference to this legislation is obsolete.
D-270.993	Support for the Screen for Life Bill (HR 1422/S. 740) to Increase Screening for Colorectal Cancer	Our AMA does not support H.R. 1422/S. 740, the "Colon Cancer Screen for Life Act." (BOT Action in response to referred for decision Res. 913, I-03)	Rescind – reference to this legislation is obsolete and the purpose of the legislation has been achieved through enactment of the Affordable Care Act.
D-290.989	Diagnosis and Treatment of Hearing and Balance Disorders	Our AMA will actively oppose the Centers for Medicare and Medicaid Services' proposed regulation CMS-2132-P, "Medicaid Provider Qualifications for Audiologists," as soon as possible. (Res. 128, A-03)	Rescind – the comment period for this proposed rule has expired, and this rule was finalized on May 28, 2004 (CMS-2132-F).

Policy Number	Title	Text	Recommendation
D-305.981	Financing Federal Consolidation Loans	Our AMA will: (1) support the refinancing of Federal Consolidation Loans; and (2) actively advocate for modification of pending and future legislation which that provides the opportunity to refinance Federal Consolidation Loans. (Res. 849, I-03)	Retain – this policy remains relevant.
D-305.984	Reduction in Student Loan Interest Rates	Our American Medical Association will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%. (Res. 316, A-03)	Retain – this policy remains relevant.
D-305.985	Injunctive Relief Against Mid-Year and Retroactive Medical School Tuition Increases	Our AMA, in collaboration with state, specialty and other interested organizations, will study and report back at the 2004 Annual Meeting on the case precedent, timing, risks, and other considerations in filing for an injunction to block mid-year and retroactive tuition increases occurring after the start of the academic year. (Res. 302, A-03)	Rescind – this policy has been accomplished and, we have policy that supersedes this policy.
D-330.941	Medicare Outpatient Therapy Caps	Our AMA will not support H.R. 1125/S. 569, the "Medicare Access to Rehabilitation Services Act of 2003." (BOT Action in response to referred for decision Res. 127, A-03)	Retain in part: modify so that the policy reflects the relevant subject matter since the specific bills are obsolete.
D-35.996	Scope of Practice Model Legislation	Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners' scope of practice, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation as a framework to deal with questions regarding non-physician independent practitioners' scope of practice. (Res. 923, I-03)	Retain – this policy remains relevant.
D-390.982	Asking Congress to Fix the CMS Physician Payment Formula	Our AMA will: (1) continue to lobby Congress to enact legislation, before the 2004 Medicare update, that will make ongoing corrections to the Medicare physician payment formula; and (2) expand its efforts to inform grassroots physicians of this ongoing problem and help organize efforts to encourage all physicians to contact their Senators and Representatives. (Res. 130, A-03)	Rescind – there is later policy that duplicates and supersedes this policy.
D-390.984	Payment by Health Insurance Plans of Medicare Deductibles and Copayments	Our AMA will: (1) seek legislation to compel all insurers paying secondary to Medicare to be required to pay the deductibles and coinsurance owed after the Medicare payment is made; (2) advise physicians that they are legally entitled to the Medicare co-payments and are required to bill the patients for them, because of existing Medicare fraud and abuse laws, and report back at the 2003 Interim Meeting to membership on the legality and measures that physicians may take when secondary carriers will not pay, and this does not apply to Medicare and Medicaid dual eligibles; and (3) seek federal legislation to require that a secondary plan not manage the primary Medicare benefit by imposing limits as if it were primary. (Res. 105 and 106, A-03)	Retain – this policy remains relevant.
D-40.993	Inequity in Military Pay for Physicians	Our AMA will work, as appropriate, with other interested organizations, to support immediate reintroduction of a bill based on H.R. 5353 (107th Congress) in this Congress. (BOT Action in response to referred for decision Res. 901, I-03)	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
D-435.988	Family Protection Act	Our AMA will: (1) propose amendments to the Bankruptcy Abuse Prevention and Consumer Protection Act of 2003 (H.R. 975) which would provide further protections, including establishment of a minimum homestead exemption; (2) develop a strategy for promoting bankruptcy reform that is consistent with our AMA's efforts to promote medical liability reform; and (3) provide a report on actions taken to implement the above recommendations at the 2004 Annual Meeting. (BOT Rep. 9, I-03)	Retain in part: Retain (2) – This policy remains relevant; Rescind (1) and (3) – This policy has been accomplished.
D-435.989	Family Protection Act	Our AMA will study potential mechanisms for legal reforms which would limit the use of an individual's personal assets to pay excessive liability awards with report back at the 2003 Interim Meeting. (Res. 205, A-03)	Rescind – this policy has been accomplished.
D-435.990	Delivery of Health Care by Good Samaritans	Our American Medical Association will work with state medical societies to educate physicians about the Good Samaritan laws in their states, and the extent of liability immunity for physicians when they act as Good Samaritans. (Res. 201, A-03)	Retain. This policy remains relevant.
D-435.992	Liability Reform	Our AMA: (1) shall recruit a broad-based coalition composed of Federation members (state/county/specialty societies), trade and professional associations, small and large businesses, medical groups, farmers, non- profit organizations, local governmental associations, patient advocacy groups and other supportive groups to promulgate a public information campaign on the issues of civil liability reform; (2) and Federation members in their public and physician communication efforts, shall specifically highlight the problems emanating from the current tort milieu, develop a state by state impact analysis of litigation costs in the current system, and highlight key elements of proposed federal tort reform legislation; (3) in concert with a coalition for civil liability reform, shall develop a broad-based and sustained grassroots member mobilization campaign to communicate its call for immediate legislative relief from the current tort system to our congressional representatives and senators; (4) will work for passage of significant legislation in both houses of the US Congress on liability reform in this congressional year; (5) will form a liability reform task force as a central clearinghouse to actively coordinate and inform all of the states of best practices for obtaining significant liability relief for the doctors and patients of America, to include but not limited to expert witness rules, caps on non-economic damages, marketing by attorneys, and modification of contingency fees. The liability reform task force will bring to the 2002 Interim Meeting a plan for a national liability reform event; and (6) will work with state and national medical specialty societies to develop and implement a comprehensive strategic plan that will address all aspects of the growing medical liability crisis to ensure that federal medical liability reform legislation continues to move forward through the legislative process. (Sub. Res. 215, A-02; Reaffirmation I-03; Appended: Sub. Res. 910, I-03)	Retain in part. Retain (3), (4), and (6) – This policy remains relevant. Rescind (1), (2), and (5) – This policy has been accomplished. In addition, the AMA is actively involved in the Health Coalition on Liability and Access (HCLA/ protectpatientsnow.org/) and the American Tort Reform Association (ATRA/ www.atra.org/). The AMA also continues to include information on litigation costs in MLR Now! (www.ama-assn.org/resources/doc/arc/mlr-now.pdf) and continues to strategically utilize grassroots campaign on medical liability reform.

Policy Number	Title	Text	Recommendation
D-90.999	Interpreters For Physician Visits	Our AMA: (1) seeks enactment of the proposed legislation to clarify the provisions in the Americans with Disabilities Act (ADA) requirement relating to the provision of qualified interpreters for hearing impaired patients; and (2) continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients. (BOT Rep. 15, I-98; Reaffirmation I-03)	Rescind in Part: rescind clause 1 since we have policy that supersedes this policy.

APPENDIX 2 – AMA Policies Superseding Policies Recommended for Rescission

D-305.985 Injunctive Relief Against Mid-Year and Retroactive Medical School Tuition Increases
Our AMA, in collaboration with state, specialty and other interested organizations, will study and report back at the 2004 Annual Meeting on the case precedent, timing, risks, and other considerations in filing for an injunction to block mid-year and retroactive tuition increases occurring after the start of the academic year. (Res. 302, A-03)

H-305.934 Medical School Tuition and Opposition to Tax Increases
1. Our American Medical Association opposes the imposition of mid-year and retroactive tuition increases at both public and private medical schools.
2. Our AMA opposes tuition taxes and any other attendance-based taxes by any government entity. (CME Rep. 2, I-02; Reaffirmed: CME Rep. 3, I-03; Appended: Res. 905, I-10)

D-305.988 Strategies to Address Medical School Tuition Increases
Our AMA will: (1) monitor proposals for medical school tuition increases and continue to work with the AMA Medical Student Section and other student groups, along with state and county medical societies, national medical specialty societies and the Association of American Medical Colleges (AAMC) to address the serious issue of rising tuition and medical student debt and to oppose any mid-year or retroactive tuition increases; (2) encourage medical schools to alert students of the probability of escalation of tuition costs and provide entering students with an estimate of tuition costs for the four years; (3) encourage federal and state agencies to review and expand options for financial aid (scholarship and loan repayment programs) for medical students, resident physicians, and young physicians by developing programs that address areas of existing and emerging national and local need; (4) continue to encourage medical schools to provide yearly financial planning/debt management counseling to medical students and the institutions that sponsor residency training to make available similar services for resident physicians; (5) encourage and work with medical schools to broaden their fundraising activities directed at obtaining revenue for medical student scholarships or for capping/decreasing tuition; (6) continue to work for a stable funding mechanism for undergraduate medical education; (7) monitor and report to the House of Delegates at regular intervals, beginning in June of 2004, on progress in limiting medical school tuition and in developing mechanisms to reduce student debt; and (8) help develop specific strategies to address the problem of mid-year and retroactive tuition increases, and report back at the 2003 Interim Meeting. (CME Rep. 2, I-02; Reaffirmation I-03; Reaffirmation I-06)

D-390.982 Asking Congress to Fix the CMS Physician Payment Formula
Our AMA will: (1) continue to lobby Congress to enact legislation, before the 2004 Medicare update, that will make ongoing corrections to the Medicare physician payment formula; and (2) expand its efforts to inform grassroots physicians of this ongoing problem and help organize efforts to encourage all physicians to contact their Senators and Representatives. (Res. 130, A-03)

H-390.852 Legislative Action to End Medicare SGR Problems
1. Our AMA, working with our state and specialty society colleagues, will pursue enactment of legislation that provides for at least two years of positive updates that accurately reflect the increases in costs of caring for Medicare beneficiaries and lays the groundwork for complete repeal in the near future. 2. The AMA's ultimate goal continues to be complete repeal of the SGR and its replacement with a fair and equitable payment system that adequately reflects increases in the cost of caring for Medicare beneficiaries. (BOT Rep. 31, A-07; Reaffirmation I-08)

H-390.855 Replacement of Sustainable Growth Rate System
Our AMA continues to assign a top priority to the prevention of further Medicare payment cuts due to the Sustainable Growth Rate system and to seek replacement of the Sustainable Growth Rate system with payment updates that reflect increases in the cost of medical practice. (Res. 910, I-04; Reaffirmed: CMS Rep. 4, A-05; Reaffirmed: BOT Rep. 35, A-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation I-08)

D-390.969 Parity in Medicare Reimbursement
Our AMA will continue its comprehensive advocacy campaign to: (1) repeal the Medicare physician payment formula, the sustainable growth rate (SGR); (2) repeal or delay the reductions in Medicare payment for imaging services furnished in physicians' offices, as mandated by the Deficit Reduction Act of 2005; (3) pass legislation allowing physicians to share in

Medicare Part A savings that are achieved when physicians provide medical care that results in fewer in-patient complications, shorter lengths-of-stays, and fewer hospital readmissions; and (4) advocate for other mechanisms to ensure adequate payments to physicians, such as balance billing and gainsharing (BOT Action in response to referred for decision Res. 236, A-06; Reaffirmation I-08)

D-390.976 Medicare Physician Payment
Our AMA will send all members of Congress a letter, signed by all willing members of the Federation, urging them to enact legislation replacing Medicare's sustainable growth rate reimbursement formula with a system based on appropriate updates. (BOT Rep. 35, A-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation I-08)

D-90.999 Interpreters for Physician Visits
~~Our AMA: (1) seeks enactment of the proposed legislation to clarify the provisions in the Americans with Disabilities Act (ADA) requirement relating to the provision of qualified interpreters for hearing impaired patients;~~…. (Retain clause 2) (BOT Rep. 15, I-98; Reaffirmation I-03)

D-160.992 Appropriate Reimbursement for Language Interpretive Services
1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English. 2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care. (Res. 209, A-03; Reaffirmation A-09; Reaffirmation A-10; Appended: Res. 114, A-12; Reaffirmed: Res. 702, A-12)

29. EMPLOYMENT STATUS AND ELIGIBILITY FOR ELECTION OR APPOINTMENT TO MEDICAL STAFF LEADERSHIP POSITIONS (RESOLUTION 1-I-12)

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
                    IN LIEU OF RESOLUTION 1-I-12 AND
                    REMAINDER OF REPORT FILED**
                    See Policies [H-235.961](#) and [H-235.970](#)

At its 2012 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 1-I-12, "Employment Status and2 Eligibility for Election or Appointment to Medical Staff Leadership Positions," for report. Resolution 1, which was introduced by the Organized Medical Staff Section, asked the AMA to:

1. Adopt as policy the principle that determinations of eligibility for election or appointment to medical staff leadership positions, for voting on medical staff matters, or for otherwise participating in the self-governance activities of the medical staff should be made without respect to a medical staff member's financial relationships, including employment or contractual relationships, or lack thereof, with a hospital or health care delivery system;

2. Draft model medical staff bylaws provisions and encourage medical staffs to adopt medical staff bylaws provisions supporting this principle; and

3. Amend AMA policy to specify how medical staffs should manage conflicts of interest of candidates for leadership positions and elected leaders.

Reference committee testimony suggested that Resolution 1 lacked clarity. Additionally, some were concerned that the first and second resolves did not adequately address conflicts of interest, and could not stand on their own in meaning apart from the third resolve. The resolution was applauded for making key policy changes, but testimony raised concerns that the current language needs greater nuance and specificity about when conflicts of interest might require recusals. Others testified, and the reference committee agreed, that AMA policy cannot address particular institutional processes.

BACKGROUND

Physicians are increasingly entering into arrangements in which their financial interests are aligned with the financial interests of the hospitals or health care delivery systems in which they practice. Such arrangements, which typically manifest as employment or contractual relationships, can create conflicts of interest that may strain relations between independent and "employed"[1] physician members of the organized medical staff. For example, independent physicians may question whether employed physicians are capable of acting in the best interest of the medical staff in situations in which the interests of the hospital administration conflict with those of the medical staff. On the other hand, employed physicians may question the motives of independent physicians, who may have competing financial interests with the hospital. Persistent distrust between independent and employed medical staff members has provoked some organized medical staffs to exclude one class of members from holding medical staff leadership positions. Depending on the composition of the medical staff, such discrimination may be perpetrated against either independent or employed physicians.

DISCUSSION

Medical staff self-governance–in short, the authority of the organized medical staff to act without interference from hospital governance/administration and other outside parties–is a fundamental right of the medical staff and is vital to the medical staff's ability to effectively perform its assigned quality and safety duties. The medical staff exercises its right to self-governance in part by: (1) establishing qualifications for those holding medical staff leadership positions; and (2) electing/appointing and removing medical staff leaders without governing body approval, affirmance, or concurrence (Policies H-220.962 and H-225.957).

Employment and contractual relationships can create conflicts of interest that render some physicians less capable than others of effectively leading and representing the interests of the organized medical staff.[2] In an effort to avoid such conflicts, and citing their right to self-governance, medical staffs may be tempted to establish leadership eligibility criteria that automatically disqualify members who maintain (or don't maintain) financial relationships with hospitals or healthcare systems, effectively denying employed (or independent) medical staff members the ability to fully participate in the governance activities of the medical staff.

This discriminatory approach contradicts the core principle that regardless of the employment status of its individual members, the organized medical staff must work collectively to improve patient care and outcomes (Policy H-225.950). A medical staff divided into tiered factions cannot properly perform its assigned duties. Accordingly, the self-governing medical staff's right to establish leadership qualifications should not be expanded to include blanket discrimination against an entire class of members defined by characteristics that are irrelevant to those members' work on behalf of the medical staff.

Medical staff members' personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect their eligibility for election or appointment to medical staff leadership positions. Nonetheless, the self-governing medical staff must be able to establish mechanisms to ensure that conflicts of interest do not compromise the medical staff's ability to perform its vital work. These mechanisms should strike a balance between: (1) promoting the broadest possible level of physician participation in the self-governance activities of the medical staff; and (2) preserving the self-governing medical staff's ability to select and retain as leaders those physicians who will most effectively represent the interests of the medical staff.

Disclosure of Potential Conflicts before Election or Appointment

While it may be inappropriate to establish broadly exclusionary policies such as blanket denial of eligibility, it is entirely within the rights of the self-governing medical staff to consider a candidate's affiliations or relationships as part of the medical staff's exercise of its right to elect or appoint medical staff leaders as it sees fit. For this reason,

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[1] The term "employed" as used throughout this report refers broadly to physicians who maintain significant financial relationships with hospitals or health systems and may include physicians employed directly by a hospital or health system, physicians under contract with a hospital or health system, physicians with ownership interests in a hospital or health system, etc.
[2] Conflicts are not necessarily restricted to employment/contractual relationships or the lack thereof. For example, a conflict may exist when a medical staff leader has a financial interest in a private firm from which the hospital purchases services, and when the medical staff has an influence on the hospital's decision to procure the services of that firm.

candidates for election or appointment to leadership positions should be expected to openly disclose potential conflicts to their peers. This requirement is supported by AMA policy (Policies H-235.970 and H-225.957) and modeled as follows in the *AMA Physician's Guide to Medical Staff Organization Bylaws*:[3]

> All nominees for election or appointment to medical staff offices, department chairships, or the medical executive committee shall, at least 20 days prior to the date of election or appointment, disclose in writing to the medical executive committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the hospital, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.[4]

The voting or appointing members of the medical staff, thusly informed of potential conflicts, are then appropriately positioned to make informed judgments as to whether candidates will be able to act in the best interest of the medical staff and select their leaders accordingly.

Management of Conflicts after Election or Appointment

Disclosure of conflicts before candidates' election or appointment to leadership positions does not preclude the existence of such conflicts among sitting medical staff leaders. After all, the members of the medical staff may yet choose to elect or appoint a candidate who has disclosed a conflict, or a conflict may materialize after a physician has been elected or appointed to a leadership position.

Consequently, in addition to establishing pre-election/appointment disclosure policies, the medical staff should establish standing conflict of interest policies to manage the conflicts of medical staff leaders whenever they may arise. The *AMA Conflict of Interest Guidelines for Organized Medical Staffs* suggest that identified conflicts should be managed in as undisruptive a manner as possible while preserving, to the maximum extent feasible, the ability of a conflicted individual to carry out the responsibilities of the leadership role to which he or she has been elected or appointed. Conflict management actions, listed in increasing order of severity, might include, for example:

1. Voluntary disclosure of the conflict of interest;
2. Voluntary abstention from voting on the matter to which the conflict relates;
3. Voluntary recusal from the deliberative process and abstention from voting on the matter to which the conflict relates; and
4. Involuntary recusal of the elected/appointed leader upon a two-thirds vote of the membership of the leadership body in question.[5]

Conflict management policies, coupled with candidate disclosure policies, will ensure that medical staff members' personal or financial affiliations or relationships do not interfere with the functioning of the self-governing medical staff or its efforts to ensure the provision of the highest quality patient care.

CONCLUSION

A physician's personal or financial affiliations or relationships, including employment or contractual relationships with a hospital or health system, should have no bearing on his or her collaboration with fellow medical staff members to promote the delivery of safe, high-quality patient care. Nonetheless, because such relationships may limit some physicians' effectiveness in leading and representing the interests of their medical staffs, the self-governing medical staff must establish mechanisms to protect itself from conflicts of interest.

Some medical staffs have responded to potential conflicts by excluding employed or independent members from holding medical staff leadership positions. A more balanced solution should ensure that eligibility to participate in the self-governance activities of the medical staff is independent of a physician's affiliations or relationships. At the same time, however, the self-governing medical staff, taking into consideration all conflicts disclosed by candidates,

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[3] The *AMA Physician's Guide to Medical Staff Organization Bylaws* is available at no charge to AMA members at www.ama-assn.org/go/omssbylaws.
[4] The *AMA Conflict of Interest Guidelines for Organized Medical Staffs* (www.ama-assn.org/go/COIguidelines) provide further guidance as to what may constitute a "disclosable" relationship.
[5] See the *AMA Conflict of Interest Guidelines for Organized Medical Staffs* for further guidance on the parameters and processes for involuntary recusal of conflicted medical staff leaders.

including employment status, should retain its ability elect or appoint those physicians who, all things considered, will most effectively represent the interests of the medical staff. This disclosure policy should be augmented by a standing conflict of interest policy that facilitates the medical staff's identification and management of conflicts that may arise among physicians who have already been elected or appointed to medical staff leadership positions.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 1-I-12 and that the remainder of this report be filed:

1. That AMA Policy H-235.970 be amended by addition and deletion to read as follows:

    H-235.970 Conflict of Interest ~~Issues in the~~ and Medical Staff Leaders
    ~~Policy of the AMA states that:~~ The AMA encourages medical staffs to adopt and incorporate into their bylaws medical staff conflict of interest policies that reflect the following principles:

    (1) Disclosure of potential conflicts. Candidates for election or appointment to medical staff leadership positions ~~offices, department or committee chairs, or the medical executive committee,~~ should disclose in writing to the medical staff, prior to the date of election or appointment, any personal, professional or financial affiliations or relationships of which they are reasonably aware, including employment or contractual relationships, which could foreseeably result in a conflict of interest with their acting ~~or responsibilities~~ on behalf of the medical staff. Elected or appointed medical staff leaders should disclose potential conflicts in writing to the medical staff whenever they arise.
    (2) Management of conflicts. When conflicts of interest exist, elected or appointed medical staff leaders should, as appropriate, recuse themselves from the deliberative process and/or abstain from voting on the matter to which the conflict relates. The medical staff should establish a process for disqualification from the deliberative process and/or from voting on the matter at hand for any elected or appointed medical staff leader with an identified conflict who fails to disclose the interest or who fails to recuse himself or herself from the deliberative process and/or from voting on the matter to which the conflict relates, as appropriate. ~~The AMA encourages hospital medical staffs to incorporate a "disclosure of interest" and provision in their medical staff bylaws based on this policy statement.~~

2. That our American Medical Association (AMA) adopt as policy the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect his or her eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the requirements of the medical staff bylaws.

3. That our AMA draft model medical staff bylaws provisions supporting the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect his or her eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the requirements of the medical staff bylaws.

4. That our AMA encourage medical staffs and their advisors to consult the *AMA Physician's Guide to Medical Staff Organization Bylaws* and the *AMA Conflict of Interest Guidelines for Organized Medical Staffs* when developing policies for the disclosure of medical staff leaders' personal or financial affiliations or relationships and the management of resulting conflicts of interest.

APPENDIX – Related AMA Policy

H-220.962 Selection of Medical Staff Officers and Clinical Department Chairs
Our AMA urges The Joint Commission to (a) require that all medical staff bylaws and hospital governing documents recognize the inherent authority of the medical staff to elect and seat its medical staff officers and provide that such elections of officers are not subject to hospital governing body approval, affirmance or concurrence, and (b) the responsibilities and selection of department chair are specified in the medical staff bylaws, rules and regulations. (Res. 278, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10)

H-225.957 Principles for Strengthening the Physician-Hospital Relationship
…6. The organized medical staff has inherent rights of self-governance, which include but are not limited to:
  …b) Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.
  …e) Establishing within the medical staff bylaws: (1) the qualifications for holding office; (2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee; and (3) the qualifications for election and/or appointment to committees, department and other leadership positions.
  …k) Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.
  l) Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff...
…9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.
…11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff…
      (Res. 828, I-07; Reaffirmed in lieu of Res. 730, A-09; Modified: Res. 820, I-09; Reaffirmed: Res. 725, A-10)

D-225.977 Physician Independence and Self-Governance
Our AMA will: (1) develop "Principles for Physician Employment" that address the relationships between and among employed physicians, hospitals, integrated delivery systems and hospital medical staffs; (2) update its Physician's Guide to Medical Staff Organization Bylaws and other relevant resources as necessary to reflect the needs and concerns of employed physicians and to ensure the continuing self-governance of the medical staff and the clinical decision-making autonomy of all physicians in the face of rising physician employment; and (3) promote physician collaboration, teamwork and partnership in emerging health care organizational structures, including but not limited to health care systems, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care. (Res. 801, I-11)

H-235.970 Conflict of Interest Issues in the Medical Staff
Policy of the AMA states that: Candidates for election or appointment to medical staff offices, department or committee chairs, or the medical executive committee, should disclose in writing to the medical staff, prior to the date of election or appointment, any personal, professional or financial affiliations or responsibilities on behalf of the medical staff; and encourages hospital medical staffs to incorporate a "disclosure of interest" provision in their medical staff bylaws based on this policy statement. (Sub. Res. 801, A-95; Reaffirmed: CLRPD Rep. 1, A-05)

30. FUTURE OF THE INTERIM MEETING OF THE HOUSE OF DELEGATES

Reference committee hearing: see report of Reference Committee F.

**HOUSE ACTION: RECOMMENDATION NOT ADOPTED AND
                                    REPORT FILED**

The Board of Trustees believes it is incumbent on the House of Delegates (HOD) to settle the matter of the future of the Interim Meeting. The Board acknowledges that the question is divisive, due at least in part to the important role of the HOD in American Medical Association (AMA) governance, and there is no question about the importance of the issue to either members of the House or the broader assemblage of societies represented in the HOD.

The HOD itself is clearly divided on the issue and many have presented arguments in support of a variety of approaches to the matter. The issue has absorbed substantial time not only for members of the HOD but also your Board, AMA staff, and staff from across the Federation. At least four reports and four resolutions have been considered over the last four calendar years, but unlike other issues with a similar volume of business, no decision has emerged.

The lack of a final decision distracts from other business and hinders the AMA's ability to effectively plan other activities. For example, HOD policy has serious logistical implications for a combined HOD-National Advocacy Conference (NAC) and could conceivably result in three policymaking meetings in a twelve-month period. For these

reasons, the Board offers this report to comprehensively address this matter and to ensure the ongoing strength and vitality of both our HOD and our entire AMA governance structure. This report, guided by the input of an Interim Meeting Task Force, represents your Board's best judgment regarding the implementation of policies adopted in the last year.

BACKGROUND

At the 2012 Interim Meeting, the HOD adopted amended Policy G-600.125, AMA Meeting Schedule, adding paragraphs 2–4:

1.   (a) Our AMA will convene as a pilot a combined interim policymaking meeting and National Advocacy Conference; (b) the combined meetings will be held at a location in the Washington, DC metropolitan area and at an appropriate time to avoid incurring contractual penalties; (c) the pilot will take place within a reasonable time frame, and with adequate notice to members of the House of Delegates; and (d) our AMA sections will be afforded the opportunity to meet immediately prior to and in close proximity to the meetings of the House of Delegates.
2.   Our AMA will organize and implement the pilot as specified in #1 above.
3.   A study and report on the feasibility and logistics of reorganized future meeting dates and schedules shall be developed and presented to the House of Delegates.
4.   State and specialty societies shall be queried on the potential number of members who would attend a new, revised interim/NAC meeting.

As outlined in Board of Trustees Report 7-I-12, implementing a pilot combined meeting as proposed is not logistically possible in the DC metro area and creates numerous associated problems for the HOD, NAC, and our councils, sections, and special groups. To reiterate,

- No single hotel or proximate combination of hotels in the District of Columbia proper can accommodate the HOD and section meetings in anything like their current configuration.
- AMA's meeting does not meet the District of Columbia minimum size requirement to secure the Washington Convention Center.
- If hotel(s) outside the District itself were utilized, members of Congress and the executive branch will be unwilling to participate in the NAC; reciprocally, transporting many hundreds of physicians and students in and out of the District is inconsistent with the realities of Hill visits whether using the Beltway or Metro.
- Scheduling a single pilot meeting is not attractive to potential vendors and ignores the lead time necessary to secure sufficient meeting space.

In light of the complexities of planning for a combined meeting, the Board Chair assembled a Task Force with representatives from the Board, the HOD and Federation executives (members are listed in Appendix A) to advise the Board. The Task Force was given the following threefold charge:

- To advise the Board .
- To offer feedback on an implementation plan.
- To assist in educating the HOD on the Board's recommendations and the implementation plan.

In addition, among other variables, the Task Force was cognizant of and sought to ensure that any proposed changes:

- Enhance, not damage, the effectiveness of the HOD and success of the NAC;
- Proactively address and support the overall governance needs of the AMA;
  - Be consistent with venue and meeting service needs and limitations;
  - Be done in a fiscally responsible manner; and
- Be accomplished within a reasonable timeframe.

Survey Regarding Potential Combined Meeting

As a first step in the process, a survey of members of the HOD as well as the executives and board chairs of medical societies represented in the House of Delegates was conducted in late 2012. Pursuant to item #4 of Policy

G-600.125, the survey inquired about participation in a joint HOD-NAC. The survey text and additional detail appear in Appendix B.

Responses to some key questions identified a striking difference between members of the HOD and their society executives and to a lesser extent the board chairs.

A majority of each group would support "convening a modified HOD meeting integrated into the AMA's National Advocacy Conference," though that majority is smaller among members of the HOD where 53% are supportive compared with just over three-fifths (61%) of society executives and nearly three-quarters (73%) of state and specialty society board chairs. Perhaps more telling, members of the HOD were far more likely to respond negatively. That is, delegates (and alternate delegates) were more likely to say they did not support convening a modified meeting (30% to 19% to 14%).

This divergence of opinion is markedly more apparent in response to the question, "Do you feel that the policymaking business of the AMA House of Delegates could be accomplished in one meeting held annually?" In this case, less than half (43%) of members of the HOD responded in the affirmative while nearly four-fifths (79%) of executives and three-fifths (60%) of state and specialty society board chairs did so. While neither side can be thought of as "right" or "wrong," the divide between members of the HOD and their sponsoring societies' leadership is significant. Additionally, society executives and board chairs are arguably closer than their AMA delegates to the policies of their own organizations and perceive more vividly the disconnect between their own generally single meeting per year schedule versus the AMA's current two meeting per year structure.

In a similar vein, a marked divide is seen in response to the question, "Is the fiscal cost to your society of its involvement in the Interim Meeting of the AMA House of Delegates a barrier or strain to your organization's continued participation?" In this case, just over one-third (35%) of delegates believe this to be the case, while nearly half (46%) say no and nearly one-fifth (19%) is unsure. At the same time, nearly all medical society executives were sure of their response, with two-thirds (68%) indicating that fiscal concerns are an issue and 29% indicating the opposite. Board chairs were between the other groups. Similarly, society executives and board chairs are much more likely (44% and 35% to 20%) to indicate that their delegations to the HOD are likely to be limited if the current schedule continues. It is reasonable to suppose that society executives are closest to the fiscal issue and most knowledgeable about the total cost of participation in HOD meetings.

Notwithstanding these differences, some interesting similarities in responses also emerged. If a modified meeting were held, at least two-thirds of each group say they would participate in both the HOD and the NAC. The figure is two-thirds for both members of the HOD and society executives and rises to four-fifths (81%) for board chairs. Among those who would attend only one meeting or the other, nearly everyone would attend only the HOD meeting, although a handful of board chairs (3%) indicate that they would attend only the NAC.

Current Federation Practice

Across the Federation, only a handful of societies have more than one House of Delegates meeting each year, and a growing number of societies have abandoned entirely the House of Delegates governance model. Records maintained by our AMA's Department of Federation Relations show only about five medical societies have more than one policymaking meeting each year, and six state societies have eliminated their houses of delegates completely. Fiscal concerns and declining attendance have also led about 14 societies to markedly shorten or curtail their policymaking meetings in recent years, while other state societies are in the midst of major governance reviews for the same reasons.

This trend is likely to continue as younger generations—physicians as well as their non-physician colleagues—tend to disfavor meetings, particularly meetings that require travel, and opt instead for other means of communication and cooperation. Our AMA meetings have not been immune to declining participation, with some delegations not attending the Interim Meeting and with the noticeable absence of many alternate delegates at both the Annual and Interim HOD Meetings.

Across the Federation, a supermajority of societies has only a single annual meeting, which generally combines policymaking elements and a general membership meeting with education sessions. While the HOD meetings are the most visible AMA-sponsored gatherings, they are not the only forums for AMA members. Our AMA also

sponsors the State Legislative Strategy Conference in January, the NAC in February or March, multiple meetings of the AMA-RUC and the CPT editorial panel as well as the AMA-convened Physician Consortium for Performance Improvement. In noteworthy contrast, fewer than 40 societies of the 174 societies seated in the HOD convene an annual legislative and advocacy meeting in the state or national capitol. Thus, the AMA is unusual among members of the Federation with respect to both the number and type of meetings it hosts.

In addition, it is worth noting that the Federal Government, for budgetary and other reasons, has curtailed meeting attendance for many government employees. It would appear that the trend across both the public and private sectors is to reduce and limit the number of in-person meetings held.

TASK FORCE DELIBERATIONS

The Task Force was provided with previous reports and resolutions dealing with the Interim Meeting, the results of the newly completed survey and other newly compiled information. Among the materials they reviewed were the report of the Speakers' Special Advisory Committee on the HOD from A-09, the follow-up report of the Speakers' Task Force on the Replacement Meeting from I-09, a Board report at I-10 recommending the status quo, various resolutions on the Interim Meeting that have been considered over the last several years, reference committee reports on these reports and resolutions, commentary from 2012's online forum on the Interim Meeting (which preceded the 2012 Annual Meeting), and the current policy. With this information in hand, the Task Force then met in-person in late-January 2013.

The Task Force set out to answer three questions:

1. Should the AMA transition to one HOD policymaking meeting per year?
2. Should the AMA establish a non-policymaking HOD activity in conjunction with the NAC?
3. Could new and revised meeting opportunities address the governance needs of the AMA and concerns for sufficient face-to-face leadership interaction?

After reviewing the materials, and particularly in light of the survey results, the Task Force unanimously concluded that the answer to the first two questions was "Yes." That is, the available evidence supports that changing to a single policymaking meeting is in the best interests of the AMA and the Federation. Additionally, their consensus opinion is that the addition of a non-policymaking HOD activity at the NAC would both engage the HOD in the advocacy work of the AMA at the NAC and advance the work of the HOD through the creation of a forum for in-depth discussion of timely issues with a well-defined agenda.

In forming this opinion, the Task Force also reviewed the volume of business at HOD meetings over the last decade, during which the annual volume of business has been relatively steady or declined slightly. However, a number of meetings have concluded a full half day early over the last several years, and, even when it is convened, the business session on the last morning of the meeting rarely goes much longer than an hour. Recent history therefore suggests that the volume of business should fit within the currently budgeted time and should not impede a switch to a single annual meeting. If the business were to require it, it would seem that the meeting could end by noon the last day and still allow sufficient time for delegates to return home that day. In addition, some items of business at the current Annual and Interim Meetings are duplicative which means that the simple annual total of items of business somewhat overstates the true volume of business we should anticipate at a single Annual Meeting. Figures for each meeting can be found in Appendix C.

The Task Force also observed that the Annual and Interim Meetings serve numerous purposes. Resolution writing and policymaking are an obviously prominent element of these gatherings. In addition, the meetings also facilitate leadership interactions, networking opportunities, educational sessions, collaborative efforts among federation societies, and other useful activities. When considering the elements to be included in the implementation plan, the Task Force noted that many of these other non-policymaking functions are not only preserved but also meaningfully enhanced by the new activities proposed. The opportunities created for education and leadership development at the proposed new HOD/NAC activities, MSS/RFS Leadership Conference, and AMA Leadership Retreat substantially augment and diversify the opportunities to foster physician and student leadership and engagement within our AMA. These are positive and substantive investments in the future of our AMA and its leadership.

With respect to the third question, the Task Force offered a qualified yes, subject to the preparation of a more detailed proposal for their later review. The nature of that proposal is described in the implementation plan that accompanies this Board report. If the HOD adopts the recommendation to eliminate the Interim Meeting, the Task Force advised that the Board support the enactment of an implementation plan such as that presented.

In essence, the Task Force found that there is a disconnect between the views of members of the HOD and their sponsoring societies' management and boards, groups that have legal and fiduciary duties that are distinct from the delegates. As importantly, the collective opinion of delegates is at odds with the usual practice of their sponsors insofar as most societies hold a single policymaking meeting, with others taking steps to reduce or eliminate meetings because of falling participation and fiscal constraints.

While the long-term implications of these changes cannot be predicted with absolute certainty, it is nonetheless obvious that these same factors are already affecting participation in the HOD. The Board believes that confronting the situation head on is preferable to a slow wasting of the HOD that today truly represents the entire house of medicine but, unaltered, could eventually come to represent only a subset of states and specialty societies.

A HOD meeting that slowly becomes partially attended and irrelevant would be a huge disservice to the profession. Acknowledging and proactively addressing these changes is the best means to ensure the primacy of the HOD in policymaking and electing our leaders. By ensuring the full and complete participation of the whole profession—by speaking with that unified voice through our HOD—physicians can continue their long history of leadership and service to the profession and the health care system.

The Task Force's overall conclusion is that the HOD can effectively set strong policy in a single policymaking meeting. A single policymaking meeting will lead our AMA into the future and better utilize the talents of the HOD membership by gathering them for purposes other than simply voting on policy. In particular, as outlined below, members of the HOD would participate in the NAC, and those serving in key positions would gather at other times of the year for purposes such as leadership development and advocacy.

PLAN TO BE IMPLEMENTED

Cancellation of the Interim Meeting will make possible a number of new and exciting investments in our AMA governance operations, including the HOD. In its barest form, if the Interim Meeting is canceled, the following lists key elements of the plan that AMA will begin immediately to implement:

1. The 2013 Interim Meeting, scheduled for November 16–19 at the Gaylord National in National Harbor, Maryland will be convened as planned.
2. All future Interim Meetings would be canceled. A penalty will be incurred for cancelling the 2014 meeting, but the expense is well below the cost of executing that meeting; the AMA would not be subject to other cancellation penalties.
3. Beginning in 2014, the NAC will be expanded to incorporate an HOD open forum or some similar event.
   - Registration fees for the NAC would be significantly reduced for all AMA members and Federation staff in attendance.
   - Members of the AMA's councils and the individuals on the governing councils of AMA sections and special groups would be invited to participate in the NAC, with their expenses eligible for AMA reimbursement.
4. The Annual Meeting would be maintained in its current form.
5. A new AMA "leadership retreat" would be established in early November for elected and appointed AMA leadership, including members of the Board, councils and section/special group governing councils. These leaders would meet to handle each group's particular needs and also assemble for a variety of interactions that will support education, leadership development, and collaboration.
6. To address the needs of students and residents/fellows, a stand-alone Fall meeting for the Medical Student Section (MSS) and Resident and Fellow Section (RFS) would be convened to allow for elections, preservation of their research poster symposium and some leadership development components.
7. A variety of mechanisms will be explored and implemented over time that will provide avenues for online communication, webcasts and webinars, periodic surveys of the HOD and the rolling release of Board or council reports that do not recommend action(s).

The unique needs of our student and resident members (point 6 above) arise from the brief four years (on average) during which they fill each of those roles. Not wishing to hamper the activities of these member groups, the Board Chair hosted multiple discussions with MSS and RFS leadership, both in-person and by telephone, to develop a program that would meet their needs despite the change to a single policymaking meeting each year. Those needs, for example, include the election of delegates and, for the students, proposed Board and council candidates. The implementation plan very specifically addresses the concerns of the MSS and RFS, as outlined by their leadership groups.

The plan and its implementation, including the allowances for the student and resident sections, are spelled out in greater detail in Appendix D. If the recommendations in this report are adopted, implementation of the plan will begin immediately, although some of the finer points (e.g., hotel properties, meeting locations and the size of room blocks for an expanded NAC) may require a year or two to establish based on availability and levels of participation.

CONCLUSION

Your Board believes the AMA is best served by taking an evidence-based approach to proactively determine the number of policymaking meetings held annually. As described above, both the Speaker's Special Advisory Committee on the HOD and the current Interim Meeting Task Force have recommended elimination of the Interim Meeting. Elimination of the Interim Meeting would enable a number of new governance activities that would enhance the effectiveness of AMA governance, including the HOD through a new HOD open forum at the NAC. In the event that the following recommendations are adopted and the bylaws changed, your Board will immediately begin implementation of the plans outlined in Appendix D of this report.

RECOMMENDATIONS

Your Board recommends AMA's bylaws be amended by deletion to read as follows and the remainder of the report be filed:

> 2.51 Regular Meetings of the House of Delegates. The House of Delegates shall meet ~~twice~~ annually~~, at an Annual Meeting and an Interim Meeting~~.
>
> ~~2.511 Business of Interim Meeting. The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.~~

APPENDIX A – Members of Task Force

1.   Steven J. Stack, MD, Chair, AMA Board of Trustees – Task Force Chair
2.   Jack Resneck, MD, Chair, AMA Council on Legislation and Delegate – Task Force Vice Chair
3.   David O. Barbe, MD, Chair-elect, AMA Board of Trustees
4.   Mary Carpenter, MD, Delegate
5.   Ardis D. Hoven, MD, President-elect, AMA
6.   Michael Sheppard, CPA, CAE, Executive Director, American Urological Association
7.   Gordon H. Smith, Esq., Executive Vice President, Maine Medical Association
8.   Patricia Turner, MD, Member, Council on Medical Education and Delegate

APPENDIX B – Survey of House of Delegates and Society Executives and Chairs

Emails were sent to all members of the HOD for whom email addresses were available inviting each to respond to an online survey. In addition, the executive director of each society seated in the HOD was sent a link for the survey along with a second note to be forwarded to the society's board chair. In the end, 423 members of the HOD responded, as did 101 society executives and 37 state and specialty society board chairs. The response rate for the HOD was 47.3% and 60.1% for society executives. The figure for board chairs cannot be accurately calculated, as it is unknown how many actually received the link to the survey; the lower limit would be 22%.

The text of the survey and responses by group follow.

Introduction:

Thank you for participating in this survey about the following policy that was adopted at I-12 in regards to the future of the Interim Meeting:
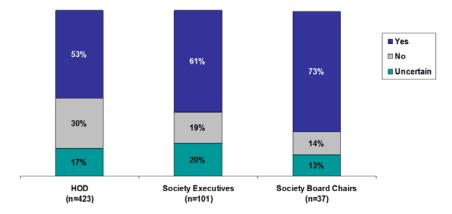
1. Our AMA will organize and implement the pilot as specified in AMA Policy G-600.125.

2. A study and report on the feasibility and logistics of reorganized future meeting dates and schedules shall be developed and presented to the HOD.

3. State and specialty societies shall be queried on the potential number of members who would attend a new, revised Interim/NAC meeting.

As the AMA considers options to implement this policy, we need your input to plan a viable path to a long-term solution. Please keep all of the above information in mind as you answer the following questions.

When you are ready to begin, please click on "Continue."

Questionnaire:

Q1. If the current House of Delegates meeting schedule were changed, would you support convening a modified HOD meeting integrated into the AMA's National Advocacy Conference?

Q2. If it were decided to convene a modified HOD meeting, integrated with the National Advocacy Conference, how would this impact the total number of delegates and alternate delegates your society is likely to send to this newly modified meeting?

Q3. Would you anticipate participating in both the House of Delegates (HOD) and National Advocacy Conference (NAC) portions of the revised meeting?

Q4. Do you feel that the policy-making business of the AMA House of Delegates could be accomplished in one meeting held annually?

[ASK IF Q4 = "YES"; OTHERWISE SKIP TO Q5B_1]
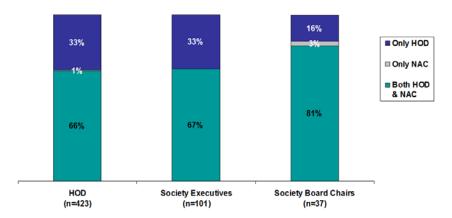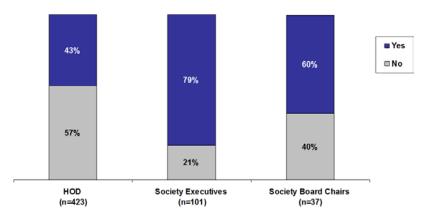
Q5A_1. Which three of the following factors describe why you feel that the business of the AMA House of Delegates could be accomplished in one policy-making meeting held annually? *Please select only three responses.* [ALLOW UP TO THREE RESPONSES]

　　Q5A_2. Below is a list of your top factors that describe why you feel the business of the AMA House of Delegates could be accomplished in one policy-making meeting held annually. Please rank each factor in order of importance by selecting a '1' for the most important factor, a '2' for the second most important factor, and a '3' for the third most important factor. *You may use each number only once.*

　　(Detailed responses to Question 5A are not presented here in light of the number and diversity of answers. The most common response was that "we can accomplish the work in a single meeting." Responses were provided by 182 members of the HOD, 80 society executives and 22 board chairs.)
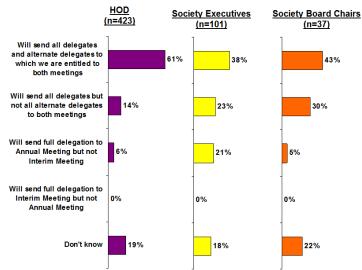
[ASK IF Q4 = "NO"; OTHERWISE SKIP TO Q6]
Q5B_1. Which three of the following factors describe why you feel that the business of the AMA House of Delegates could not be accomplished in one policy-making meeting held annually? *Please select only three responses.* [ALLOW UP TO THREE RESPONSES]

    Q5B_2. Below is a list of your top factors that describe why you feel the business of the AMA House of Delegates could not be accomplished in one policymaking meeting held annually. Please rank each factor in order of importance by selecting a '1' for the most important factor, a '2' for the second most important factor, and a '3' for the third most important factor. *You may use each number only once.*

    (Detailed responses to Question 5B are not presented here in light of the number and diversity of answers. The most common response was that "we need two meetings to cover all of the policymaking decisions." Responses were provided by 241 members of the HOD, 21 society executives and 15 board chairs.)

Q6. If the current House of Delegates Annual and Interim Meeting schedule continues in the existing form for the next decade; how would this impact the total number of delegates and alternate delegates your society is likely to send to each meeting?

Q7. Is the fiscal cost to your society of its involvement in the Interim Meeting of the AMA House of Delegates a barrier or strain to your organization's continued participation?

Q8. In the space below, please include any additional comments or questions you may have regarding the future of the Interim Meeting.

Demographics:

These last few questions will be used to categorize your responses with others.

D1A. Which of the following describe you? *Please select all that apply.*

Delegate or alternate delegate	423
Medical society executive director / vice president	101
Medical society board chair	37

D1B. How many years have you been attending AMA HOD meetings?

Years attending HOD Meetings	HOD (n=423)	Executives (n=101)	Board chairs (n=37)
1 year	2%	5%	14%
2–4 years	17%	18%	16%
5–9 years	28%	24%	27%
10 or more years	52%	53%	43%

D2A. Are you a member of any AMA councils?

	HOD (n=423)
Member of an AMA council	
Yes	13%

[ASK IF D2A = "YES"; OTHERWISE SKIP TO D3]
    D2B. Of which of the following AMA councils are you a member? (select from list)

    (Not reported here to ensure respondent privacy.)

D3. In which state do you live? (drop down list)

10 states with most respondents

California
Texas
Illinois
Massachusetts
Pennsylvania
Michigan
New York
Maryland
Florida
Tennessee

D4. Which of the following describes your specialty? (select from list)

10 most common specialties

Family Medicine
General Internal Medicine
Psychiatry
General Surgery
Obstetrics and Gynecology
Anesthesiology
Radiology
Emergency Medicine
Pediatrics
Ophthalmology (tie)
Orthopedic surgery (tie)

D5. What is your age?

Age	HOD (n=423)	Executives (n=101)	Board chairs (n=37)
30 or younger	6%	1%	
31-40	9%	8%	5%
41-50	13%	20%	22%
51-64	42%	62%	49%
65 or older	28%	6%	24%
Prefer not to answer	3%	3%	

D6. What is your gender?

Gender	HOD (n=423)	Executives (n=101)	Board chairs (n=37)
Male	75%	71%	86%
Female	21%	26%	11%
Prefer not to answer	4%	3%	3%

APPENDIX C – HOD Business Since 2002

Meeting	Reports	Resolutions	Resolutions not considered	Total items considered	Yearly volume
A-02	96	216		312	-
I-02	47	75	25	97	409
A-03	98	214		312	-
I-03	52	94	33	113	425
A-04	86	229		315	-
I-04	63	85	21	127	442
A-05	83	234		317	-
I-05	50	60	12	98	415
A-06	87	213		300	-
I-06	51	68	14	105	405
A-07	96	254		350	-
I-07	38	90	13	115	465
A-08	96	239		335	-
I-08	43	99	15	127	462
A-09	87	224		311	-
I-09	40	90	7	123	434
A-10	70	198		268	-
I-10	32	98	12	118	386
A-11	75	189		264	-
I-11	36	108	15	129	393
A-12	69	216		285	-
I-12	30	76	9	97	382

APPENDIX D – Implementation Plan: Transition to one House of Delegates Meeting Annually

If the House of Delegates (HOD) amends the AMA bylaws to specify a single annual HOD meeting by adopting Board of Trustees Report 30-A-13 as proposed, the Board will enact the following changes to facilitate a smooth transition to a single HOD policymaking meeting annually and a successful governance structure.

Transition Timeline

The following timeline illustrates the transitions to existing and new major meetings. The major changes will occur in 2014, but some associated changes will take until 2015 for full implementation due to venue restrictions, budgeting considerations, and governance needs. By 2015, we anticipate that all new major meeting changes will be fully implemented.

2013

The Interim Meeting in 2013 would be held as planned November 16-19. All Interim Meetings following 2013 will be cancelled.

2014

March 17	HOD open forum, Washington, DC
March 17-19	National Advocacy Conference (NAC), Washington DC
June 5-7	Section Meetings, Chicago, IL
June 7-11	HOD Annual Meeting, Chicago, IL
October	Medical Student Section (MSS)/Resident and Fellow Section (RFS) Fall Leadership Development Meetings**
November	Leadership Retreat (the location of this meeting will be determined by multiple variables, but the goal will be Chicago)

2015

February 23	HOD open forum, Washington, DC
February 23-25	NAC, Washington DC
June 4-6	Section Meetings, Chicago, IL
June 6-10	HOD Annual Meeting Chicago, IL
October	MSS/RFS Fall Leadership Development Meetings**
November	Leadership Retreat, Chicago, IL

** These MSS and RFS leadership meeting locations are described in the section on Sections and Special Groups.

Broken down by major constituencies, the impact of this change on AMA meeting participants is described below.

House of Delegates

Under this plan, the members of the HOD will still have the opportunity to come together twice a year—once for policymaking and elections at the Annual Meeting in June and a second time for an open forum at the NAC.

The Annual Meeting will retain the schedule of meetings that exists now, including meetings of the sections, councils and other special groups that come together as part of the Annual Meeting. This will also include all of the caucus and section council meetings that currently take place.

The meeting location would remain Chicago. The location of the AMA headquarters and its largest resource, its staff, make Chicago the ideal location. In addition, maintaining the location and current timing allows for avoidance of disruption to Federation meetings. Over time, transitioning to a different time frame could be proposed, but, for at least the next five years, staying in Chicago in June is the optimal choice. Dates have already been published on the HOD website through 2017 and contracts are already signed for the Hyatt on Wacker through 2021.

The second meeting of the HOD will be an open forum. Topics will be determined prior to the meeting and will focus on issues that are current, of compelling interest to our profession, and potentially the subject of resolutions that will be coming to the HOD in June. The Speaker and Vice Speaker will preside over this forum and will oversee its content. No quorum will be required, and no formal actions will be taken at this meeting.

AMA Councils and AMPAC

All of the AMA councils will retain their current number of meetings to accomplish the work of their council. The councils will schedule one of their regular meetings to be in conjunction with a November meeting of the Board. This meeting in November will be considered the AMA Leadership Retreat and will allow for the councils to conduct their regular meetings and to participate in joint leadership development activities with the other councils, governing councils of the sections and special groups, and the Board. In addition, council members will be invited to attend the NAC and HOD open forum meeting in the Spring each year. Some of the councils may have business and may hold a meeting of their leadership group but many will not. Individual group needs and venue capacity will guide this evolution which may vary from year-to-year as it does currently.

Under this plan, all action reports from the councils will be presented at the Annual Meeting for adoption by the HOD. Informational reports, however, may be distributed between meetings. Any future changes to the virtual dialogue, publication schedule and action on council reports would be the result of the ongoing evolution of our governance processes.

Funding for council meetings will remain as it is currently, with additional funding added to finance the attendance of council members at the NAC and HOD open forum.

Sections and Special Groups

The sections and special groups will attend the Annual Meeting as they currently do. In addition, the governing councils of these groups will receive AMA funding to attend the NAC, HOD open forum and the new AMA Leadership Retreat. One of the regular meetings of these governing councils will occur in conjunction with the new AMA Leadership Retreat. In addition, the governing councils will retain the ability to have a single independent meeting of their leadership group at a time to be determined by them. In general, each governing council will have the opportunity to meet in person three times per year to conduct the business of their constituency group.

Special consideration has been given to the MSS and RFS due to unique considerations related to their professional life-cycle sections. These concerns are addressed in the following section.

Fall MSS/RFS Leadership Development Meeting

The MSS and RFS present some unique considerations. Specifically, most students and residents have only four years within their sections. For students, their matriculation at medical school is also their very first entry into the medical profession and organized medicine. The newness and brevity of these individuals' eligibility within these sections requires rapid assimilation and elevation into leadership. As such, their request for the preservation of a fall leadership meeting has been given careful thought and attention. To this end, the Board Chair collaborated personally with the leadership of the MSS and RFS to create a focused plan to address their unique concerns.

As such, in addition to having their governing councils attend the AMA Leadership Retreat in November and NAC/HOD open forum in the Spring, the MSS and RFS would also have a new Fall Leadership Development Meeting.

At this meeting, they will convene brief Assembly meetings to hold elections and possibly host an open discussion forum. The Fall meeting for the students and residents will not include any policymaking. As with the HOD and all other sections and special groups, all policymaking will occur in conjunction with the Annual Meeting of the HOD.

In addition, this Fall meeting could house the MSS/RFS research poster symposium that the sections currently host. Opportunity for some leadership development programming and even the MSS community service project may also be present. The prioritizing and programming of the content of this meeting will largely fall to the MSS and RFS leadership groups. This Fall meeting would be held in various cities around the continental United States with a requirement that they have medical schools from where poster judges could be found.

The AMA will fund the MSS and RFS governing council attendance at this meeting. The AMA will not provide funding for others to attend. Recognizing that cost of participation is of heightened concern for most students and residents, much attention and investment will be made to drive down the cost of participation. By using smaller cities (i.e. Cleveland, Columbus, Omaha, Portland, Salt Lake City, San Jose, St. Louis, etc.) the average sleeping room rate will be markedly less (likely <$150/night) than in major convention cities such as Chicago, San Francisco, Washington DC. Additionally, the AMA will provide for receptions and many buffet meals to further reduce the out-of-pocket expenses for the students and residents. Finally, the Board Chair will send a personal communication to Federation societies requesting that they provide economic support for student and resident leaders to participate in this new Fall MSS/RFS leadership meeting.

National Advocacy Conference

The programming at NAC would remain largely as we know it now, albeit with a larger participation. The meeting will incorporate a new HOD open forum and Hill briefings on Monday, educational
and interactive sessions on Tuesday and Wednesday mornings, and open time Tuesday afternoon for Hill visits. The HOD will gather to receive information and dialogue on specific issues to be determined prior to the meeting. AMA members and Federation staff will be offered a discounted registration for the NAC to cover the cost of materials and meals at the meeting. State and specialty societies will realize significant financial savings by both the elimination of the Interim Meeting and by not having to convene caucuses at this second meeting of the HOD.

All AMA council and governing council members will be invited to attend the NAC and HOD open forum and AMA funding will be provided to support their attendance. This will not be part of the councils' or governing councils' regular meetings unless, venue capacity permitting, they individually determine to schedule their free-standing meeting in conjunction with this event.

This event will take a couple years of adjustment to get some details to their new end points. For example, in 2014 the availability of meeting space at the already contracted venue may impact the maximum attendance capacity in this first year. It is anticipated that for 2015 and beyond, there will be more flexibility in this regard. Also, in order to avoid substantial penalties for failure to fill our contracted room block, it may take a couple years to get a sense for the new steady-state attendance for this event and to size the room block and conference events accordingly. Finally, the registration fee will eventually be substantially reduced but that may have to occur only partially in 2014 or be deferred entirely to 2015 to account for unique budget pressures in 2014 as we make multiple simultaneous changes to our governance meetings in the 2014 calendar year.

Leadership Retreat

A Leadership Retreat with the Board, councils and the governing councils of the sections and special groups will be scheduled annually in early November, beginning in 2014. This joint meeting would incorporate a Board meeting and meetings for the 19 councils, sections and special groups. The Board meeting would be prior to the other meetings, and Board members would participate as liaisons in their assigned group meetings. Estimated total attendance would be 200. Special programming would be put together to foster interaction and integration among the Board, councils, and governing councils.

Attempts may be made to book this in 2014 at the Hilton Anatole to offset some of the Interim Meeting cancellation charge incurred for this one year. The intention, however, is to host this meeting in Chicago on an annual basis in early November.

Financial Implications

The first financial implication of this change is the cancellation fee for the 2014 Interim Meeting at the Anatole in Dallas, Texas. This is a one-time cancellation fee, however, and the remaining funds that would have been spent on the Interim Meeting will be allocated to cover the new meeting structure. Cancellation of the Interim Meeting in 2015 and beyond will not carry penalties as they are still outside the penalty range.

The most significant impact will be the adjustments to the NAC with funding to the councils and governing councils to attend the NAC and HOD open forum. Registration for the NAC will also be reduced to encourage delegates and alternates to attend. The registration fee is necessary to cover the many meals and receptions provided to foster networking as well as some materials provided. As noted above, it will likely require a transition over 2014 and 2015 to get this event to its new "normal." The current facility, however, should allow for growth in the number of attendees and should accommodate the HOD open forum.

The fiscal impact of the new HOD open forum will be minimal to the AMA, but the cost savings to the state, county and specialty societies will be significant. While delegates and alternates will need to travel to the HOD open forum, there will not be the additional costs of caucus meetings and meals. Additionally, the consolidation of the Interim Meeting and NAC into a single modified format represents substantial additional savings through the elimination of an entire independent meeting expense for the Federation societies as well as staff support necessary to prepare for the policymaking activities associated with the Interim Meeting.

The Fall MSS/RFS Leadership meeting will exceed the current budget for the MSS and RFS associated with the Interim Meeting. In providing many of the meals, two receptions, and moving the meeting to a lower cost venue, the AMA has gone a long way to make this event economically accessible to MSS and RFS members and to mitigate cost to the AMA while still providing value to the MSS and RFS.

The Leadership Retreat will be a new activity, but its cost is essentially covered by the already budgeted Board, council, and governing council meetings already currently held in conjunction with the Interim Meeting. Additionally, by holding the meeting in Chicago, staff expenses will be kept to a minimum.

In consideration of the substantial overall cost savings the Federation societies would realize, it is strongly hoped and asked that the Federation continue to support strong delegations to attend the new HOD open forum /NAC event as well as provide funding to support their MSS and RFS leaders to attend the new Fall Leadership Development Meeting described above. Strong physician leadership at the national level is critical to our profession and to society as a whole. Such leadership cannot occur without the continued investment of the entire House of Medicine in support of its physician and student leaders.

31. AMA PERFORMANCE, ACTIVITIES, AND STATUS IN 2012

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy G-605.050 calls for the Board of Trustees to submit a report at the American Medical Association (AMA) Annual Meeting each year summarizing AMA performance, activities, and status for the prior year.

INTRODUCTION

The AMA's mission is to promote the art and science of medicine and the betterment of public health. No other physician group has more resources, expertise and opportunity to improve the future of health care in this country than the American Medical Association. With our robust House of Delegates, a solid base of physician members, a thriving advocacy influence, the most revered journals and resources, and respected practice tools as our foundation, in 2012 the AMA dedicated primary focus to ensuring sustainable physician practices that result in better health outcomes for patients. This work is captured in the AMA's five-year strategic plan, which aims to ensure that enhancements to health care in the United States are physician-led, advance the physician-patient relationship, and ensure that health care costs can be prudently managed.

BOARD OF TRUSTEES AND SENIOR MANAGEMENT

The AMA Board approved a five-year, "rolling" strategic plan for the AMA. The plan, approved in February and shared with the AMA House of Delegates in June, provides long-range strategic direction for the AMA, emphasizing three core areas of focus:

- Improving health outcomes;
- Accelerating change in medical education; and
- Enhancing physician satisfaction and practice sustainability by shaping delivery and payment models.

Working closely with senior management, the Board worked throughout much of 2012 to guide specific strategies and activities in support of these three core objectives. Strategic/operational plans for all three areas were developed by year's end. The Board spent considerable time communicating the new strategy to AMA Councils, Sections and Special Groups along with other Federation and physician audiences.

Senior management continued to conduct internal and external reviews of all AMA departments and business units to sharpen the focus of AMA's work and to ensure stronger alignment with strategic plan and overall organizational goals.

EDUCATION AND RESEARCH

Improving Health Outcomes Initiative

Over the next decade, the AMA will commit our talent, resources and reach to achieve the goal of measurable improvements in health outcomes associated with a significant disease burden for the United States population and, importantly, create a professional movement to sustain those efforts. This initiative will support, and align with, the Health and Human Services' national strategy, a three part aim to achieve better patient care, improved community health, and affordable care. The health outcomes topics selected and made public meet the "AIM" criteria; that is, the topics meet these benchmarks: Actionable - have a strong evidence base, produce effective interventions at the primary, secondary, and tertiary levels, and influence existing strategies across locations and practices; Impact the U.S. Population - selected initiatives are public and private priorities and associated with high burdens of illness, costs, and health disparities; Measureable - measures are available, clinically meaningful, and have available data sources.

A major component of the initiative's strategy includes forming partnerships, seeking collaborators, learning from experts, and identifying clinical sites to evaluate what works where, how, and why. An AMA national dashboard will enable tracking population-level outcomes and evaluating progress toward and impact on improving national productivity and reducing health care costs. Importantly, strategies will include efforts to improve care delivery but also enable patients and consumers to make healthy lifestyle choices. In this way, the Health Outcomes Initiative is combining the AMA's previous experiences with quality of care and population health.

AMA Accelerating Change in Medical Education Initiative

After extensive research into the need for change in undergraduate medical education, a request for proposals (RFP) was developed with input from AMA leadership and national medical education experts from across the country. The funding opportunity will provide $10 million to 8-12 medical schools over a five-year period. The purpose is to

alter undergraduate medical education significantly through bold, rigorously evaluated innovations that align medical student training with the evolving needs of patients, communities and the rapidly changing health care system. The RFP with supporting documentation was completed and posted on the Accelerating Change in Medical Education microsite in December of 2012. By the end of December 2012, 70 medical schools contacted the AMA and expressed interest in receiving more information about this unique and exciting opportunity.

Learning Environment Study

The Learning Environment Study, an AMA sponsored research consortium of 28 medical schools, completed its 3rd year of a longitudinal prospective study of the learning environment in medical schools. More than 4,000 medical students participated in the study during 2012. The aim is to define aspects of the educational climate that significantly influence the development of professional attributes of students. In 2012, the consortium held two meetings in Chicago at the AMA with team members from the schools to develop measures used in the study, share early analyses of data produced by those measures, and prepare for dissemination of the results through preparation of scholarly papers.

Liaison Committee for Medical Education (LCME)

AMA and the AAMC signed an historic agreement in 2012, formalizing the 70 year sponsorship of the LCME by the two organizations. The LCME accredits all US and Canadian MD Programs. The agreement also established a new LCME Council to support enhanced communications among the AMA, AAMC and LCME. The new Council will also help determine strategic direction for the LCME and coordinate the nominations process for the LCME.

Delivery and Payment: Professional Satisfaction

As the nation's health care system continues to evolve, the AMA is dedicated to helping physicians navigate the environment successfully by ensuring sustainable physician practices that result in good health outcomes for patients and greater professional satisfaction for physicians. To that end, in 2012 the AMA established an Advisory Committee for the Physician Satisfaction: Care Delivery and Payment work that is part of its strategic focus. The Advisory Committee is a group of distinguished and thoughtful health care leaders that is contributing significantly to the successful planning and initial execution of this important initiative.

We initiated a 10-month program with Rand Health to examine and analyze the best ways to improve physician practice satisfaction and sustainability. We are exploring how practice structure and management and new options for payment work best for physicians across a variety of practice settings. This work will position the AMA to play a vital role in helping physicians navigate the evolving health care environment successfully.

ADVOCACY

Medicare SGR and Sequestration Cuts Averted

A nearly 30 percent cut in Medicare physician payments was averted on January 1, 2013, when H.R. 8, the American Taxpayer Relief Act, was passed. The centerpiece of the bill for physicians was a provision that extends current Medicare physician payment rates through December 31, 2013. This provision avoided the 26.5 percent cut required by the sustainable growth rate (SGR) formula. Other health related provisions included (1) the Geographic Work Adjustment (1.0 floor) was extended through December 31, 2013; (2) sequestration cuts were deferred for two months until April 1, 2013, which included a 2 percent cut in Medicare payments and larger program cuts for other health programs, including research, public health programs and health professions training; (3) ways to create a path to improve the provision of relevant and timely data to physicians were included (physicians need such data for new delivery and payment models); (4) physicians will be allowed to participate in clinical registries to meet Medicare quality reporting requirements; and (5) funding for the National Quality Forum was reauthorized for one year.

Advancing Payment and Delivery Reforms

A detailed proposal for transitioning to a new Medicare physician payment system following repeal of the sustainable growth rate (SGR) formula was developed and shared with policymakers, generating a positive response.

Strategies for better aligning quality incentive programs were developed, including better alignment of measures under the Physician Quality Reporting System (PQRS) and EHR Meaningful Use programs. A pathway was established to provide more relevant and timely quality and resource use data to physicians, and physician participation in clinical registries will soon qualify for meeting Medicare quality reporting requirements. Regulatory advocacy led to a significantly improved framework for developing new Medicare shared savings models, including an advanced payment model to help small physician practices, and new transitional care management services were incorporated into the Medicare fee schedule.

Regulatory Relief

The AMA secured a broad array of regulatory improvements to reduce administrative burdens on physician practices, including: exemption opportunities for electronic prescribing; a one-year delay in implementation of the ICD-10 coding system; eased requirements for reporting, ordering and referring physician enrollment and for face-to-face encounter requirements for Durable Medical Equipment (DME) orders; and practical improvements to Medicare's provider enrollment (PECOS) processes.

Drug Shortages and Safety

The final version of Food and Drug Administration reauthorization legislation signed into law last summer included many provisions that AMA worked to improve upon throughout the legislative process. These provisions address the drug shortage crisis, incentivize the development of new antibiotics, place various chemical substances known as "bath salts" in schedule I of the Controlled Substances Act, and require the Comptroller General to prepare a report on issues posed by rogue pharmacies. Additionally, the bill omits provisions of significant concern to the AMA, including a proposed reclassification of combination products containing hydrocodone, and instead requires the Secretary of Health and Human Services to meet with stakeholders to solicit recommendations on how to address abuse of these drugs.

Adoption of Transitional Care Management Codes

The Centers for Medicare & Medicaid Services (CMS) accepted 85% of the AMA/Specialty Society RVS Update Committee's (RUC) recommendations for inclusion in the 2013 Medicare Physician Payment Schedule. Notably, CMS adopted the RUC recommendations for Transitional Care Management, resulting from the work of the Chronic Care Coordination Workgroup (C3W), created jointly by the CPT Editorial Panel and the RUC. On January 1, 2013, Medicare began payment for CPT codes 99495 and 99496 for the care of transitioning patients from a hospital or skilled nursing facility to the home. CMS expects to spend $600 million annually for the provision of this service to Medicare patients. CMS will consider in future rule-making payment for the monthly Complex Chronic Care Coordination codes (CPT 99487-99489) also developed by the C3W, which describe a medical home model of care for the chronically ill..

Physician Practice Benchmark Survey

The AMA successfully designed and conducted a new online Physician Practice Benchmark Survey of nearly 3,500 physicians that collected the most up-to-date information on physician practice arrangements, recent changes in practice ownership structure, and the payment methods in place between insurers and physician practices. Initiated jointly by Health Policy and Market Research, and completed in less than five months at a cost that was nearly 20% under budget, the survey findings will provide valuable information as to the readiness of physician practices to transition to evolving payment and delivery models, will inform the ongoing Professional Satisfaction Site Visit Project being conducted by RAND; and will provide guidance for Advocacy, Membership and Business Operations strategies in 2013.

State Level Advocacy

At the state legislative and regulatory levels, AMA's national leadership, influence and expertise, in collaboration with state and national medical specialty societies, have led to over 125 victories across the nation during the carry-over sessions of 2011-12. These victories include protecting physician interests during implementation of the ACA, preserving medical liability reforms, ensuring insurer transparency, passing truth-in-advertising laws and protecting the patient-physician relationship.

Advocacy Grassroots

The AMA maintains two active grassroots networks – the AMA Physicians' Grassroots Network and the AMA Patients' Action Network – to ensure physicians and patients alike have an effective platform for making their voices heard in Washington, D.C. In addition, the AMA has developed the "Very Influential Physicians" (VIP) key contact program that taps into high-level relationships that physician activists maintain with Members of Congress and leverages them on behalf of medicine. A total of 918,788 grassroots contacts were made with Congress on SGR and other urgent matters facing medicine in 2012.

Private Sector Advocacy

Efforts by the AMA lead to a transformation in the chaotic health insurance billing and payment system contributing to a 50% reduction in the number of medical claims paid incorrectly by large health insurance companies, according to the findings released in the 2012 National Health Insurer Report Card (NHIRC). Error rates for private health insurers on paid medical claims dropped from 19.3% in 2011 to 9.5% in 2012. This improvement resulted in enormous savings to both physicians and health insurers due to the reduction in unnecessary administrative work to reconcile errors; the nearly 10% reduction in payment errors reduces the claims requiring investigation and potential rework by nearly 180 million per year. Other areas demonstrating significant improvement since the NHIRC's inception in 2008 include improved response times to medical claims by 17% and increased transparency of rules used to edit medical claims by 33%.

Leading Medicine's State ACA Implementation Efforts

The AMA leads medicine's efforts on state Affordable Care Act (ACA) implementation by advocating for physicians and their patients to national policymaking groups, such as the National Association of Insurance Commissioners (NAIC), National Conference of Insurance Legislators (NCOIL), and the National Governors Association (NGA). These organizations are critical to how the ACA is implemented at the state level. The AMA, through its state Advocacy Resource Center (ARC) produces advocacy resources for state medical associations, national medical specialty societies and other patient and physician advocates to use in their implementation work.

Physicians Represented at National State Policy-Making Hearings

As the implementation of the ACA moves forward, the AMA is rapidly responding to regulatory proposals issued by federal agencies and advocating to state policymaking organizations on behalf of patients and physicians. The AMA is advocating – often as the only voice for medicine - on numerous issues (e.g. medical loss ratio, health insurance exchanges, rate review, Medicaid innovations, drug diversion, etc.) before the NAIC, NCOIL, NGA, National Conference of State Legislatures, as well as the National Association of Attorneys General, and more.

Protecting the Patient-Physician Relationship

The protection of the sanctity of the patient-physician relationship, including defending the freedom of communication between patients and their physicians, is a core priority for the AMA. The ability of physicians to have open, frank and confidential communications with their patients has always been a cornerstone, a fundamental element of a highly functioning health care system. As a result, the AMA created new state advocacy materials for state and specialty societies to use in their efforts to defeat any legislation seen as an assault on the sanctity of this relationship. The AMA tracks hundreds of pieces of legislation every year on these issues of critical importance and in 2012 worked collaboratively with seven state medical associations to secure hard fought victories – ensuring defeat of onerous legislation.

Litigation Center

The Litigation Center of the AMA and the state medical societies continued its activities at a high level of intensity across a wide spectrum of legal issues of concern to physicians. By early 2013, seven matters in which the Litigation Center [or the AMA individually] had filed amicus briefs were pending before the US Supreme Court and more than a dozen other matters were under consideration by the highest courts of various states.

PRACTICE TOOLS

Business Products and Services

The Business Products and Services (BPS) team supports AMA's strategic direction by delivering impactful and profitable physician solutions and services which fund AMA's mission-focused activities, operations, and administration.

In 2012, BPS offered member value by providing products and services that enable physicians and their medical staff to solve problems in their day to day practice. BPS improved the usefulness of CPT content such as implementation of new diagnostic testing codes. BPS began a strategic initiative to strengthen the quality and effectiveness of the AMA Physician Masterfile. The AMA Insurance Agency continues to provide a comprehensive suite of products for over 65,000 physicians. AMA's Unified Service Center earned recognition as a Benchmark Portal Certified Center of Excellence, operating on par with the top 10% of all contact centers in the industry.

Office of the General Counsel

Assistance in transitioning of the Amagine initiative to ATT to assure continued availability to physicians of valuable options for reporting of patient care represented a major effort. Similarly, assistance in finalizing the recently completed and announced relationship with McKesson to extend the CPT product line by mapping to Z codes entailed development of a new type third party relationship.

The AMA's affinity programs were realigned to the AMA Insurance Agency. Support of the CPT Editorial Panel has been ongoing and focused on managing contentious or complicated matters. An extensive procedures manual for use by participants in the CPT code development process was developed to facilitate future problem resolution. Similar support was provided to the RUC.

Close support has been provided to the AMA convened Physician Consortium for Performance Improvement and has involved both the Consortium's transition in focus from performance to outcome measures and also creation of the PCPI Foundation to assist in developing future funding for measure development and performance improvement initiatives of the Consortium.

Periodical Publishing

Over the last 15 months the JAMA Network has achieved several key milestones in the strategic transformation from a print-focused editorial and business model to a digital-focused model. In February 2012 The JAMA Network itself was announced. The Network consists of JAMA and the 9 specialty journals with a shared vision around content, use of technology and article type. The business model for the Network leverages this shared vision across titles to drive online usage and revenues, especially among Institution customers. In the Spring 2012, JAMA and the 9 specialty journals moved to a new web platform hosted by Silverchair.

In the summer we announced that all 9 specialty journals would have their name changed, for example, from Archives of Surgery to JAMA Surgery, again, consistent with the vision of The JAMA Network. In the Fall 2012 a single portal of submission for authors was created – allowing authors to submit their paper to JAMA and in the event it was not accepted for publication to one other Journal. Throughout this transition, the online first initiative is being implemented for all 9 specialty journals, ensuring that all of their major content is posted on-line ahead of print shortly after it is accepted for publication. A new network- wide HTML5 app was released in March, 2013, and a print redesign of all 9 journals will be introduced in the Summer of 2013.

All of these changes support the transformation of the JAMA Network business model and position us as the most forward-thinking, innovative medical journal publisher.

GOVERNANCE (SECTIONS AND SPECIAL GROUPS)

Facilitated the launch of the Integrated Physician Practice Section (IPPS) and integration with the AMA's focus on enhancing physician satisfaction and practice sustainability by shaping delivery and payment models.

Supported goals of the newly convened AMA Accelerating Change in Medical Education National Advocacy Panel by seating two representatives from the Medical Student Section (MSS) Governing Council. Additionally, improved the Resident Fellow Section (RFS) planning process by providing comprehensive feedback from medical students.

Co-sponsored with senior physicians and medical students programming on how to achieve congruence with the expectations and the reality of practice life. This connection has been shown to increase physician satisfaction.

Designed and implemented the first AMA Group Practice Career Fair resulting in the participation of some of the largest and most prestigious physician groups and the JAMA Career Center.

Developed and presented for adoption to the House of Delegates "AMA Principles for Physician Employment." This is one in a suite of resources intended to help physicians improve their relationship and satisfaction with practice in the hospital setting.

AMA COUNCILS

Council on Constitution and Bylaws

The Council on Constitution and Bylaws (CCB) updated the House of Delegates Reference Manual: Procedures, Policies and Practices and the AMA Constitution and Bylaws (with changes for A-12 and I-12) and achieved widespread electronic distribution of both. CCB amended the Bylaws to establish the Integrated Physician Practice Section and the Senior Physicians Section, and submitted several bylaw amendments for the recently established Minority Physicians Section, including the election of the governing council by all eligible MAS members, election of the chair-elect by the governing council, and provisional non-voting membership in the MAS for physicians or medical students who were not AMA members.

CCB worked through the Board of Trustees to establish the Internal Operating Procedures (IOPs) of the newly formed Integrated Physician Practice Section, which govern IPPS membership, representation, elections, and meetings. CCB also created an interactive database of IOP provisions and bylaws governing all the AMA sections, which was distributed to the House and posted online. CCB worked through the Board of Trustees to update and adopt CCB Rules to clarify how CCB nominates and elects its officers.

In collaboration with the Council on Medical Education, CCB amended the bylaws to remove the requirement that at least one CME member be a private practitioner of medicine who is not a salaried faculty member of a medical school and thus eliminate the need for a separate. Also, CCB, in collaboration with CLRPD, issued 4 reports related to the AMA Policy project: (1) to establish a reconciliation process for AMA policies; (2) to modify existing policies related to policy establishment, consolidation, and implementation; (3) to review and sunset where appropriate those policies from 2002; and (4) to review and provide recommendations for sunset, retention and/or consolidation of all AMA governance directives.

At the request of the Board of Trustees, CCB has also been reviewing updated chapters from the Code of Medical Ethics, to see if CCB concurs with those changes CEJA believes are not substantial.

Council on Ethical and Judicial Affairs

Two reports by the Council on Ethical and Judicial Affairs were adopted by the AMA House of Delegates in 2012, addressing physician stewardship of health care resources, responsibilities for safe patient discharge. The recommendations of these reports were published as Opinions E-9.0652 and E-9.141 of the same titles. The House also adopted CEJA Report 1-I-12 amending Opinion E-9.011, Continuing Medical Education. In addition, under its ongoing project to review and modernize the Code of Medical Ethics¸ CEJA presented draft updated opinions for feedback to the Council on Constitution and Bylaws in the following areas: privacy and confidentiality, genetics and reproductive medicine, end-of-life care, and organ transplantation.

Council on Science and Public Health

The Council on Science and Public Health developed 12 reports for the House of Delegates in 2012. Several of these received significant national media attention including screening mammography, labeling of bioengineered foods,

taxes on sugar-sweetened beverages, and the adverse health effects of light at night. The Council's recommendations on addressing drug shortages were largely reflected in the final federal legislation reauthorizing the Food and Drug Administration. The report on bioengineered foods received more than 600 media mentions and was a fundamental resource used by opponents of the California ballot initiative seeking mandatory labeling of such foods. The Council also sponsored an educational forum on Personalized Medicine at I-12 that was heavily attended and which received excellent reviews. In addition, the Council collaborated with the Council on Legislation in developing their advisory report to the Board of Trustees on establishing an AMA framework for advancing Personalized Medicine.

Council on Long Range Planning and Development

The Council on Long Range Planning and Development (CLRPD) continues in its advisory role to the Board of Trustees. To that end, the CLRPD solicits and synthesizes input from constituent groups into an annual report, "Synthesis of Stakeholder Input," which plays an important role in the AMA's strategic planning process. Of the various issues raised by stakeholders in last year's input process, the CLRPD identified mode of practice as an overarching issue that will have a significant impact on the future health care system and delivery. In an effort to assist the AMA with the development of contingency plans, as well as guiding strategy adjustment and redirection over time, the CLRPD built scenarios for the AMA Board of Trustees around mode of practice.

In 2012, the CLRPD completed all 11 chapters of the 2010–12 edition of the Health Care Trends (HCT), which are combined into a single document and is posted online at www.ama-assn.org/go/healthcaretrends along with Fact Sheets for six of the chapters. A recent analysis of registrants for the HCT demonstrated an increase of 52% in the number of registrations from 2011 to 2012. Twenty percent of all registrants for the report are AMA members. During the 2012 Interim Meeting, the HOD adopted the report, "Proposal for a Senior Physicians Section," which transitioned the Senior Physicians Group to a delineated section.

MEMBERSHIP

AMA Membership grew by 3.2% and ended 2012 with 224,503 members. The total 2011 membership count was 217,490. For additional information, please refer to CLRPD Report, *Demographic Characteristics of the House of Delegates and AMA Leadership.*

EVP COMPENSATION

During 2012, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD as AMA Executive Vice President was $818,000 in base salary, $180,000 in bonus. Additional taxable amounts per the contract were paid as follows: $7,524 for life insurance, $3,960 for executive life insurance and $540 for parking. A $50,000 contribution to a deferred compensation account was made by the AMA. This will not be taxable until vested pursuant to provisions in the deferred compensation agreement.

32. PATIENT PROTECTION AND AFFORDABLE CARE ACT NON-DISCRIMINATION LANGUAGE

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FILED

At the 2012 American Medical Association (AMA) Interim Meeting, the House of Delegates (HOD) considered Board of Trustees (BOT) Report 8-I-12 on implementation of Policy H-35.968. That policy calls on the AMA to "promptly initiate a specific lobbying effort and grassroots campaign to repeal the provider portion of the Patient Protection and Affordable Care Act's (ACA) "Non-Discrimination in Health Care" language, including direct collaboration with other interested components of organized medicine." In the report, the Board advised the HOD that no specific grassroots activities had taken place as directed by H-35.968 due to the lack of opportunity to advance the repeal of Section 2706; however, the AMA would pursue activity when the legislative environment is conducive. BOT Report 8 was amended by the HOD to include four recommendations as follows:

That our American Medical Association reaffirm Policy H-35.968.

That our AMA create and actively pursue legislative and regulatory opportunities to repeal the so called "Non-Discrimination in Health Care" clause in Public Health Service Act Section 2706, as enacted in the Patient Protection and Affordable Care Act (PPACA).

That our AMA lead a specific lobbying effort and grassroots campaign in cooperation with members of the federation of medicine and other interested components of organized medicine to repeal the provider portion of PPACA's "Non-Discrimination in Health Care" language.

That our AMA Board of Trustees report back at the 2013 AMA Annual Meeting.

This informational report updates the HOD on AMA efforts to implement Policy H-35.968 and the additional directives adopted by the HOD.

LEGISLATIVE UPDATE

To date, no legislative opportunities to implement H-35.968 have been identified. Congress remains bitterly divided over the ACA, and efforts to amend the law have been thwarted by those who would prefer that it be repealed altogether rather than improved. This divide has been on display as recently as the week of April 22, 2013 when efforts by House Majority Leader Eric Cantor (R-VA) to extend the federal high-risk pool created under the ACA by shifting money from prevention funding were quashed by opponents who oppose any efforts to "fix" the law.

REGULATORY UPDATE

At this time, no regulations have been promulgated by the Department of Health and Human Services, the Department of Labor, or the Internal Revenue Service to implement Section 2706, nor has the Administration given any indication that regulations on this provision are forthcoming.

ACTIVITIES AT THE STATE LEVEL

The ACA non-discrimination clause has been identified as an issue with the potential for misuse by non-physician health care providers seeking to expand their scope of practice. The AMA Advocacy Resource Center (ARC) and the AMA Scope of Practice Partnership (SOPP) monitor developments related to the non-discrimination clause at the state level in the context of the hundreds of bills the ARC monitors annually related to scope of practice and team-based care. The ARC has consulted with advocacy staff of state medical associations in those states where the non-discrimination clause has been raised as an issue either directly or tangentially, to ensure that the clause does not facilitate an inappropriate expansion of scope of practice for non-physician providers beyond their training and expertise and to promote the importance of physician-led health care teams.

CONSULTATION WITH THE FEDERATION

In addition to working with state medical associations, the AMA convened a meeting of federal lobbyists from interested specialties in March 2013 to discuss the implications of the provision and any information regarding negative consequences that have been experienced as a result of Section 2706. Though most attendees agreed that the provision in question does have the potential to cause confusion in states regarding the underlying requirements for plan participation, no concrete evidence was available to demonstrate to potential bill sponsors the need for action. This is likely due to the fact that state and federal exchanges have only just begun accepting applications from health plans to participate and consequently those plans have not yet faced network issues that might be affected by Section 2706.

SUMMARY

Timing is a critical factor in successful legislative efforts. Given the current stalemate on modifications to the ACA, it would be futile to launch a legislative campaign to repeal the anti-discrimination provisions at this juncture. The AMA continues to closely monitor state and federal activities related to this directive. As state and federal exchanges come on line and insurers begin to build networks to meet the requirements of those exchanges, the AMA will closely monitor those developments and seek opportunities to prevent supporters of Section 2706 from

inappropriately characterizing this provision. Additionally, the AMA will continue to seek modification or repeal of this provision when there is a viable opportunity to amend the ACA.

33. 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) Annual 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 Annual Meeting:

Aerospace Medical Association
American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgery, Inc.
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Psychiatry and the Law
American Association for Hand Surgery
American Association of Clinical Urologists, Inc.
American Clinical Neurophysiology Society
American College of Medical Quality
American Society of Addiction Medicine
American Society of Ophthalmic Plastic and Reconstructive Surgery
The Endocrine Society
International Spinal Intervention Society

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: Aerospace Medical Association, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgery, Inc., American Academy of Family Physicians, American Academy of Neurology, American Academy of Psychiatry and the Law, American Association for Hand Surgery, American Association of Clinical Urologists, Inc., American Clinical Neurophysiology Society, American College of Medical Quality, American Society of Addiction Medicine, American Society of Ophthalmic Plastic and Reconstructive Surgery, The Endocrine Society and the International Spinal Intervention Society meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the American Academy of Hospice and Palliative Medicine did not meet the membership requirements for specialty organizations represented in the HOD, and therefore, are not in compliance with the five-year review requirements.

RECOMMENDATIONS

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

1. That the Aerospace Medical Association, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgery, Inc., American Academy of Family Physicians, American Academy of Neurology, American Academy of Psychiatry and the Law, American Association for Hand Surgery, American Association of Clinical Urologists, Inc., American Clinical Neurophysiology Society, American College of Medical Quality, American Society of Addiction Medicine, American Society of Ophthalmic Plastic and Reconstructive Surgery, The Endocrine Society and the International Spinal Intervention Society retain representation in the American Medical Association House of Delegates.

2. That the American Academy of Hospice and Palliative Medicine be given a grace period of one year to meet the membership requirements to retain their position in the American Medical Association House of Delegates.

APPENDIX

Exhibit A – Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership	
Aerospace Medical Association	196 of 852	(23%)
American Academy of Dermatology	2,085 of 9,743	(21%)
American Academy of Facial Plastic and Reconstructive Surgery, Inc.	182 of 628	(29%)
American Academy of Family Physicians	9,564 of 68,596	(14%)
American Academy of Hospice and Palliative Medicine	570 of 3,790	(15%)
American Academy of Neurology	2,130 of 13,598	(16%)
American Academy of Psychiatry and the Law	383 of 1,409	(27%)
American Association for Hand Surgery	163 of 520	(31%)
American Association of Clinical Urologists, Inc.	737 of 2,926	(25%)
American Clinical Neurophysiology Society	142 of 654	(22%)
American College of Medical Quality	135 of 320	(42%)
American Society of Addiction Medicine	465 of 2,121	(22%)
American Society of Ophthalmic Plastic and Reconstructive Surgery	143 of 483	(30%)
The Endocrine Society	1,205 of 6,750	(18%)
International Spinal Intervention Society	495 of 2,427	(20%)

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.

The following report was presented by Andrew W. Gurman, MD, Speaker; and Susan R. Bailey, MD, Vice Speaker:

RECOMMENDATION FOR POLICY RECONCILIATION

HOUSE ACTION: FILED

At the 2012 Annual Meeting the House of Delegates (HOD) adopted Policy G-600.111, Consolidation and Reconciliation of AMA Policy, which notes that "AMA's policy database should not include duplicative, conflicting or inconsistent AMA policies" and calls for reports to be presented to HOD when "a new or modified policy supersedes or renders obsolete one or more existing AMA policies." The policy encourages any entity seated in the HOD to identify inconsistent or obsolete policies and calls for the "Speaker [to] present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete. Where a report is needed to reconcile disparate policies, the Speakers will identify the appropriate council or group responsible for the reconciliation report on a specific topic."

This report represents the first reconciliation report prepared by your Speakers pursuant to the policy. Other reconciliation reports, as well as sunset reports, have been prepared by AMA councils. This report deals with a single policy adopted at the 2012 Interim Meeting that your Speakers believe supersedes an earlier policy.

POLICY TO BE RECONCILED

Policies adopted in 2012 were compared to policy statements adopted in prior years. In many cases, the newer language amended an existing statement, thus providing a single statement that implicitly reconciled potentially competing statements, but your Speakers have found one exception.

At the 2012 Interim Meeting, Resolution 203 was adopted as amended and recorded as Policy D-405.986. This new policy is policy is inconsistent with Policy H-305.982, which has been superseded and will be removed from the policy database. The verbatim language of the two policies follows:

- D-405.986, Student Loans and Medicare / Medicaid Participation - Our AMA will seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt.

- H-305.982, Student Loan Repayment Defaults - The AMA encourages the HHS Inspector General to pursue all legal avenues within his jurisdiction to withhold Medicare and Medicaid reimbursements, research grant awards, and salaries or stipends from physicians who have defaulted on repayments of student loans, unless a physician can prove hardship. (Sub. Res. 69, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

On its face the latter policy would seem to allow, with exceptions, the decertification of physicians who have defaulted on their student loans. The new policy makes a blanket statement, thus making the earlier policy obsolete.