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*Last updated 10/29/2018*
### Agenda

- OMSS meeting agenda

### Meeting App

- Download the meeting app

### FAQs

### Convention Center Information

- Gaylord National Resort & Convention Center
  - 201 Waterfront Street
  - National Harbor, MD 20745
  - (301) 965-4000

- Facility map

### WiFi access

- Network ID: AMAHOD2018
- Password: AMAHOD2018
AMA Organized Medical Staff Section
2018 Interim Meeting
Gaylord National Resort & Convention Center (National Harbor, MD)
November 8-10, 2018

All meeting locations are on the **Ballroom Level** unless noted otherwise.

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<tr>
<th>Day</th>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td><strong>Wednesday, November 7</strong></td>
<td>4 p.m.</td>
<td>Deadline to submit late resolutions (email to <a href="mailto:keith.voogd@ama-assn.org">keith.voogd@ama-assn.org</a>)</td>
<td></td>
</tr>
<tr>
<td><strong>Thursday, November 8</strong></td>
<td>10:30 a.m. – 7 p.m.</td>
<td>General meeting registration</td>
<td>Maryland Pre-Function Area</td>
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<tr>
<td></td>
<td>11:30 a.m. – 3 p.m.</td>
<td>OMSS credentialing</td>
<td>Potomac Ballroom D</td>
</tr>
<tr>
<td></td>
<td>11:15 a.m. – 12 p.m.</td>
<td>Committee on Late Resolutions meeting</td>
<td>Chesapeake J</td>
</tr>
<tr>
<td></td>
<td>12 – 1:30 p.m.</td>
<td>Caucus meetings</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Cowchip caucus</td>
<td>Maryland 2</td>
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<tr>
<td></td>
<td></td>
<td>Great Atlantic Seaboard caucus</td>
<td>Maryland 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heartland caucus</td>
<td>Potomac Ballroom D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Western caucus</td>
<td>Mezzanine 6 (Lobby Level)</td>
</tr>
<tr>
<td></td>
<td>2 – 5:30 p.m.</td>
<td>Business meeting and Reference Committee hearing</td>
<td>Potomac Ballroom D</td>
</tr>
<tr>
<td></td>
<td>6 p.m.</td>
<td>Joint reception with Integrated Physician Practice Section</td>
<td>Potomac Foyer</td>
</tr>
<tr>
<td><strong>Friday, November 9</strong></td>
<td>7 a.m. – 6 p.m.</td>
<td>General meeting registration</td>
<td>Maryland Pre-Function Area</td>
</tr>
<tr>
<td></td>
<td>8 – 11 a.m.</td>
<td>OMSS credentialing</td>
<td>Potomac Ballroom D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Caucus meetings</td>
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<td></td>
<td></td>
<td>Cowchip caucus</td>
<td>Chesapeake 3</td>
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<tr>
<td></td>
<td></td>
<td>Great Atlantic Seaboard caucus</td>
<td>National Harbor 13 (National Harbor Conference Rooms)</td>
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<td></td>
<td></td>
<td>Heartland caucus</td>
<td>Potomac Ballroom D</td>
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<tr>
<td></td>
<td></td>
<td>Western caucus</td>
<td>Chesapeake 12</td>
</tr>
<tr>
<td></td>
<td>9:30 – 10:30 a.m.</td>
<td>Can system-level and individual medical staff needs coexist?</td>
<td>Potomac Ballroom D</td>
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<tr>
<td></td>
<td></td>
<td>Spoiler: Yes!</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Event</td>
<td>Location</td>
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<tr>
<td>10:00 a.m.</td>
<td>Deadline to submit amendments (deliver to staff at table outside Potomac Ballroom D)</td>
<td>Potomac Ballroom D</td>
<td></td>
</tr>
<tr>
<td>10:45 a.m. – 12:15 p.m.</td>
<td>Business meeting</td>
<td>Potomac Ballroom D</td>
<td></td>
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<tr>
<td>12:30 – 1:30 p.m.</td>
<td>Lunch and open forum</td>
<td>Potomac Ballroom D</td>
<td></td>
</tr>
<tr>
<td>1:45 – 2:45 p.m.</td>
<td>Alternative privileging criteria: Evaluating competency without MOC</td>
<td>Potomac Ballroom D</td>
<td></td>
</tr>
<tr>
<td>3 – 4:30 p.m.</td>
<td>State Chairs meeting</td>
<td>Potomac 5</td>
<td></td>
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</table>

**Saturday, November 10**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 – 8:30 a.m.</td>
<td>Scope of Practice: How the AMA protects physicians’ role in providing patient-centric care</td>
<td>Potomac Ballroom D</td>
</tr>
<tr>
<td>8:45 – 9:45 a.m.</td>
<td>Our turn to serve: How to improve health care for veterans</td>
<td>Potomac Ballroom D</td>
</tr>
<tr>
<td>10 – 11 a.m.</td>
<td>Mind the gap: Improving undocumented patients’ access to care</td>
<td>Potomac Ballroom D</td>
</tr>
<tr>
<td>12 – 1:30 p.m.</td>
<td>Older and wiser: Assessing competency of elder physicians</td>
<td>Woodrow Wilson A</td>
</tr>
<tr>
<td>1:30 – 5:30 p.m.</td>
<td>House of Delegates meeting – Opening session</td>
<td>Maryland Ballroom</td>
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</tbody>
</table>

**Sunday, November 11**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:45 – 7:45 a.m.</td>
<td>OMSS caucus briefing</td>
<td>Azalea 1</td>
</tr>
<tr>
<td>8 – 8:30 a.m.</td>
<td>House of Delegates meeting – Second opening session</td>
<td>Maryland Ballroom</td>
</tr>
<tr>
<td>8:30 a.m. – 12 p.m.</td>
<td>House of Delegates Reference Committee hearings</td>
<td>Potomac Ballroom A</td>
</tr>
<tr>
<td></td>
<td>Reference Committee on Amendments to Constitution and Bylaws</td>
<td>Potomac Ballroom A</td>
</tr>
<tr>
<td></td>
<td>Reference Committee B (Legislative advocacy issues)</td>
<td>Potomac Ballroom B</td>
</tr>
<tr>
<td></td>
<td>Reference Committee C (Medical education)</td>
<td>National Harbor 10-11 (National Harbor Conference Rooms)</td>
</tr>
<tr>
<td></td>
<td>Reference Committee F (AMA finance, AMA governance)</td>
<td>Maryland Ballroom</td>
</tr>
<tr>
<td></td>
<td>Reference Committee J (Advocacy related to medical service, medical practice, insurance and related topics)</td>
<td>Potomac Ballroom C</td>
</tr>
<tr>
<td></td>
<td>Reference Committee K (Advocacy related to medical education, science and public health and related topics)</td>
<td>Potomac Ballroom D</td>
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<tr>
<td>1 – 2 p.m.</td>
<td>OMSS caucus debriefing</td>
<td>Azalea 1</td>
</tr>
</tbody>
</table>

*Updated 10/28/2018*
Downloading the App

Get the app

1. **Go to the right store.** Access the App Store on iOS devices and the Play Store on Android.

   *If you’re using a Blackberry or Windows phone, skip these steps. You’ll need to use the web version of the app found here: [https://event.crowdcompass.com/ama2018interim](https://event.crowdcompass.com/ama2018interim)*

2. **Install the app.** Search for CrowdCompass AttendeeHub Once you’ve found the app, tap either **Download** or **Install**. After installing, a new icon will appear on the home screen.

Find your event

1. **Search the AttendeeHub.** Once downloaded, open the AttendeeHub app and enter AMA 2018 Interim Meeting

2. **Open your event.** Tap the name of your event to open it.
The “CrowdCompassAttendeeHub” Mobile App - FAQ

Where can I download the mobile app?

Go to the correct store for your device type. Access the App Store on iOS devices and the Play Store on Android.

Install the app. Search for CrowdCompass AttedeeHub. Once you have found the app, tap either Download or Install. After installing, a new icon will appear on your home screen.

If you’re using a Blackberry or Windows phone, skip these steps. You’ll need to use the web version of the app found here https://event.crowdcompass.com/ama2018interim

How do I find the Event?

Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter: AMA 2018 Interim Meeting

The app is asking me to log in. Why do I need to log-in?

Once you log in to the mobile app, you will be able to access the same schedules, bookmarks, reminders, notes, and contacts on your phone, tablet, and desktop. Below is a list of some other great things you can do after logging in:

- Take notes
- Share photos
- Rate sessions
- Join the attendee list
- Check-in
- Share contacts
- Share over social media
- Take Surveys
- Message fellow attendees

Where can I get my log-in information?

The log-in process is largely self-managed. Just follow the steps below to log in from your device:

1. Access the Sign In page: Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.
2. **Enter your info:** You’ll be prompted to enter your first and last name. Tap Next. Enter an email address, and then tap next again.

3. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You’ll see your confirmation code has already been carried over. Just tap Finish. You’ll be taken back to the Event Guide with all those features unlocked.

**I’ve requested log-in information, but I never received an email.**

If you haven’t received your log-in information, one likely culprit may be your spam filter. We try to tailor our email communications to avoid this filter, but some emails end up there anyway. Please first check the spam folder of your email. The sender may be listed as CrowdCompass.

**I lost my log-in info, and I forgot my confirmation code. How do I log myself back in?**

To have a verification email resent to you, start by accessing the sign-in page.

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You’ll be prompted to enter your first and last name. Tap Next.

3. **Click on Forgot Code:** If you’ve already logged in before, the app will already know your email address and will send a verification email to you again.

4. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You’ll see your confirmation code has already been carried over. Just tap Finish. You’ll be taken back to the Event Guide with all those features unlocked.

**How do I create my own schedule?**

1. **Open the Schedule.** After logging in, tap the Schedule icon.

2. **Browse the Calendar.** Switch days by using the date selector at the top of the screen. Scroll up and down to see all the sessions on a particular day.

3. **See something interesting?** Tap the plus sign to the right of its name to add it to your personal schedule.

**How can I export my schedule to my device’s calendar?**

1. **Access your schedule.** After logging in, tap the hamburger icon in the top right, then My Schedule.

2. Here you’ll see a personalized calendar of the sessions you’ll be attending. You can tap a session to see more details.
3. **Export it.** Tap the download icon at the top right of the screen. A confirmation screen will appear. Tap Export and your schedule will be added directly to your device’s calendar.

**How do I allow notifications on my device?**

Allowing Notifications on iOS:

1. **Access the Notifications menu.** From the home screen, tap Settings, then Notifications.

2. **Turn on Notifications for the app.** Find your event’s app on the list and tap its name. Switch Allow Notifications on.

Allowing Notifications on Android:

Note: Not all Android phones are the same. The directions below walk you through the most common OS, Android 5.0.

1. **Access the Notification menu.** Swipe down on the home screen, then click the gear in the top right. Tap Sounds and notifications.

2. **Turn on Notifications for your event’s App.** Scroll down and tap App notifications. Find your event’s app on the list. Switch notifications from off to on.

**How do I manage my privacy within the app?**

Set Your Profile to Private...

1. **Access your profile settings.** If you’d rather have control over who can see your profile, you can set it to private.

2. After logging in, tap the hamburger icon in the top left, and then tap your name at the top of the screen.

3. **Check the box.** At the top of your Profile Settings, make sure that the box next to “Set Profile to Private” is checked.

...Or Hide Your Profile Entirely

1. **Access the Attendee List.** Rather focus on the conference? Log in, open the Event Directory, and tap the Attendees icon.

2. **Change your Attendee Options.** Click the Silhouette icon in the top right to open Attendee Options.

3. **Make sure the slider next to “Show Me On Attendee List” is switched off.** Fellow attendees will no longer be able to find you on the list at all.
How do I message other attendees within the app?

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send your message.** Find the person you want to message by either scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon to start texting.

3. **Find previous chats.** If you want to pick up a chat you previously started, tap the hamburger icon in the top right, then *My Messages*.

How do I block a person from chatting with me?

1. **Access the Attendee List.** Rather focus on the conference? Just as before, log in and tap the Attendees icon.

2. **Block the person.** Find the person you’d like to block about by scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon. But, don’t type anything, instead tap Block in the top right.

I want to network with other attendees. How do I share my contact info with them?

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send a request.** Find the person you want to share your contact information by either scrolling through the list or using the search bar at the top of the screen.

3. Tap their name, then the plus icon to send a contact request. If they accept, the two of you will exchange info.

I want to schedule an appointment with other attendees. How do I do that?

1. **Navigate to My Schedule.** Tap the hamburger icon in the top left, then *My Schedule*.

2. **Create Your Appointment.** In the top right corner of the *My Schedule* page you’ll see a plus sign. Tap on it to access the Add Activity page.

3. **Give your appointment a name, a start and end time, and some invitees.** When you’re finished, tap done. Invitations will be immediately sent to all relevant attendees.

How do I take notes within the app?

Write Your Thoughts…

1. **Find your Event Item.** After logging in, find the session, speaker, or attendee you’d like to create a note about by tapping on the appropriate icon in the Event Directory, then scrolling through the item list. Once you’ve found the item you’re looking for, tap on it.
2. Write your note. Tap the pencil icon to bring up a blank page and your keyboard. Enter your thoughts, observations, and ideas. Tap done when you’ve finished.

...Then Export Them

1. Navigate to My Notes. Tap the hamburger icon in the top right, then My Notes. Here you’ll find all the notes you’ve taken organized by session.

2. Choose where to send your notes. Tap the share icon in the top right and CrowdCompass will automatically generate a draft of an email that contains all your notes. All you have to do is enter an email address, and then tap Send.
Meeting Space Map

Gaylord National® Resort & Convention Center

Ballroom Level
- Maryland Ballroom
- Chesapeake Conference Rooms
- Potomac Ballroom
- Baltimore Rooms
- Fort Washington Boardroom
- Annapolis Rooms
- Woodrow Wilson Ballroom

Cherry Blossom Ballroom
- Magnolia Rooms
- Camellia Rooms
- Azalea Rooms
- Presidential Boardroom

Lobby Level
- Mezzanine Conference Rooms

Lower Atrium
- Prince George’s Exhibition Hall
- Town Meeting Space
- Eastern Shore Meeting Space
## Business

### Resolutions

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<th>Negligent Credentialing Actions Against Hospitals</th>
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<td>Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs</td>
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<tr>
<td>Resolution 3</td>
<td>Preservation of the Patient-Physician Relationship</td>
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<td>Resolution 4</td>
<td>E-Cigarettes, Revisited</td>
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### Reports

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<tbody>
<tr>
<td>Governing Council Report B</td>
<td>Emeritus Membership Category</td>
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</tbody>
</table>
Whereas, Patients' rights are already protected under various medical liability or medical malpractice laws that provide them with the right to sue for any injuries resulting from professional negligence by their physicians, as well as hospital liability under a wide range of events (e.g., slip and falls, hospital-borne infections, faulty equipment, etc.); and

Whereas, Nevertheless, many courts in the United States recognize another cause of action—negligent credentialing, a tort action allowing patients to sue a hospital for any injuries caused by a physician based on the theory that the hospital granted privileges to that physician when it should not have; and

Whereas, Recently, the Kentucky Supreme Court refused to recognize negligent credentialing as a cause of action because its far-reaching implications are largely unknown; and

Whereas, The threat of liability for negligent credentialing may result in hospitals and health plans adopting much more stringent criteria to credential licensed physicians, making the credentialing process another significant barrier for physicians, and in effect, could give rise to patient access and quality of care issues; therefore be it

RESOLVED, That our American Medical Association recognize that “negligent credentialing” causes of action undermine the overall integrity of the credentialing process and a physician's ability to maintain independence or otherwise exercise professional medical judgment, potentially resulting in adverse impacts to patient access and quality of care (New HOD Policy); and be it further

RESOLVED, That our AMA actively oppose state legislation and court action recognizing “negligent credentialing” as a cause of action that would allow for patients to sue a hospital based on the theory that the hospital negligently granted a physician’s clinical privileges (Directive to Take Action); and be it further

RESOLVED, That our AMA work with state medical societies and medical specialty associations in those states that recognize the tort of negligent credentialing to advocate that such claims should place the highest standard of proof on the plaintiff. (Direct to Take Action)

Fiscal Note: Modest – Between $1,000 and $5,000
Resolution 2
(I-18)

Introduced by: Massachusetts Medical Society OMSS; Ronald Dunlap, MD

Subject: Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs

Referred to: OMSS Reference Committee
(Vimal Nanavati, MD, Chair)

Whereas, The performance analysis results for Medicare Shared Savings ACOs show lower savings for hospital integrated systems as opposed to physician-owned systems; and

Whereas, The system infrastructure costs needed to form ACOs that engage in population health have resulted in many physician practices being taken over and consolidated by hospital-owned systems; and

Whereas, The fact that hospital integrated systems generated lower savings or even higher costs compared to those savings realized by physician-owned groups is a major concern; and

Whereas, CMS is advocating for ACOs to move to the Next Gen by taking on downside risk as the major route to participate in alternative payment models; and

Whereas, This will be attempted in an environment where the savings of hospital integrated systems are not financially significant; and

Whereas, This move places physicians in those systems at increased risk for practice failure or loss of their positions through compensatory staff reductions; and

Whereas, The great majority of Medicare Shared Savings Program ACOs have decided not to move to the Next Gen model based upon the aforementioned economic inadequacies; and

Whereas, Hospital integrated systems that have failed to generate significant savings are under pressure to either downsize medical staffs (a demoralizing action) or take over the involved health care system entirely, leading to further consolidation (an even worse scenario driven in some situations by financial entities with no previous commitment to, or involvement in, medicine); and

Whereas, The role of the medical staff in governance may be further reduced following each subsequent consolidation, with the diminished role in governance most extreme among the physicians involved in hospital integrated systems; therefore be it

RESOLVED, That our American Medical Association assess the effect of hospital integrated system ACOs failure to generate savings on downsizing of the medical staff and further consolidation of medical practices (Directive to Take Action); and be it further

RESOLVED, That our AMA assess the root causes for failure to generate savings in
hospital integrated ACOs, as compared to physician-owned ACOs. Such organizations may include a broader range of services, differences in the cost of facility charges, higher utilization of expensive services, overhead due to HIT, administration, practice acquisitions, and the more complex infrastructure necessary to create and manage an ACO. (Directive to Take Action)

Fiscal Note: Modest – Between $1,000 and $5,000
Whereas, The patient-physician relationship is among the most important elements of our medical profession; and

Whereas, The quality of the patient-physician relationship is crucial to the care of the patient, improving the value of the patient-physician encounter to both parties and greatly enhancing the chances that the patient’s concern can be met; and

Whereas, Dr. Bernard Lown, in his book “The Lost Art of Healing: Practicing Compassion in Medicine” states that “the three thousand year tradition which bonded doctor and patient in a special affinity of trust is being traded for a new type of relationship; healing is replaced with treating, caring is supplanted by managing, and the art of listening is taken over by technology;” and

Whereas, Dr. Lown’s observations are even more relevant now than they were 22 years ago due to: (1) increasing time constraints on the clinician due to scheduling issues, (2) the intrusion of electronic devices in the consultation room which can make sustained eye contact between the patient and his/her physician more challenging, and (3) curriculum changes in some medical schools such that history taking and examination skills are not emphasized as they once were; and

Whereas, Clinicians who make eye contact are perceived as more empathetic and patient satisfaction is improved with increased eye contact and less distraction; and

Whereas, We members of the medical profession owe it to both our patients and ourselves to do everything we can to preserve the patient-physician relationship, thereby doing all possible to provide the best care of our patients; therefore be it

RESOLVED, That our AMA conduct a study, with report back at the 2020 Annual Meeting, from the perspective of both the patient and the physician to access the perceived quality of the patient-physician relationship in regards to:

1. Adequacy of the time spent during the clinical encounter;
2. The engagement of each participant in terms of eye contact, attention given, and the sense of caring;
3. The impact of the use of electronic devices during the clinical encounter (if they were used); and
4. The impact of the presence of another individual such as a “scribe” during the patient-physician encounter. (Directive to Take Action)

Fiscal Note: Modest – Between $1,000 and $5,000
Whereas, Years ago, a resolution was introduced in an effort to put the AMA in a leadership and  
out-front role in the opening battle over e-cigarettes; and

Whereas, The AMA did little to become a major defender of public health regarding the  
introduction of the then-new addiction; and

Whereas, In ensuing years, the marketing and strategies to push this product have become  
ever more clear, as have the dangers—and still, the AMA seems mute; and

Whereas, Ever mounting data shows a serious problem for the public’s welfare and especially  
for younger users getting hooked/addicted to the use and acceptance of these nicotine delivery  
machines; and

Whereas, A real effort by the AMA may help I better defining the health risks, problems, and  
consequences for public health; therefore be it

RESOLVED, That our American Medical Association expedite processes to come out forcefully  
and soon against e-cigarette devices, and to push back against the marketing, pushing, and  
strategic forces trying to gain acceptance for addicting e-cigarette devices (Directive to Take  
Action); and be it further

RESOLVED, That our AMA’s efforts around counteracting e-cigarettes include a broad range of  
countermeasures, from bans to strict regulations, at least equal to treating them as cigarettes,  
as equivalent addicting agents and as harmful to the public. (Directive to Take Action)

Fiscal Note: Modest – Between $1,000 and $5,000

RELEVANT AMA POLICY

H-495.972 Electronic Cigarettes, Vaping, and Health

1. Our AMA urges physicians to:
   a. educate themselves about electronic nicotine delivery systems (ENDS), including e-
cigarettes, be prepared to counsel patients about the use of these products and the  
potential for nicotine addiction and the potential hazards of dual use with  
conventional cigarettes, and be sensitive to the possibility that when patients ask  
about e-cigarettes, they may be asking for help to quit smoking;
   b. consider expanding clinical interviews to inquire about "vaping" or the use of e-
cigarettes;
c. promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and
d. advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly.

2. Our AMA:
   a. encourages further clinical and epidemiological research on e-cigarettes;
   b. supports education of the public on the health effects, including toxins and carcinogens of electronic nicotine delivery systems (ENDS) including e-cigarettes; and
   c. recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction.

H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products

Our AMA:
1. supports the U.S. Food and Drug Administration’s (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act;
2. supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that:
   a. establishes a minimum legal purchasing age of 21;
   b. prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered;
   c. applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople;
   d. prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA;
   e. requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes;
   f. establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use;
   g. requires transparency and disclosure concerning product design, contents, and emissions; and
   h. prohibits the use of characterizing flavors that may enhance the appeal of such products to youth; and
3. urges federal officials, including but not limited to the U.S. Food and Drug Administration to:
   a. prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and
   b. require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

D-495.992 Legal Action to Compel FDA to Regulate E-Cigarettes

Our AMA will consider joining other medical organizations in an amicus brief supporting the American Academy of Pediatrics legal action to compel the U.S. Food and Drug Administration
to take timely action to establish effective regulation of e-cigarettes, cigars and other nicotine tobacco products.

**H-495.986 Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes**

Our AMA: (1) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors….

**H-495.987 Taxation of All Tobacco Products and Electronic Nicotine Delivery Systems (ENDS)**

1. Our AMA will work for and encourages all levels of the Federation and other interested groups to support efforts, including education and legislation, to increase federal, state, and local excise taxes on all tobacco products and electronic nicotine delivery systems (ENDS), including e-cigarettes, in order to discourage use.
2. An increase in federal, state, and local excise taxes for such products should include provisions to make substantial funds available that would be allocated to health care needs and health education, and for the treatment of those who have already been afflicted by tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts.
3. Our AMA continues to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of all tobacco products; and advocates that the added tax revenues obtained as a result of reducing or eliminating such advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion and health education.
OMSS Governing Council Report A identifies resolutions and reports relevant to medical staffs that have been submitted for consideration by the AMA House of Delegates (HOD) at the 2018 AMA Interim Meeting. This report is submitted to the Assembly to facilitate the instruction of the OMSS Delegate and Alternate Delegate regarding the positions they should take in representing the Section in the HOD. Instructions are generally given with regard to the intent of a resolution or report, rather than to specifics, thereby allowing the Delegate and Alternate Delegate to more fully represent the views expressed by the OMSS Assembly during its discussion of this report.

The following recommendations regarding OMSS positions on HOD resolutions and reports are presented for the consideration of the Assembly:

**REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS**

(1) **CEJA Report 1 – Competence, Self-Assessment and Self-Awareness**

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians’ technical knowledge and skills.

However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:


b. Recognize that different points of transition in professional life can make different demands on competence.
c. Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations.

d. Seek feedback from peers and others.

e. Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient’s best interest.

f. Intervene in a timely and appropriate manner when a colleague’s ability to practice safely is compromised by impairment, in keeping with ethics guidance.

Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.

**Recommendation:** The Governing Council recommends that the OMSS Delegate be instructed to support the intent of CEJA Report 1.

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**REFERENCE COMMITTEE B (LEGISLATION)**

(2) **BOT Report 8 – 340B Drug Discount Program**

In light of these considerations, your Board of Trustees recommends that the following recommendations be adopted in lieu of the third resolve Resolution 225-A-18 and the remainder of this report be filed:

1. That our American Medical Association support a revised 340B drug discount program covered entity eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well as standalone community practices.

2. Our AMA will confer with national medical specialty societies on providing policymakers with specific recommended covered entity criteria for the 340B drug discount program.

**Recommendation:** The Governing Council recommends that the OMSS Delegate be instructed to support the intent of BOT Report 8.

(3) **Resolution 201 – Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application**

Introduced: by Virginia, American Association of Clinical Urologists, Georgia

RESOLVED, That our American Medical Association develop model state legislation for physicians being credentialed by a health plan to treat patients and retroactively receive payments if they are ultimately credentialed.

**Recommendation:** The Governing Council recommends that the OMSS Delegate be instructed to support the intent of Resolution 201.

(4) **Resolution 221 – Regulatory Relief from Burdensome CMS "HPI" EHR Requirements**

Introduced by: Kentucky

RESOLVED, That our American Medical Association advocate for regulatory relief from the burdensome Centers for Medicare and Medicaid Services (CMS) History of Present Illness (HPI) requirements arbitrarily equating “keystroking” in an electronic health record (EHR) with validation of the fact that a face to face encounter has been performed by the physician/NPP; and be it further
RESOLVED, That our AMA advocate for the acceptance of the physician's electronic signature as substantiation and verification that the HPI was reviewed and appropriate additional information was obtained and recorded whomever "keystroked" this information.

Recommendation: The Governing Council recommends that the OMSS Delegate be instructed to support the intent of Resolution 221.

(5) Resolution 225 – "Surprise" Out of Network Bills
Introduced by: New York

RESOLVED, That our American Medical Association advocate that any federal legislation on “surprise” out of network medical bills be consistent with AMA Policy H-285.904, “Out-of-Network Care,” and apply to ERISA plans not subject to state regulation; and be it further
RESOLVED, That our AMA advocate that such federal legislation protect state laws that do not limit surprise out of network medical bills to a percentage of Medicare or health insurance fee schedules.

Recommendation: The Governing Council recommends that the OMSS Delegate be instructed to support the intent of Resolution 225.

(6) Resolution 226 – Support for Interoperability of Clinical Data
Introduced by: Utah

RESOLVED, That our American Medical Association review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.

Recommendation: The Governing Council recommends that the OMSS Delegate be instructed to support the intent of Resolution 226.

(7) Resolution 227 – CMS Proposal to Consolidate Evaluation and Management Services

RESOLVED, That our American Medical Association actively seek and support congressional action before January 1, 2019 that would prevent implementation of changes to consolidate evaluation and management services as put forward in the CY 2019 Medicare physician fee schedule proposed rule if CMS in the final rule moves forward with the consolidation of evaluation and management services.

Recommendation: The Governing Council recommends that the OMSS Delegate be instructed to support the intent of Resolution 227.
REFERENCE COMMITTEE C (MEDICAL EDUCATION)

(8) CME Report 1 – Competency of Senior Physicians

The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed.

1. That our American Medical Association (AMA) make available to all interested parties the Assessment of Senior/Late Career Physicians Guiding Principles:
   a. Evidence-based: The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician’s competency can be highly variable, and wide variations are seen in cognitive performance with aging.

   b. Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues’ competency.

   c. Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians’ ability to perform the tasks specifically required in their practice environment.

   d. Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.

   e. Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians’ practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome.

   f. Transparent: Guidelines, procedures or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment.

   g. Supportive: Education and/or remediation practices that result from screening and/or assessment procedures should be supportive of physician wellness, ongoing, and proactive.
h. Cost conscious: Procedures and screening mechanisms that are distinctly different from “for cause” assessments should not result in undue cost or burden to senior physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed senior physicians. Similar procedures and screening mechanisms should be available to senior physicians who are not employed by hospitals and health care systems.

2. That our AMA encourage the Federation of State Medical Boards, Council of Medical Specialty Societies, and other interested organizations to develop educational materials on the effects of age on physician practice for senior/late career physicians.

3. That Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” be rescinded, as having been fulfilled by this report.

Recommendation: The Governing Council recommends that the OMSS Delegate be instructed to support the intent of CME Report 1.

(9) Resolution 957 – Board Certifying Bodies

Introduced by: Florida

RESOLVED, That our American Medical Association conduct a study of the certifying bodies that compete with the American Board of Medical Specialties and issue a report opining on the qualifications of each such certifying body and whether each such certifying body should be added to the list of approved certifying entities in states where they are not currently approved; and be it further

RESOLVED, That our AMA develop model state legislation that would encourage competition among qualified certifying bodies and would modify board certification requirements such that maintenance of certification participation would not be a requirement for board recertification.

Recommendation: The Governing Council recommends that the OMSS Delegate be instructed to support the intent of Resolution 957.

REFERENCE COMMITTEE F (AMA GOVERNANCE AND FINANCE)

No recommendations on items under consideration in Reference Committee F
REFERENCE COMMITTEE J (MEDICAL SERVICE, MEDICAL PRACTICE, INSURANCE)

(10) CMS Report 4 – The Site-of-Service Differential

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 817-I-17, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-240.993, which urges more aggressive implementation by the US Department of Health and Human Services of existing provisions in federal legislation calling for equity in payment between services provided by hospitals on an outpatient basis and similar services in physician offices. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy D-330.997, which encourages the Centers for Medicare & Medicaid Services (CMS) to define Medicare services consistently across settings and adopt payment methodology for hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) that will assist in leveling the playing field across all sites-of-service. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-400.957, which encourages CMS to expand the extent and amount of reimbursement for procedures performed in the physician office, to shift more procedures from the hospital to the office setting, which is more cost effective, and to seek to have practice expense relative value units reflect the true cost of performing office procedures. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-400.966, which directs the AMA to aggressively promote the compilation of accurate data on all components of physician practice costs, and the changes in such costs over time, as the basis for informed and effective advocacy concerning physician payment under Medicare. (Reaffirm HOD Policy)

5. That our AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. (New HOD Policy)

6. That our AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting. (New HOD Policy)

7. That our AMA urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured. (New HOD Policy)

8. That our AMA encourage CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care. (New HOD Policy)

9. That our AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments
to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery. (Directive to Take Action)

**Recommendation:** The Governing Council recommends that the OMSS Delegate be instructed to support the intent of CMS Report 4, so long as such policy would not reduce payments for services in outpatient settings.

(11) **Resolution 807 – Emergency Department Copayments for Medicaid Beneficiaries**  
Introduced by: American College of Emergency Physicians

RESOLVED, That our American Medical Association oppose imposition of copays for Medicaid beneficiaries seeking care in the emergency department. (New HOD Policy)

**Recommendation:** The Governing Council recommends that the OMSS Delegate be instructed to oppose the intent of Resolution 807. The Delegate’s testimony should suggest that, rather than restricting access to care, a better approach to the problem of ED overuse is to increase patient access to outpatient primary care by increasing Medicaid payment rates.

(12) **Resolution 812 – ICD Code for Patients Harm From Payer Interference**  
Introduced by: Craig A. Backs, MD, Delegate

RESOLVED, That our American Medical Association support the creation and implementation of an ICD code(s) to identify administrator or payer influence that affects treatment and leads to or contributes to, directly or indirectly, patient harm. (New HOD Policy)

**Recommendation:** The Governing Council recommends that the OMSS Delegate be instructed to support the intent of Resolution 812.

(13) **Resolution 814 – Prior Authorization Relief in Medicare Advantage Plans**  
Introduced by: Indiana

RESOLVED, That our American Medical Association support legislation that would apply the following legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:

- Listing services that require a PA on a website.
- Notifying providers of any changes at least 45 days prior to change.
- Standardizing a PA request form.
- Not denying payment for PA that has been approved unless fraudulently obtained or ineligible at time of service.
- Defining a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans (New HOD Policy); and be it further

RESOLVED, That our AMA apply these same legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans, to include:

- Medications already working when a patient changes health plans cannot be changed by the plan without discussion and approval of the ordering physician.
- Minimizing PA requirements as much as possible within each plan.
• Making an easily accessible and reasonably responsive direct communication tool available to resolve disagreements between plan and ordering provider. (New HOD Policy)

Recommendation: The Governing Council recommends that the OMSS Delegate be instructed to support the intent of Resolution 814.

(14) Resolution 820 – Ensuring Quality Health Care for Our Veterans

Introduced by: Michigan

RESOLVED, That our American Medical Association amend policy H-510.986, “Ensuring Access to Care for our Veterans,” by addition to read as follows:

Ensuring Access to Safe and Quality Care for our Veterans H-510.986
1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.
5. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains first-rate, competent, and ethical physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.
6. Our AMA will engage the Veterans Health Administration in dialogue on accreditation practices by the Veterans Health Administration to assure they are similar to those of hospitals, state medical boards, and insurance companies.

Recommendation: The Governing Council recommends that the OMSS Delegate be instructed to support the intent of Resolution 820.

REFERENCE COMMITTEE K (SCIENCE AND PUBLIC HEALTH)

No recommendations on items under consideration in Reference Committee K
EXECUTIVE SUMMARY

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient’s well-being.

To fulfill their ethical responsibility of competence, physicians at all stages in their professional lives should cultivate and exercise skills of self-awareness and active self-observation; take advantage of tools for self-assessment that are appropriate to their practice settings and patient populations; and be attentive to environmental and other factors that may compromise their ability to bring their best skills to the care of individual patients. As a profession, medicine should provide meaningful opportunity for physicians to hone their ability to be self-reflective.
The expectation that physicians will provide competent care is central to medicine. This expectation shaped the founding mission of the American Medical Association (AMA) and runs throughout the AMA Code of Medical Ethics [1-4]. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society [5]. The profession promises that practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses [6-9].

Yet despite the centrality of competence to professionalism, the Code has not hitherto examined what the commitment to competence means as an ethical responsibility for individual physicians in day-to-day practice. This report by the Council on Ethical and Judicial Affairs (CEJA) explores this topic to develop ethics guidance for physicians.

DEFINING COMPETENCE

A caveat is in order. Various bodies in medicine undertake point-in-time, cross-sectional assessments of physicians’ technical knowledge and skills. However, this report is not concerned with matters of technical proficiency assessed by medical schools and residency programs, specialty boards (for purposes of certification), or hospital and other health care organizations (e.g., for privileging and credentialing). Such matters lie outside the Council’s purview.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole. For purposes of this analysis, competence is understood as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served” and as “developmental, impermanent, and context dependent” [10].

Moreover, the Council is keenly aware that technical proficiency evolves over time—what is expected of physicians just entering practice is not exactly the same as what is expected of mid-
career physicians or physicians who are changing or re-entering practice or transitioning out of active practice to other roles. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues.

The concept that informs this report differs as well from the narrower definition of competence as the knowledge and skills an individual has to do a job. Rather, this report explores a broader notion of competence that encompasses deeper aspects of wisdom, judgment and practice that enable physicians to assure patients, the public, and the profession that they provide safe, high quality care moment to moment over the course of a professional lifetime.

FROM SELF-ASSESSMENT TO “INFORMED” SELF-ASSESSMENT

Health care institutions and the medical profession as a whole take responsibility to regulate physicians through credentialing and privileging, routinely testing knowledge (maintenance of certification, requirements for continuing education, etc.) and, when needed, taking disciplinary action against physicians who fail to meet expectations for competent, professional practice. However, the better part of the responsibility to maintain competence rests with physicians’ “individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs to maintain a level of competence commensurate with [their] clinical roles” [11].

Self-assessment has thus become “integral to many appraisal systems and has been espoused as an important aspect of personal professional behavior by several regulatory bodies and those developing learning outcomes for students” [12]. Undergraduate and graduate medical education programs regularly use self-assessment along with third-party evaluations to ensure that trainees are acquiring the knowledge and skills necessary for competent practice [5,10,13-16].

Yet how accurately physicians assess their own performance is open to question. Research to date suggests that there is poor correlation between how physicians rate themselves and how others rate them [5,12,13]. Various studies among health professionals have concluded that clinicians and trainees tend to assess their peers’ performance more accurately than they do their own; several have found that poor performers (e.g., those in the bottom quartile) tend to over-estimate their abilities while high performers (e.g., those in the top quartile), tend to under-estimate themselves [5,12,17].

The available findings suggest that self-assessment involves an interplay of factors that can be complicated by lack of insight or of metacognitive skill, that is, ability to be self-observant in the moment. Similarly, personal characteristics (e.g., gender, ethnicity, or cultural background) and the impact of external factors (e.g., the purpose of self-assessment or whether it is designed to assess practical skills or theoretical knowledge) can all affect self-assessment [12,18]. The published literature also indicates that interventions intended to enhance self-assessment may seek different goals—improving the accuracy of self-assessors’ perceptions of their learning needs, promoting appropriate change in learning activities, or improving clinical practice or patient outcomes [12].

Self-assessment tools alone are not sufficient measures of physicians’ ability to provide safe, high quality care. Feedback from third parties is essential—or as one researcher has observed, “The road to self-knowledge may run through other people” [19]. However, physicians are often wary of assessment. They have indicated that while they want feedback, they are not sure how to use information that is not congruent with their self-appraisals [20]. Physicians can be hesitant to seek feedback for fear of looking incompetent or exposing possible deficiencies or out of concern that soliciting feedback could adversely affect their relationships with those whom they approach [20].
They may also question the accuracy and credibility of the assessment process and the data it generates [21].

To be effective, feedback must be valued both by those being assessed and by those offering assessment [14]. When there is tension between the stated goals of assessment and the implicit culture of the health care organization or institution, assessment programs can too readily devolve into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20]. Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews (“360° reviews”), for example, are generally better suited to providing feedback on communication and interpersonal skills than on technical knowledge or skills—and easy for evaluators to understand and use [14]. High quality feedback will come from multiple sources; be specific and focus on key elements of the ability being assessed; address behaviors rather than personality or personal characteristics; and “provide both positive comments to reinforce good behavior and constructive comments with action items to address deficiencies” [22]. Beyond such formal mechanisms, physicians should welcome and seek out informal input from colleagues. They should be willing to offer timely comments to colleagues as well.

One study among physicians and physicians in training found that participants used a dynamic, multidimensional process to assess their own abilities. Under this process of what researchers identified as “informed self-assessment,” participants interpreted and responded to multiple types of information, such as cognitive and affective data, from both formal and informal sources [23]. Participants described “critically reflecting ‘in action,’ that is, during an activity or throughout the day:”

I think we do a lot of it without thinking of it as reflection. We do it every day when we look at a patient’s chart. You look back and see the last visit, “What did I do, or should I have done something different?” I mean that’s reflection, but yet I wouldn’t have thought of that as self-assessment or self-reflection, but we do it dozens of times a day [23].

EXPERTISE & EXPERT JUDGMENT

On this broad understanding of competence, physicians’ thought processes are as important as their knowledge base or technical skills. Thus, understanding competence requires understanding something of the nature of expertise and processes of expert reasoning, themselves topics of ongoing exploration [24,25,26,27]. Prevailing theory distinguishes “fast” from “slow” thinking; that is, reflexive, intuitive processes that require minimal cognitive resources versus deliberate, analytical processes that require more conscious effort [26]. Some scholars take expertise to involve “fast” processes, and specifically decision making that involves automatic, nonanalytic resources acquired through experience [24]. Others argue that expertise consists in using “slow,” effortful, analytic processes to address problems [24]. A more integrative view argues that expertise resides in being able to transition between intuitive and analytical processes as circumstances require. On this account, experts use automatic resources to free up cognitive capacity so that they maintain awareness of the environment (“situational awareness”) and can determine when to shift to effortful processes [24].

Expert judgment is the ability “to respond effectively in the moment to the limits of [one’s] automatic resources and to transition appropriately to a greater reliance on effortful processes when needed” [24], a practice described as “slowing down.” Knowing when to slow down and be reflective has been demonstrated to improve diagnostic accuracy and other outcomes [26]. To respond to the unexpected events that often arise in a clinical situation, the physician must “vigilantly monitor relevant environmental cues” and use these as signals to slow down, to
transition into a more effortful state [25]. This can happen, for example, when a surgeon confronts an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should” serves as a critical marker for intraoperative surgical judgment [24].

INFLUENCES ON CLINICAL REASONING

Clinical reasoning is a complex endeavor. Physicians’ capabilities develop through education, training, and experiences that provide tools with which to shape their clinical reasoning. Every physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or differ from the analytical and investigative processes of their colleagues in innumerable ways. When something goes wrong in the clinic, it can be difficult to discern why. Nonetheless, all physicians are open to certain common pitfalls in reasoning, including relying unduly on heuristics and habits of perception, and succumbing to overconfidence.

Heuristics

Physicians often use various heuristics—i.e., cognitive short cuts—to aid decision making. While heuristics can be useful tools to help physicians identify and categorize relevant information, these time-saving devices can also derail decision making. For example, a physician may mistakenly assume that “something that seems similar to other things in a certain category is itself a member of that category” (the representative heuristic) [28], and fail to diagnose a serious health problem. Imagine a case in which a patient presents with symptoms of a possible heart attack or a stroke that the physician proceeds to discount as stress or intoxication once the physician learns that the patient is going through a divorce or smells alcohol on the patient’s breath. Or a physician may miscalculate the likelihood of a disease or injury occurring by placing too much weight “on examples of things that come to mind easily, . . . because they are easily remembered or recently encountered” (the availability heuristic) [28]. For example, amidst heavy media coverage of an outbreak of highly infectious disease thousands of miles away in a remote part of the world, a physician seeing a patient with symptoms of what is actually a more commonplace illness may misdiagnose (or over diagnose) the exotic condition because that is what is top of mind.

Clinical reasoning can be derailed by other common cognitive missteps as well. These can include misperceiving a coincidental relationship as a causal relationship (illusory bias), or the tendency to remember information transferred at the beginning (or end) of an exchange but not information transferred in the middle (primary or recency bias) [28,29,30].

Habits of Perception

Like every other person, physicians can also find themselves prone to explicit (conscious) or implicit (unconscious) habits of perception or biases. Physicians may allow unquestioned assumptions based on a patient’s race or ethnicity, gender, socioeconomic status, or health behavior, among other features, to shape how they perceive the patient and how they engage with, evaluate and treat the individual. Basing one’s interactions with a patient on pre-existing expectations or stereotypes deems the patient, undermines the patient’s relationship with the physician and the health care system, and can result in significant health disparities across entire communities [31]. This is of particular concern for patients who are members of minority and historically disadvantaged populations [31]. Physicians may fall victim to the tendency to seek out information that confirms established expectations or dismiss contradicting information that does not fit into predetermined beliefs (confirmatory bias) [28]. These often inadvertent thought processes can result in a physician pursuing an incorrect line of questioning or testing that then leads to a misdiagnosis or the wrong treatment.
No matter how well a patient may seem to fit a stereotype, it is imperative that the physician look beyond categories and assumptions to investigate openly the health issues experienced by the patient. Although all human beings exhibit both conscious and unconscious habits of perception, physicians must remain vigilant in not allowing preconceived or unexamined assumptions to influence their medical practice.

**Overconfidence**

Finally, another obstacle to strong clinical reasoning that physicians may encounter is overconfidence. Despite their extensive training, physicians, like all people, are poor at identifying the gaps in their knowledge [28,30]. Physicians may consider their skills to be excellent, when, in fact, their peers have identified areas for improvement [30]. Overconfidence in one’s abilities can lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the advice of others, or not acknowledging one’s limits [28,30].

To avoid falling into such traps, physicians must recognize that many factors can and will influence their clinical decisions [28]. They need to be aware of the information they do and do not have and they need to acknowledge that many factors can and will influence their judgment. They should keep in mind the likelihood of diseases and conditions and take the time to distinguish information that is truly essential to sound clinical judgment from the wealth of possibly relevant information available about a patient. They should consider reasons their decisions may be wrong and seek alternatives, as well as seek to disprove rather than confirm their hypotheses [28]. And they should be sensitive to the ways in which assumptions may color their reasoning and not allow expectations to govern their interactions with patients.

Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming aware of areas in which their skills are not at their strongest and seeking additional education or consulting with colleagues, physicians can enhance their practice and best serve their patients.

Physicians’ ability to practice safely can be affected by their own health, of course. The *Code of Medical Ethics* addresses such situations in guidance on physicians’ health and wellness (E-9.3.1) and their responsibilities to impaired colleagues (E-9.3.2).

**FROM INFORMED SELF-ASSESSMENT TO SELF-AWARENESS**

Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally conceived has significant shortcomings, several scholars have argued that a different understanding of self-assessment is needed, along with a different conceptualization of its role in a self-regulating profession [32]. Self-assessment, it is suggested, is a mechanism for identifying both one’s weaknesses and one’s strengths. One should be aware of one’s weaknesses in order to self-limit practice in areas in which one has limited competence, to help set appropriate learning goals, and to identify areas that “should be accepted as forever outside one’s scope of competent practice” [32]. Knowing one’s strengths, meanwhile, allows a physician both to “act with appropriate confidence” and to “set appropriately challenging learning goals” that push the boundaries of the physician’s knowledge [32].

If self-assessment is to fulfill these functions, physicians need to reflect on past performance to evaluate not only their general abilities but also specific completed performances. At the same time, they must use self-assessment predictively to assess how likely they are to be able to manage new challenges and new situations. More important, physicians should understand self-assessment as an ongoing process of monitoring tasks during performance [3]. The ability to monitor oneself in
the moment is critical to physicians’ ethical responsibility to practice safely, at the top of their expertise but not beyond it.

Expert practitioners rely on pattern recognition and other automatic resources to be able to think and act intuitively. As noted above, an important component of expert judgment is transitioning effectively from automatic modes of thinking to more effortful modes as the situation requires. Self-awareness, in the form of attentive self-observation (metacognitive monitoring), alerts physicians when they need to direct additional cognitive resources to the immediate task. For example, among surgeons, knowing when to “slow down” during a procedure is critical to competent professional performance, whether that means actually stopping the procedure, withdrawing attention from the surrounding environment to focus more intently on the task at hand, or removing distractions from the operating environment [25].

Physicians should also be sensitive to the ways that interruptions and distractions, which are common in health care settings, can affect competence in the moment [34,35], by disrupting memory processes, particularly the “prospective memory”—i.e., “a memory performance in which a person must recall an intention or plan in the future without an agent telling them to do so”—important for resuming interrupted tasks [35,36]. Systems-level interventions have been shown to help reduce the number or type of interruptions and distractions and mitigate their impact on medical errors [37].

A key aspect of competence is demonstrating situation-specific awareness in the moment of being at the boundaries of one’s knowledge and responding accordingly [33]. Slowing down, looking things up, consulting a colleague, or deferring from taking on a case can all be appropriate responses when physicians’ self-awareness tells them they are at the limits of their abilities. The capacity for ongoing, attentive self-observation, for “mindful” practice, is an essential marker of competence broadly understood:

Safe practice in a health professional’s day-to-day performance requires an awareness of when one lacks the specific knowledge or skill to make a good decision regarding a particular patient . . . . This decision making in context is importantly different from being able to accurately rate one’s own strengths and weaknesses in an acontextual manner. . . . Safe practice requires that self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of self-efficacy and ongoing ‘reflection-in-practice,’ addressing emergent problems and continuously monitoring one’s ability to effectively solve the current problem [32].

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills [32]. Self-aware physicians are also alert to how external stressors—such as the death of a loved one or other family crisis, or the reorganization of their practice, for example—may be affecting their ability to provide care appropriately at a given time. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient’s well-being.

MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

For physicians, the ideal is not simply to be “good” practitioners, but to excel throughout their professional careers. This ideal holds not just over the course of a sustained clinical practice, but equally when physicians re-enter practice after a hiatus, transition from active patient care to roles as educators or administrators, or take on other functions in health care. Self-assessment and self-awareness are central to achieving that goal.
A variety of strategies are available to physicians to support effective self-assessment and help physicians cultivate the kind of self-awareness that enables them to “know when to slow down” in day-to-day practice. One such strategy might be to create a portfolio of materials for reflection in the form of written descriptions, audio or video recording, or photos of encounters with patients that can provide evidence of learning, achievement and accomplishment [16] or of opportunities to improve practice. A strength of portfolios as a tool for assessing one’s practice is that, unlike standardized examinations, they are drawn from one’s actual work and require self-reflection [15].

As noted above, to be effective, self-assessment must be joined with input from others. Well-designed multi-source feedback can be useful in this regard, particularly for providing information about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple response that elicits feedback about how well one maintains trust and professional relationships with patients, one’s communication and teamwork skills, and accessibility offers a valid, reliable tool that can have practical value in helping to correct poor behavior and, just as important, consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful feedback will not have the rigor of a validated tool but can accomplish similar ends.

Reflective practice, that is, the habit of using critical reflection to learn from experience, is essential to developing and maintaining competence across a physician’s practice lifetime [38]. It enables physicians to “integrate personal beliefs, attitudes, and values in the context of professional culture,” and to bridge new and existing knowledge. Studies suggest that reflective thinking can be assessed, and that it can be developed, but also that the habit can be lost over time with increasing years in practice [38].

“Mindful practice,” that is, being fully present in everyday experience and aware of one’s own mental processes (including those that cloud decision making) [39], sustains the attitudes and skills that are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on behavior over consciousness, erects barriers to mindful practice, while an individual’s unexamined negative emotions, failure of imagination, and literal-mindedness can do likewise. Mindfulness can be self-taught, but for most it is most effectively learned in relationship with a mentor or guide. Nonetheless, despite challenges, there are myriad ways physicians can cultivate mindfulness. Meditation, which may come first to mind, is one, but so is keeping a journal, reviewing videos of encounters with patients, or seeking insight from critical incident reports [39].

“Exemplary physicians,” one scholar notes, “seem to have a capacity for self-critical reflection that pervades all aspects of practice, including being present with the patient, solving problems, eliciting and transmitting information, making evidence-based decisions, performing technical skills, and defining their own values” [39].

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians’ technical knowledge and skills.

However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual
patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:

(a) Cultivate continuous self-awareness and self-observation.

(b) Recognize that different points of transition in professional life can make different demands on competence.

(c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations.

(d) Seek feedback from peers and others.

(e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient’s best interest.

(f) Intervene in a timely and appropriate manner when a colleague’s ability to practice safely is compromised by impairment, in keeping with ethics guidance.

Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500.
REFERENCES


Subject: 340B Drug Discount Program 
(Resolution 225-A-18 Resolve 3)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B 
(Doctors P. MacMillan, Jr., MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting of the House of Delegates (HOD), the third resolve of Resolution 225-A-18 was referred for report back at the 2018 Interim Meeting. Resolution 225-A-18, sponsored by American Society of Clinical Oncology (ASCO), asked that our American Medical Association (AMA):

   (3) support discontinuing the use of the Disproportionate Share Hospital (DSH) adjustment as a determining measure for 340B program eligibility;

The reference committee heard mixed testimony on this resolve. Testimony was offered that additional research and analysis is needed to assess how to identify the DSH hospitals that should not benefit from 340B program rebates and those that should. The reference committee recommended adopting Resolves 1, 2, and 4, and referral of Resolve 3 for a report back at the 2018 Interim Meeting.

AMA POLICY

Our AMA has an extensive policy that supports increased pharmaceutical drug and biological affordability and policies to ensure patient access to medically necessary prescription medication. However, our AMA does not have specific policy concerning the 340B program other than the HOD adopted resolves of Resolution 225-A-18 (Policy H-110.985, “340B Drug Discount Program”). There is a policy related to rebates which provides that our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. (Policy H-110.987, “Pharmaceutical Cost”). Thus, there is support for rebate programs to the extent such programs benefit underinsured patients and patients living on low-incomes. Consistent with the foregoing, AMA policy provides support for the subsidization of prescription drugs for Medicare patients based on means testing (Policy H-330.902, “Subsidizing Prescription Drugs for Elderly Patients”). However, AMA policy also includes support for economic assistance, including coupons (and other discounts), for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured (Policy H-125.977, “Non-Formulary Medication and the Medicare Part D Coverage Gap”).
BACKGROUND

The 340B program, which is administered by the U.S. Department of Health and Human Services’ (HHS) Health Resources and Services Administration (HRSA), requires pharmaceutical manufacturers to sell outpatient prescription medication at a discount to covered entities. Congress established the 340B program in order to produce savings for certain safety-net health care providers by allowing them to purchase outpatient drugs at these discounted prices.1 The U.S. House of Representatives’ report, accompanying the original legislation, stated that these savings would “enable [participating] entities to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.”2 Pharmaceutical manufacturers are required to enter into an agreement, called a pharmaceutical pricing agreement (PPA), with the HHS Secretary. Under the PPA, the manufacturer agrees to provide front-end discounts on covered outpatient prescription medication purchased by “covered entities.”

The 340B program definition of “covered entity” includes six categories of hospitals: (1) disproportionate share hospitals (DSHs); (2) children’s hospitals; (3) cancer hospitals exempt from the Medicare prospective payment system; (4) sole community hospitals; (5) rural referral centers; and (6) critical access hospitals (CAHs).3 In addition, to qualify hospitals must be (1) owned or operated by state or local government, (2) a public or private non-profit corporation which is formally granted governmental powers by state or local government, or (3) a private non-profit organization that has a contract with a state or local government to provide care to low-income individuals who do not qualify for Medicaid or Medicare.4 Also, hospitals must meet payer-mix criteria related to the Medicare DSH program with the exception of CAHs.5 There are also 11 categories of non-hospital covered entities that are eligible based on receiving federal funding that include: federally qualified health centers (FQHCs); FQHC “look-alikes;” state-operated AIDS drug assistance programs; Ryan White Comprehensive AIDS Resources Emergency Act clinics and programs; tuberculosis, black lung, family planning, and sexually transmitted disease clinics; hemophilia treatment centers; Title X public housing primary care clinics; homeless clinics; urban Indian clinics; and Native Hawaiian health centers.6 Covered entities may provide drugs purchased through the 340B program to all eligible patients, regardless of a patient’s payer status and whether the drug is intended for self-administration or administration by a clinician. Discounts have been estimated to range from 20-50 percent of the drug’s cost.

DISCUSSION

Affordability and access to prescription medication is an area of increased focus by Congress and the Trump Administration. In the past year the 340B program has become the subject of significant scrutiny. A central question posed by a number of stakeholders: do the rapidly increasing number of DSH hospitals eligible for the 340B program discounts provide low-income patients the benefit of the prescription drug rebates that they receive? (Other aspects of the 340B program, addressed by the newly adopted AMA policy concerning the 340B program, have also been flagged including manufacturer and covered entity noncompliance with 340B program requirements and insufficient federal agency authority and resources to provide appropriate oversight.)

The Affordable Care Act increased the size and scope of the 340B program by expanding eligibility to more types of hospitals, such as critical access hospitals and sole community hospitals, and expanded Medicaid eligibility. As a result of the latter, the number of hospitals qualifying as DSH hospitals increased as DSH designation is calculated based on a formula that utilizes the number of Medicaid covered patients that a hospital serves. The number of participating unique covered entities has grown from 3,200 in 2011 to 12,722 in October 2017.8 The number of hospitals has grown significantly, from 591 in 2005 to 2,479 as of October 2017.9
There have also been a number of unintended consequences of the 340B program. A 2015 Avalere study found that hospitals participating in the 340B program were more likely than non-340B hospitals to acquire independent physician practices. These acquisitions create financial windfalls for hospitals due to the 340B program yet do not necessarily improve affordability for patients. Patient costs and resultant co-pays/co-insurance and deductibles for care in a hospital outpatient department (HOPDs) can be higher than those in physician offices. (In those instances, patient care in HOPDs is more costly for health insurers too.) Furthermore, some 340B eligible hospitals may have commercial contracts that pay substantially more than the Medicare rate for drugs, so the profit margin can be multiples of the cost of the drug. Patients may face a 20 percent coinsurance on this higher amount. Yet, hospitals eligible for the 340B program obtain drugs at a substantial discount. The 340B program does not require that the hospital pass the savings to uninsured or underinsured low-income patients. To the extent that the hospital does not pass along the savings, the combined payment by insurer and patient provides profit for the 340B hospital; the additional volume generated when 340B hospitals acquire independent physician practices results in even greater profits. There are also reports that hospital systems have acquired 340B program eligible hospitals in order to purchase drugs for their suburban clinics utilizing the discounts even though such clinics do not serve uninsured or underinsured low-income patients.

There have been several congressional hearings on the 340B program convened by the U.S. Senate’s Health, Education, Labor, and Pension (HELP) Committee as well as the U.S. House of Representatives’ Energy and Commerce (E&C) Committee. Testimony offered by the U.S. Government Accountability Office (GAO), the HHS Office of the Inspector General (OIG), and other witnesses included concerns with the 340B program’s: (1) inadequate “patient” definition; (2) eligibility criteria for covered entity; (3) oversight of covered entities and manufacturers; and (4) oversight of the use of contract pharmacies. The lack of program data to assess the extent to which 340B program covered entities are ensuring low-income patients benefit from the rebates and the savings has particularly troubled policymakers and other stakeholders.

In addition to the hearings, over 17 federal bills have been introduced concerning the 340B program in this Congress. A number of the bills would mandate reporting on care provided to low-income individuals and would impose new eligibility requirements for certain categories of covered entities. For example, in December 2017, Representative Larry Buschon (R-IN) introduced H.R. 4710, Protecting Access for Underserved and Safety-net Entities Act (340B PAUSE Act). The bill would impose a moratorium on registration for certain new 340B program hospitals and associated sites. H.R. 4710 would also mandate data collection by covered entities including the number and percentage of insured (by insurer) and uninsured individuals who are dispensed or administered 340B program discounted drugs. In January 2018, Senator Bill Cassidy (R-LA) introduced S. 2312, Helping Ensure Low-income Patients have Access to Care and Treatment Act (HELP Act). The bill would impose a registration moratorium on new non-rural 340B program covered entities and associated sites as well as new eligibility requirements for covered entities. It would also require reports on the level of charity care provided by covered entities. Similarly, in April 2018, Representative Earl Carter (R-GA) introduced H.R. 5598, 340B Optimization Act. The bill would amend the Public Health Service Act to require certain disproportionate share hospital covered entities under the 340B drug discount program submit to HHS reports on low-income utilization rates of outpatient hospital services furnished by such entities.

In order to address the lack of data available directly from 340B program hospital covered entities or HRSA vis-à-vis the benefit to low-income patients, the House E&C Committee Chairman Greg Walden (R-OR) and health subcommittee Chairman Michael Burgess (R-TX) requested a report on the topic from the GAO. On June 18, 2018, the GAO issued the report, Drug Discount Program:
Characteristics of Hospitals Participating and Not Participating in the 340B Program. The report found that:

[i]n 2016 … the median amount of charity care provided by all 340B hospitals … was similar to the median amount provided by all non-340B hospitals, and the median amount of uncompensated care provided by these 340B hospitals was higher than that provided by their non-340B counterparts. But again, the differences between the 340B and non-340B hospitals varied across the different hospital types. For example, while the median amount of uncompensated care provided by 340B general acute care hospitals (340B DSH) was higher than that of their non-340B counterparts, the median amount provided by 340B CAHs was lower than that of non-340B CAHs.

While the report provides additional needed analysis and data, more information is needed concerning the programs implementation and benefit to low income patients. To ensure the 340B program covered entity criteria aligns with the goal of ensuring low income patients are able to access affordable treatments, at least one national medical specialty society has recommended that Congress establish new metrics that such entities must meet that are objective, universal, verifiable and align program eligibility with the care provided by the covered entity to indigent and underserved individuals. Consistent with the foregoing, alternative eligibility measures could be calculated by analyzing the amount of charity care provided by hospitals in the outpatient setting. Ultimately, eligibility should be designed to qualify entities based on the amount of care delivered to underserved populations in outpatient settings. This would dovetail with new AMA policy to work with policymakers to establish 340B program eligibility for all physician practices demonstrating a commitment to serving low-income and underserved patients, new covered entity criteria should promote participation by institutions and practices of all sizes in all settings. To advance this goal, ASCO has convened an expert workgroup to develop recommendations for a revised eligibility formula in order to appropriately capture the level of outpatient charity care provided by hospitals, as well as standalone community practices. ASCO will provide policymakers and other stakeholders with the recommendations during the current congressional session.

CONCLUSION

The significant growth of the 340B program, particularly among DSH hospitals, should align with newly adopted HOD policy concerning 340B program and related AMA policies. Specifically, the program should promote access to affordable prescription drugs by low-income patients receiving care from 340B program covered entities. In addition, our AMA should engage with national medical specialty societies to leverage expertise and align recommendations to federal policymakers.

RECOMMENDATIONS

In light of these considerations, your Board of Trustees recommends that the following recommendations be adopted in lieu of the third resolve Resolution 225-A-18 and the remainder of this report be filed:

1. That our American Medical Association support a revised 340B drug discount program covered entity eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well as standalone community practices. (New HOD Policy)
2. Our AMA will confer with national medical specialty societies on providing policymakers with specific recommended covered entity criteria for the 340B drug discount program. (Directive to Take Action)

Fiscal Note: Less than $5000

REFERENCES

1 Section 340B of the Public Health Service Act, codified at 42 U.S.C. § 256b.
3 42 U.S.C. § 256b(a)(4)(A)–(K))
4 Id.
5 Id.
6 Id.
9 Id.
11 An Avalere report on Cost of Cancer Care stated that its “risk-adjusted results suggest that treatment for patients receiving chemotherapy in a HOPD costs on average 24 percent more than treatment received in a physician’s office.” Available from http://www.communityoncology.org/pdfs/avalere-cost-of-cancer-care-study.pdf
Intended by: Virginia, American Association of Clinical Urologists, Georgia

Subject: Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, AMA Policy H-180.956, “Physician Privileges Application – Timely Review by Managed Care,” states Medicare, Medicaid, and managed care organizations should retroactively compensate physicians for services rendered from the date of their credentialing; and

Whereas, HB 139 was successfully passed by the 2018 Virginia General Assembly and signed into law by Governor Northam. This allows physicians who are waiting to be credentialed by a health plan to see patients and retroactively receive payments if they are ultimately credentialed; and

Whereas, Physicians awaiting credentialing could be reimbursed $1000 per day during the credentialing process (Virginia Medical News – Spring/Summer 2018); therefore be it

RESOLVED, That our American Medical Association develop model state legislation for physicians being credentialed by a health plan to treat patients and retroactively receive payments if they are ultimately credentialed. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 08/28/18

RELEVANT AMA POLICY

Physician Privileges Application - Timely Review by Managed Care H-180.956
Our AMA policy is that: (1) final acceptance of residents who otherwise are approved by a health plan should be contingent upon the receipt of a letter from their program director stating that their training has been satisfactorily completed; (2) health plans which require board certification should allow the completing resident to be included in their plan after showing evidence of having completed the required training and of working towards fulfilling the requirements in the time frame established by their respective Board for completion of certification; and (3) Medicare, Medicaid, and managed care organizations should (a) make final physician credentialing determinations within 45 calendar days of receipt of a completed application; (b) grant provisional credentialing pending a final credentialing decision if the credentialing process exceeds 45 calendar days; and (c) retroactively compensate physicians for services rendered from the date of their credentialing.
Whereas, The AMA has adopted principles that support that information technology available to physicians should support the physician’s obligation to put the interests of patients first; and

Whereas, The information technology available to physicians should support the integrity and autonomy of physicians; and

Whereas, The AMA has affirmed a commitment to working with federal and state agencies, policy makers and other relevant stakeholders to improve EHRs; and

Whereas, Dissatisfaction among EHR end-users has contributed to physician burnout, and a diminished patient-physician relationship; and

Whereas, The Centers for Medicaid and Medicare Services (CMS) has determined that the History of Present Illness (HPI) cannot be performed incident to the physician by ancillary employees (ie, RN, LPN, MA or any other individual not able to bill Medicare for physicians’ services); and

Whereas, The “keystroking” of the information contained in the HPI as contained by the EHR is NOT necessarily validation that a face to face visit by the physician was performed; and

Whereas, The “keystroking” of orders signed by a physician is acceptable to CMS and these orders are much more likely to directly result in error; and

Whereas, A physician’s signature and declarative sentences regarding the nature of their work and involvement in the “HPI” portion of patient care should be sufficient to document their involvement in the care of the patient and doing so does not indicate that this information was treated as anything less than preliminary; therefore be it

RESOLVED, That our American Medical Association advocate for regulatory relief from the burdensome Centers for Medicare and Medicaid Services (CMS) History of Present Illness (HPI) requirements arbitrarily equating “keystroking” in an electronic health record (EHR) with validation of the fact that a face to face encounter has been performed by the physician/NPP (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the acceptance of the physician's electronic signature as substantiation and verification that the HPI was reviewed and appropriate additional information was obtained and recorded whomever "keystroked" this information. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Received: 10/05/18
Whereas, Legislation is under consideration in the United State Senate to create new rules for payment of “surprise” out of network bills for patients treated in hospitals; and

Whereas, Components of this draft legislation would call for health insurers to pay for out of network “surprise” bills as a percentage of in-network rates; and

Whereas, These “surprise” out of network bills are often the result of health insurers creating narrow networks that limit patient choice and dis-incentivize physician participation; and

Whereas, Failure to ensure fair payment for out of network emergency care could have an enormously adverse impact on the ability of hospitals to assure necessary availability of on-call specialty physician care to meet patient need; and

Whereas, Several states across the country have enacted laws that provide patients protection against these “surprise” bills; and

Whereas, The AMA has adopted policy H-285.904, “Out-of-Network Care,” that includes a component that “Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties”; and

Whereas, AMA Policy H-285.904 also states that “Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company”; and

Whereas, AMA policy H-285.904 also states, with regard to “unanticipated” out of network services, that “Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization”; and

Whereas, Current AMA policy does not expressly call for the AMA to advocate for federal legislation consistent with these principles; and
Whereas, Current federal legislation does not address health insurer network adequacy problems; and

Whereas, Federal legislation has the potential to pre-empt state laws that have been shown to address these problems in ways that are fair to patients, health insurers, hospitals and physicians; and

Whereas, Even if such federal legislation were to not pre-empt state law, it has the potential to create new standards that states with existing “surprise” bill laws may seek to match; therefore be it

RESOLVED, That our American Medical Association advocate that any federal legislation on “surprise” out of network medical bills be consistent with AMA Policy H-285.904, “Out-of-Network Care,” and apply to ERISA plans not subject to state regulation (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that such federal legislation protect state laws that do not limit surprise out of network medical bills to a percentage of Medicare or health insurance fee schedules. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/10/18

RELEVANT AMA POLICY

Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:
   A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
   B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
   C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
   D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
   E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
   F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
   G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
   H. Mediation should be permitted in those instances where a physician's unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

Citation: Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18
Whereas, As of 2016 78% of physicians and 96% of hospitals routinely use electronic health records (EHRs) during care,1 and nationally only half of hospitals have necessary patient information electronically available from providers or sources outside their systems at the point of care;2; and

Whereas, Accessing patient data through a health information exchange (HIE) in an emergency department has been shown to reduce hospital admissions, and decrease unneeded diagnostic imaging and procedures3; and

Whereas, An HIE increases provider access to data necessary for treatment such as results of tests conducted in another health care practice while lack of exchange may result in duplicate and unnecessary testing3-6; and

Whereas, An HIE has been shown to reduce net annual costs for patient care, even after accounting for costs related to the HIE,3,7 and cost reductions are seen in healthcare markets that have operational HIEs caring for Medicare patients8,9; and

Whereas, Clinicians across the country need ready access to data from clinical settings outside their own to deliver cost effective, non-duplicative care for their patients; and to be competitive in new payment arrangements that incentivize coordinated care, reduction in unneeded testing and imaging, and a view of the health of their patient in and outside of the clinical setting; therefore be it

RESOLVED, That our American Medical Association review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/11/18
References
Whereas, Our AMA and the state and specialty medical societies of the AMA federation are committed to working with the Centers for Medicare and Medicaid Services (CMS) to reduce provider burden and increase Medicare beneficiaries’ access to appropriate care; and

Whereas, CMS is to be commended for recognizing the problems with the current evaluation and management documentation guidelines and codes, and for including a significant proposal to address them in the CY 2019 Medicare physician fee schedule proposed rule; and

Whereas, CMS in its physician fee schedule proposed rule put forward a plan to cut and consolidate evaluation and management services, which would severely reduce Medicare patients’ access to care by cutting payments for complex office visits, adversely affecting the care and treatment of patients with complex conditions; and

Whereas, The proposals to consolidate the billing codes for physician evaluation and management so as to pay the same amount for office visits regardless of the complexity of the patient would cut payments for visits that are currently reimbursed at higher levels than simple or routine office visits, penalizing doctors who treat sicker or complex patients, or patients with multiple conditions; and

Whereas, Payments from newly proposed add-on codes, which have been put forward with the intention of protecting complex care by making up for severe cuts, are not certain and likely would not be sufficient to ensure continued patient access, and moreover the application of new codes to some specialties and not others would effectively result in CMS picking winners and losers; and

Whereas, We agree with CMS’ ultimate goal of increasing the amount of time physicians have to spend with patients instead of paperwork and computers, but the collapsing of evaluation and management codes would have an immediate and lasting effect of restricting patient access to care; and
Whereas, CMS is expected to release the CY 2019 physician fee schedule final rule in November of 2018, less than two months ahead of the proposed implementation date of January 1, 2019; and

Whereas, Given the negative impacts of this well-intentioned proposal, CMS should not finalize these concepts as proposed; and

Whereas, The physician community stands ready to work with CMS to identify alternative approaches that would accomplish its goal of reducing paperwork and administrative burden without endangering patient access to care, and while ensuring that physicians have the resources they need to provide patients with the high-quality care they deserve; therefore be it

RESOLVED, That our American Medical Association actively seek and support congressional action before January 1, 2019 that would prevent implementation of changes to consolidate evaluation and management services as put forward in the CY 2019 Medicare physician fee schedule proposed rule if CMS in the final rule moves forward with the consolidation of evaluation and management services. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/11/18

RELEVANT AMA POLICY

Medicare Guidelines for Evaluation and Management Codes H-70.952
Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services; (2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse; (3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians; (4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS); (5) will facilitate review and corrective action regarding the excessive content of the evaluation and management documentation guidelines in collaboration with the national medical specialty societies and to work to suspend implementation of all single system examination guidelines until approved by the national medical specialty societies affected by such guidelines; (6) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS; (7) urges CMS to establish a test period in a specific geographic region for these new guidelines to determine any effect their implementation will have on quality patient care, cost effectiveness and efficiency of delivery prior to enforcement of these mandated regulations; (8) opposes adoption of the Medicare evaluation and management documentation guidelines for inclusion in the CPT; and (9) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required.
Citation: (Sub. Res. 801, I-97; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10)

Preservation of Evaluation/Management CPT Codes H-70.985
It is the policy of the AMA to (1) oppose the bundling of procedure and laboratory services within the current CPT Evaluation/Management (E/M) services; (2) oppose the compression of E/M codes and support efforts to better define and delineate such services and their codes; (3) seek feedback from its members on insurance practices that advocate bundling of procedures and
laboratory services with or the compression of codes in the CPT E/M codes, and express its views to such companies on behalf of its members; (4) continue to work with the PPRC and all other appropriate organizations to insure that any modifications of CPT E/M codes are appropriate, clinically meaningful, and reflective of the considered views of organized medicine; and (5) work to ensure that physicians have the continued opportunity to use CPT as a coding system that is maintained by the medical profession.

Citation: (Sub. Res. 98, A-90; Reaffirmed by Res. 850, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10)

**Preservation of Five Levels of Evaluation and Management Services D-70.979**

Our AMA will communicate to the Centers for Medicare and Medicaid Services and to private payers that the current levels of Evaluation and Management services should be maintained and not compressed, with appropriate payment for each level.

Citation: Sub. Res. 804, I-01; Reaffirmation A-06; Reaffirmed in lieu of Res. 823, I-06; Modified: CMS Rep. 01, A-16
EXECUTIVE SUMMARY

Older physicians remain an essential part of the physician workforce as they continue to practice into their 70s and 80s. Although some studies of physicians have shown decreasing practice performance with increasing years in medical practice, the effect of age on any individual physician’s competence can be highly variable. The call for increased accountability by the public has led regulators and policymakers to consider implementing some form of age-based competency screening to assure safe and effective practice. In addition, some hospitals and medical systems have initiated age-based screening, but there is no national standard. Older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice. It is critical that physicians take the lead in developing standards for monitoring and assessing their personal competency and that of fellow physicians to head off a call for nationally implemented mandatory retirement ages or imposition of guidelines by others that are not evidenced based.

The Council on Medical Education studied this issue and prepared its first report on this topic in 2015. American Medical Association (AMA) Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” was adopted and the Council, in collaboration with the Senior Physicians Section, identified organizations to work together to develop preliminary guidelines for screening and assessing the competency of the senior/later career physician. The AMA Work Group on Assessment of Senior/Late Career Physicians included key stakeholders that represented physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other health care institutions, and patients’ advocates as well as content experts who research physician competence and administer assessment programs.

The work group concurred that it was important to investigate the current screening practices and policies of the state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs as well as to collect data and review the current literature to learn more about age and risk factors associated with the assessment of senior/later career physicians in the United States and internationally. This report summarizes the activities of the work group and additional research findings on this topic.

This report also outlines a set of guiding principles developed by the Council with extensive feedback from members of the work group as well as from other content experts who research physician competence and administer assessment programs. The guiding principles provide direction and serve as a reference for the development of guidelines for screening and assessing senior/later career physicians. The underlying assumption is that guidelines must be based on evidence and on the principles of medical ethics. Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not result in undue cost or burden to senior physicians. The primary driver for the establishment of guidelines should be to fulfill the ethical obligation of the profession to the health of the public and patient safety.
American Medical Association (AMA) Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” directs our AMA to: “1) identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior/late career physicians remain able to provide safe and effective care for patients; and 2) convene organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings.”

The first report on this topic, Council on Medical Education Report 5-A-15, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” recommended that a work group be convened to further study the topic of assessing the competency of senior/late career physicians. This report summarizes the activities of the work group and additional research findings on this topic. This report also outlines a set of guiding principles to provide direction and serve as a reference for the development of guidelines for screening and assessing senior/later career physicians.

BACKGROUND: SCOPE OF THE ISSUE

Older physicians remain an essential part of the physician workforce. The total number of physicians 65 years and older has increased greatly from 50,993 in 1975 to 300,752 in 2017.1 Physicians 65 and older currently represent 26.6 percent of all physicians in the United States.1 Within this age group, two-fifths (40.6 percent) are actively engaged in patient care, while half (52.7 percent) are listed as inactive in the AMA Physician Masterfile.1 Many physicians are hesitant to retire and may continue to practice into their 70s and 80s due to professional satisfaction, increased life expectancy, and concerns regarding financial security.2

Evidence supports findings that physical health and some cognitive abilities decline with aging.3 Research shows that cognitive dysfunction is more prevalent among older adults, although aging does not necessarily result in cognitive impairment.4 The effect of age on any individual physician’s competence can be highly variable, and aging is just one of several factors that may impact performance.2,5 Other factors may influence clinical performance, i.e., practice setting, lack of board certification, high clinical volume, certain specialty practices, etc.6,7 Fatigue, stress, burnout, and health issues unrelated to aging are also risk factors that can affect clinical performance.7 Performance also may be broadly determined by characteristics ranging from intelligence to personality.3 However, some attributes relevant to the practice of medicine—such as
wisdom, resilience, compassion, and tolerance of stress—may actually increase as a function of aging.\textsuperscript{5,8-11}

Although age alone may not be associated with reduced competence, the variation around cognitive abilities as physicians age suggests that the issue cannot be ignored. There are a limited number of valid tools for measuring competence/performance, but these tools are primarily used when a physician is “referred for cause.” In addition, physicians’ practices vary throughout the United States and from specialty to specialty. A few hospitals have introduced mandatory age-based evaluations, but there is no national standard.\textsuperscript{12-13} Furthermore, there is cultural resistance to externally imposed assessment approaches and concern about discriminatory regulatory policies and procedures.

Knowing when to give up practice remains an important decision for most doctors and a critically difficult decision for some.\textsuperscript{14} For this reason, physicians with decades of experience and contributions to medicine and to their patients, as they experience health changes that may or may not allow continued clinical practice, deserve the same sensitivity and respect afforded their patients.\textsuperscript{15} Shifting away from procedural work, allocating more time with individual patients, using memory aids, and seeking input from professional colleagues might help physicians successfully adjust to the cognitive changes that accompany aging.\textsuperscript{5,14}

It is in physicians’ best interest to proactively address issues related to aging in order to maintain professional self-regulation. Self-regulation is an important aspect of medical professionalism, and helping colleagues recognize their declining skills is an important part of self-regulation.\textsuperscript{16} Furthermore, contemporary methods of self-regulation (e.g., clinical performance measurement; continuing professional development requirements, including novel performance improvement continuing medical education programs; and new and evolving maintenance of certification programs) have been created by the profession to meet shared obligations for quality assurance and patient safety.

WORK GROUP MEETINGS

To fulfill the directive of Policy D-275.956, the Council on Medical Education, in collaboration with the Senior Physicians Section, identified organizations to participate in a joint effort to develop preliminary guidelines for screening and assessing the senior/late career physician. As summarized below, one work group meeting and two conference calls were convened to develop a research agenda that could guide those interested in this field and serve as the basis for guidelines supported by research findings.

March 16, 2016 Work Group Meeting

The work group meeting, held March 16, 2016, brought together key stakeholders that represented physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other health care institutions, and patients’ advocates as well as content experts who research physician competence and administer assessment programs. Work group participants concurred that this first meeting raised important issues related to the rationale for developing guidelines to screen and assess the competence and practice performance of senior physicians, which are challenging for a number of reasons. Discussion centered around the evidence and factors related to competency and aging physicians, existing and needed policies, screening and assessment approaches, and legal requirements and challenges. Although current evidence and preliminary research pointed toward the need for developing guidelines, most work group participants felt that additional information/data should be gathered on aging physicians’ competence and practice performance. In
addition, the participants felt that a set of guiding principles should be developed to reflect the values and beliefs underlying any guidelines that may be developed for screening and assessing senior/late career physicians.

**July 19, 2016 Work Group Conference Call**

The purpose of this conference call was to convene a smaller group of participants to develop guiding principles to support the subsequent development of guidelines to screen and assess senior/late career physicians. During the call, the conversation focused upon the thresholds at which screening/assessment should be required. Although physicians of all ages can be assessed “for cause,” the group discussed whether age alone is a sufficient cause for some kind of monitoring beyond what is typical for all physicians. Other factors discussed included the influence of practice setting and medical specialty, as well as the metrics and standards for different settings that would have to be developed to determine at “what age” and “how do you test,” etc. The need for surveillance, associated risk factors, and the ability to take appropriate steps, if needed, were also discussed. It was noted that there is a need to be able to fairly and equitably identify physicians who may need help while assuring patient safety. It was also noted that very few hospitals have specific age guidelines, and that there was evidence that the number of disciplinary actions increase at ages 65 and 70. The cost of and who will pay for screening/assessments were also discussed.

The group felt that more information and data were needed before the guiding principles could be finalized and agreed to reconvene after gathering more information and studying evidence-based data from the United States and other countries related to age and risk factors.

**December 15, 2017 Work Group Conference Call**

The purpose of this conference call was to reconvene the same smaller group of participants to review the literature and data that had been gathered, and to finalize guiding principles to support the subsequent development of guidelines to screen and assess senior/late career physicians. Background information to help guide the development of the guiding principles included:

1. Results from a survey of members of the Federation of State Medical Boards (FSMB), Council of Medical Specialty Societies (CMSS), and International Association of Medical Regulatory Authorities (IAMRA) regarding the screening and assessment of senior physicians.

2. A literature review of available data related to senior physician screening and assessment, focusing on international work in this area.

3. Data from large health systems regarding their screening and assessment policies and procedures.

**Survey Results Related to Screening and Assessing Senior Physicians**

To support the development of guiding principles, data were gathered through surveys of professional associations (CMSS), state medical boards (FSMB), and international regulatory authorities (IAMRA). The goal was to learn if these organizations had processes in place to screen and assess senior physicians for clinical or cognitive competence, and if not, whether they had thought about developing such screening and assessment processes.
The survey data showed that most respondents were not screening or assessing senior physicians. A slightly larger number of respondents have thought about this, but those numbers were still fairly small.

Most respondents did not have clinical or cognitive screening/competence assessment policies in place. In addition, most did not know (42, or 46.7 percent) or were unsure (26, or 28.9 percent) whether other organizations had age-based screening in place. Regarding whether age-based screening should be included within physician wellness programs, 28 (32.9 percent) said yes, while nine (10.6 percent) said no, and 48 (56.5 percent) were unsure.

Respondents were asked if their organizations/boards offered educational resources regarding the effects of age on physician practice; eight (9.2 percent) said yes, 72 (82.8 percent) said no, and seven (8.0 percent) were unsure. The survey also asked organizations if they were interested in having resources that promoted physician awareness of screening aging physicians in practice. Very few groups offered these types of resources, but 100 percent (11) of IAMRA respondents, 60.8 percent (31) of FSMB respondents, and 25 percent (3) of CMSS respondents were interested in offering them.

Highlights from the Literature Review

A review of current literature focusing on age and risk factors associated with the assessment of senior/later career physicians in the United States and internationally is summarized below. Peer-reviewed studies recently published focus on institutional policies related to cognitive assessment of senior physicians. Dellinger et al. concluded that as physicians age, a required cognitive evaluation combined with a confidential, anonymous feedback evaluation by peers and coworkers regarding wellness and competence would be beneficial both to physicians and their patients.17 The authors also recommended that large professional organizations identify a range of acceptable policies to address the aging physician, while leaving institutions the flexibility to customize the approach.17 Institutions such as Cooper University Health Care in Camden, New Jersey, are developing late career practitioner policies that include cognitive assessment with peer review and medical assessment to assure the hospital and physicians that competency is intact and that physicians can continue to practice with confidence.18

Studies related to professionalism, self-reporting, and peer review indicate that these methods are not always reliable.16, 19-20 Since early “red flags” of cognitive impairment may include prescription errors, billing mistakes, irrational business decisions, skill deficits, patient complaints, office staff observations, unsatisfactory peer review, patient injuries, or lawsuits, Soonsawat et al. encouraged improved reporting of impaired physicians by patients, peers, and office staff.2 LoboPrabhu et al. suggested that either age-related screening for cognitive impairment should be initiated, or rigorous evaluation after lapses in standard of care should be the norm regardless of age.21

Any screening process needs to achieve a balance between protecting patients from harm due to substandard practice while at the same time ensuring fairness to physicians and avoiding any unnecessary reductions in workforce.3 A recent study of U.S. senior surgeons showed that a steady proportion of surgeons, even in the oldest age group (>65), are still active in new surgical innovations and challenging cases.22 Individual and institutional considerations require a dialogue among the interested parties to optimize the benefits while minimizing the risks for both.23-24

In Canada, the aging medical workforce presents a challenge for medical regulatory authorities charged with protecting the public from unsafe practice. Adler and Constantinou note that normal
aging is associated with some cognitive decline as part of the aging process, but physicians, who are highly educated individuals with advanced degrees may be less at risk.14

A review of the aging psychiatric workforce in Australia showed how specific cognitive and other skills required for the practice of psychiatry vary from those applied by procedural specialists.25 The Australian medical boards are responsible for protecting the public from unsafe medical practice. There is some uniformity in the way that Australian regulatory bodies deal with impairment that supports the dual goals of protecting the public and rehabilitating the physician.26 However, there are no agreed upon guidelines to help medical boards decide what level of cognitive impairment in a physician may put the public at risk.14 In Australia, the primary approach to dealing with older physicians (age 55 and older) is individualized and multi-levelled, beginning with assessment, followed by rehabilitation where appropriate; secondary measures proposed for older impaired physicians include early notification and facilitating career planning and timely retirement.26

It is the responsibility of licensing bodies in New Zealand, Canada, and the United Kingdom to use reasonable methods to determine whether performance remains acceptable.27 However, high performance by all physicians throughout their careers cannot be fully ensured.

A better understanding of physician aging and cognition can inform more effective approaches to continuous professional development and lifelong learning in medicine—a critical need in a global economy, where changing technology can quickly render knowledge and skills obsolete.9 The development of recertification programs, such as maintenance of certification (MOC) by the member boards of the American Board of Medical Specialties, provides an opportunity to study the knowledge base across the professional lifespan of physicians.28-29 For example, a recent study of initial certification and MOC examinees in the subspecialty of forensic psychiatry using a common item test question bank compared the two examinee groups’ performance and demonstrated that performance for those younger than 50 was similar to those 60 and older, and that diplomates recertifying for the second time outperformed those doing so for the first time.30

The Royal Australasian College of Surgeons developed strategies to support senior surgeons over 65 years of age (expected to be about 25 percent of surgeons by 2050) and a position statement that provides clear guidelines to aging surgeons, with a focus on continuing professional development.31-32 An assessment of the competence of practicing physicians in New Zealand, Canada, and the United Kingdom showed that “maintenance of professional standards” by continuing education did not identify the poorly performing physician; rather, assessment of clinical performance was needed.27 The most common approach to assessment may be responsive—following a complaint—or periodic, either for all physicians or for an identified high-risk group. However, a single, valid, reliable, and practical screening tool is not available.27

A literature review conducted in Europe to explore the effects of aging on surgeons’ performance and to identify current practical methods for transitioning surgeons out of practice at the appropriate time and age, suggested that competence should be assessed at an individual level, focusing on functional ability over chronological age; this may inform retirement policies for surgeons, which differ worldwide.22 Research conducted in Canada suggested that some interventions (external support, deliberate practice, and education and testing) might prove successful in remediating older physicians, who should be tested more thoroughly.33

Careful planning, innovative thinking, and the incorporation of new patterns of medical practice are all part of this complex transition of timing into retirement in the United States.23,34 A literature review that looked at retirement ages for doctors in different countries found that there is no
mandatory retirement age for doctors in most countries. Anecdotal reports published in the British Medical Journal suggest that retirement has never been easy and is getting harder for some physicians because requirements for reappraisal and other barriers are discouraging some from considering part-time work after retirement. In Canada, Ireland, and India, the retirement age (65) is limited to public sectors only, but older physicians can continue to practice in the private sector. In Russia and China, the mandated retirement age is 60 for men and 55 for women.

Studies show that doctors can mitigate the impact of cognitive decline by ceasing procedural work, allocating more time to each patient, using memory aids, seeking advice from trusted colleagues, and seeking second opinions. Peisah, et al. (Australia) proposed a range of secondary and primary prevention measures for dealing with the problem of the older impaired doctor; these included educating the medical community, encouraging early notification, and facilitating career planning and timely retirement of older doctors. Racine (Canada) suggested that physicians retire before health or competency issues arise. Lee (Canada) suggested that older practicing physicians consider slowing down in aspects of practice that require rapid cognitive processing and listen carefully to the concerns of colleagues, patients, friends, and family. The University of Toronto, Department of Surgery, has developed Guidelines for Late Career Transitions that require each full-time faculty surgeon to undergo an annual assessment of academic and surgical activity and productivity. As surgeons age, the University creates individual plans for a decrease in on-call surgical responsibilities and encourages late-career surgeons to engage in greater levels of teaching, research, and administration.

How Some U.S. Organizations Are Addressing the Screening and Assessment of Competency of Senior Physicians

Since the call for increased accountability by the public has led regulators and policymakers to consider implementing some form of age-based competency screening to assure safe and effective practice, the work group concurred that it was important to investigate the current screening practices and policies of state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs. Some of the more significant findings are summarized below.

All physicians must meet state licensure requirements to practice medicine in the United States. In addition, some hospitals and medical systems have initiated age-based screening, but there is no national standard. Older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice.

The American College of Surgeons (ACS) explored the challenges of assessing aging surgeons. Recognizing that the average age of the practicing surgeon is rising and approximately one-third of all practicing surgeons are 55 and older, the ACS was concerned that advanced age may influence competency and occupational performance. In January 2016, the ACS Board of Governors’ Physician Competency and Health Workgroup published a statement that emphasized the importance of high-quality and safe surgical care. The statement recognized that surgeons are not immune to age-related decline in physical and cognitive skills and stressed the importance of a healthy lifestyle. The ACS recommended that, starting at ages 65 to 70, surgeons undergo a voluntary and confidential baseline physician examination and visual testing for overall health assessment, with regular reevaluation thereafter. In addition, the ACS encouraged surgeons to voluntarily assess their neurocognitive function using confidential online tools and asserted a professional obligation to disclose any concerning findings, as well as inclusion of peer review reports in the re-credentialing process.
The American College of Obstetricians and Gynecologists (ACOG) recommends that when evaluating an aging physician, focus should be placed on the physician’s quality of care provided to patients. ACOG’s recommendations regarding the later-career obstetrician–gynecologist also state that: 1) it is important to establish systems-based competency assessments to monitor and address physicians’ health and the effect age has on performance and outcomes; 2) workplace adaptations should be adopted to help obstetrician–gynecologists transition and age well in their practice and throughout their careers; and 3) to avoid the potential for legal challenges, hospitals should address the provisions of the Age Discrimination in Employment Act, making sure that assessments are equitably applied to all physicians, regardless of age.

At Kaiser Permanente, within its Permanente Medical Group, physicians are classified as “in partnership” or “incorporated.” In a region where a partnership exists, such as Southern California, the mandatory retirement age as a partner is at the end of the calendar year when one turns 65. Southern California Permanente Medical Group has approximately 3,000 partners, of which 300 retire each year at full retirement age. In the incorporated regions, there is no mandatory retirement for clinicians. In the partnership regions, retired physicians (partners emeritus) may apply for employment at age 66, but they are not guaranteed employment. If granted employment, these physicians see a dramatic decrease in remuneration, and they are usually not required to have a patient panel. Rehiring is at the discretion of the medical director and the budget. Therefore, a limited number of opportunities are available. Approximately 10 percent of these physicians apply for rehiring, and approximately 15 to 20 percent of those are rehired. They are usually limited to no more than 20 hours per week performing either clinical or administrative work. As a result, very few Permanente physicians work until age 70 or older.

The University of California, San Diego, Physician Assessment and Clinical Education (PACE) Program is the largest assessment and remediation program for health care professionals in the country. Recently, PACE conducted a pilot screening project to assess physicians. Thirty volunteer physicians, aged 50 to 83, were recruited to participate in the screening regimen. Preliminary data analysis showed that a number of senior physicians performed less than optimally (seven of 30 participants). However, when age-based capacity was reviewed (i.e., did those individuals between 50 to 59 or those between 60 to 69 years old perform better than those age 70 and older), the results were not statistically significant. The pilot study did have sufficient power to reach significance. However, the trend of the data was that older physicians did perform less optimally. It was also noted that 75 percent of the physicians who didn’t perform well on the MicroCog (a computerized assessment that detects early signs of cognitive impairment) were still working in a clinical capacity. The study did not include enough participants to provide a breakdown on specialties.

PROPOSED GUIDING PRINCIPLES

The Council on Medical Education proposes a set of guiding principles as a basis for developing guidelines for the screening and assessment of senior/later career physicians. The underlying assumption is that guidelines must be based on evidence and on the principles of medical ethics. Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not result in undue cost or burden to senior physicians. The primary driver for the establishment of guidelines should be to fulfill the ethical obligation of the profession to the health of the public and patient safety.

The Council developed the following eight guiding principles with extensive feedback from members of the AMA Work Group on Assessment of Senior/Late Career Physicians as well as feedback from other content experts who research physician competence and administer screening and assessment programs.
1. **Evidence-based:** The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician’s competency can be highly variable, and wide variations are seen in cognitive performance with aging.

2. **Ethical:** Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues’ competency.

3. **Relevant:** Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians’ ability to perform the tasks specifically required in their practice environment.

4. **Accountable:** The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.

5. **Fair and equitable:** The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians’ practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome.

6. **Transparent:** Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment.

7. **Supportive:** Education and/or remediation practices that result from screening and/or assessment procedures should be supportive of physician wellness, ongoing, and proactive.

8. **Cost conscious:** Procedures and screening mechanisms that are distinctly different from “for cause” assessments should not result in undue cost or burden to senior physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed senior physicians. Similar procedures and screening mechanisms should be available to senior physicians who are not employed by hospitals and health care systems.

**AMA POLICY**

The AMA has policy in which it urges members of the profession to discover and rehabilitate if possible, or exclude if necessary, the physicians whose practices are incompetent, and to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, are in need of help or whose practices are incompetent (H-275.998). AMA policy urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions
that impair a physician’s current ability to practice medicine (H-275.978[6]). AMA policy also reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and CME activities (H-300.973 and H-275.996). These and other related policies are attached (see Appendix).

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education concurs that physicians should be allowed to remain in practice as long as patient safety is not endangered, and they are providing appropriate and effective treatment. However, data and anecdotal information support the development of guidelines for the screening and assessment of senior/late career physicians. The variations around cognitive skills as physicians age, as well as the changing demographics of the physician workforce, are also key factors contributing to this need. It is critical that physicians take the lead in developing standards for monitoring and assessing their personal competency and that of fellow physicians to head off a call for nationally implemented mandatory retirement ages or imposition of guidelines by others. The guiding principles outlined in this report provide direction and serve as a reference for setting priorities and standards for further action.

The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed.

1. That our American Medical Association (AMA) make available to all interested parties the Assessment of Senior/Late Career Physicians Guiding Principles:

   a) Evidence-based: The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician’s competency can be highly variable, and wide variations are seen in cognitive performance with aging.

   b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues’ competency.

   c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians’ ability to perform the tasks specifically required in their practice environment.

   d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.

   e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians’ practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome.

   f) Transparent: Guidelines, procedures or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment.
g) Supportive: Education and/or remediation practices that result from screening and/or assessment procedures should be supportive of physician wellness, ongoing, and proactive.

h) Cost conscious: Procedures and screening mechanisms that are distinctly different from “for cause” assessments should not result in undue cost or burden to senior physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed senior physicians. Similar procedures and screening mechanisms should be available to senior physicians who are not employed by hospitals and health care systems. (New HOD Policy)

2. That our AMA encourage the Federation of State Medical Boards, Council of Medical Specialty Societies, and other interested organizations to develop educational materials on the effects of age on physician practice for senior/late career physicians. (Directive to Take Action)

3. That Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: $1,000
APPENDIX: AMA POLICIES

D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians”

Our American Medical Association: (1) will identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior/late career physicians remain able to provide safe and effective care for patients; and (2) will convene organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings. (CME Rep. 5, A-15)

H-275.936, “Mechanisms to Measure Physician Competency”

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency. (Res. 320, I-98 Amended: Res. 817, A-99 Reaffirmed: CME Rep. 7, A-02 Reaffirmed: CME Rep. 7, A-07 Reaffirmed: CME Rep. 16, A-09 Reaffirmed in lieu of Res. 313, A-12 Modified: Res. 309, I-16)

H-275.996, “Physician Competence”

Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-regISTRATION of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10; Reaffirmed in lieu of Res. 320, A-14)

H-275.998, “Physician Competence”

Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful. (4) State governments to provide to their state medical licensing boards resources
adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRDP Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CME Rep. 2, A-13)

H-275.978, “Medical Licensure”

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;
(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;
(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;
(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;
(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;
(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and
(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.
REFERENCES

18. Heymann WR. Assessing the competence of aging physicians who are young at heart. *JAMA Dermatology*. 2018;
36. Godlee F. We need to separate “old” and “age.” BMJ. 2013;347:f6823.
37. Jessop JR. We need to get another life after retirement. BMJ. 2013;347:7173.
Whereas, The United States Department of Justice, Antitrust Division, set forth its views on Maryland House Bill 857 in a letter dated September 10, 2018 addressed to Dan K. Morhaim, M.D., a member of the Maryland House of Delegates; and

Whereas, The Division’s letter focused on two questions – first, whether ABMS may harm competition by imposing overly burdensome conditions on physicians who wish to maintain their ABMS certification; and second, what are the policy options available to the Maryland legislature if the legislature concludes that the ABMS Program for Maintenance of Certification (MOC) program harms healthcare competition in Maryland; and

Whereas, The Division’s letter recognized that “more entry and more competition by bona fide certifying bodies may offer important benefits – including lowering the costs for physicians to be certified or improving the quality of certification services – for healthcare providers, consumers, and payers”; and

Whereas, The Division’s letter encouraged the Maryland legislature to consider ways to facilitate competition by legitimate certifying bodies, consistent with patient health and safety, and, towards that end, encouraged drafters of Maryland House Bill 857 to consider ways to allow for entry by additional, legitimate certifying bodies; and

Whereas, Multiple states are pursuing legislation to address issues arising from a lack of competition among bona fide certifying bodies; therefore be it

RESOLVED, That our American Medical Association conduct a study of the certifying bodies that compete with the American Board of Medical Specialties and issue a report opining on the qualifications of each such certifying body and whether each such certifying body should be added to the list of approved certifying entities in states where they are not currently approved (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model state legislation that would encourage competition among qualified certifying bodies and would modify board certification requirements such that maintenance of certification participation would not be a requirement for board recertification. (Directive to Take Action)

Fiscal Note: Estimated cost to implement the resolution is $30,000.

Received: 09/27/18
RELEVANT AMA POLICY

Maintenance of Certification H-275.924
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians’ self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in MOC.

27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.


An Update on Maintenance of Licensure D-275.957

Our American Medical Association will: 1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.

3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.

4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.

5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.

6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.

7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.

8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time.

Citation: (CME Rep. 3, A-15; Modified: CME Rep. 2, I-15)
EXECUTIVE SUMMARY

The site-of-service differential is a longstanding payment policy issue stemming from the Medicare program’s use of separate payment systems in its rate-setting calculations. This report addresses disparities in Medicare Part B payment for covered items and services across outpatient care settings, including the offices of physicians and other health professionals, hospital outpatient departments (HOPDs), and ambulatory surgical centers (ASCs). Most outpatient procedures can be provided across multiple clinical settings, and although the choice of outpatient site for many services has no discernible effect on patient care, it significantly impacts Medicare’s payment for such services and patient cost-sharing expenses. Generally speaking, Medicare pays higher rates for outpatient services performed in hospital facilities than to physician offices or ASCs for furnishing the same service to similar patients. The scope of the payment differential varies, depending on the procedure.

This report describes ongoing disparities in Medicare payment for outpatient procedures across care settings, explains how Medicare determines payments for outpatient services in each setting, compares Medicare physician payment updates to inflation, and summarizes relevant American Medical Association (AMA) policy and activity. The Council recommends reaffirmation of existing AMA policy as well as new policy addressing the site-of-service differential. The Council recommends that the AMA support Medicare payment policies for outpatient procedures that are site-neutral without lowering total Medicare payments. The Council further recommends that the AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting.

While the focus of this report is the site-of-service differential, the Council recognizes that broader physician payment issues must also be addressed. To help build the case for future Medicare payment reforms that support site-neutrality without lowering total Medicare payments, the Council recommends that the AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.
At the 2017 Interim Meeting, the House of Delegates referred Resolution 817-I-17, "Addressing the Site of Service Differential," introduced by the New Mexico Delegation, for report back at the 2018 Annual Meeting. The Board of Trustees assigned this item to the Council on Medical Service. Resolution 817-I-17 asked the American Medical Association (AMA) to:

1) Study the site-of-service differential with a report back no later than the 2018 Interim Meeting, including: a) the rising gap between independent practice expenses and Medicare reimbursement, taking into account the costs of the regulatory requirements; b) the increased cost of medical personnel and equipment, including electronic health record (EHR/EMR) purchase, software requirements, and ongoing support and maintenance; c) the expense of maintaining hospital-based facilities not common to independent practices, such as burn units and emergency departments, and determine what payment should be provided to cover those explicit costs; and d) the methodology by which hospitals report their uncompensated care, and the extent to which this is based on actual costs, not charges; and

2) Advocate for a combined health care payment system for patients who receive care that is paid for by the Centers for Medicare & Medicaid Services (CMS), that: a) follows the recommendation of MedPAC to pay "site-neutral" reimbursement that sufficiently covers practice expenses regardless of whether services are performed under the Hospital Outpatient Prospective Payment System (OPPS) or the Physician Fee Schedule (PFS); b) pays appropriate facility fees for both hospital-owned facilities and independently owned non-hospital facilities, computed using the real costs of a facility based on its fair market value; and c) provides independent practices with the same opportunity to receive reimbursement for uncompensated care as is provided to hospital-owned practices.

This report describes ongoing disparities in Medicare payment for outpatient procedures across care settings, summarizes relevant AMA policy and activity, and presents policy recommendations addressing the outpatient site-of-service differential.

BACKGROUND

The site-of-service differential is a longstanding payment policy issue stemming from the Medicare program’s use of more than a dozen separate payment systems—some of which are based on the location where services are provided—in its rate-setting calculations. Several of these payment systems base payments on the location where services are provided. This report addresses disparities in Medicare Part B payment for covered items and services across outpatient care.
settings, including the offices of physicians and other health professionals, hospital outpatient
departments (HOPDs), and ambulatory surgical centers (ASCs). Most outpatient procedures can be
provided across multiple clinical settings, and although the choice of outpatient site for many
services has no discernible effect on patient care, it significantly impacts Medicare’s payment for
such services and patient cost-sharing expenses. Generally speaking, Medicare pays higher rates
for outpatient services performed in hospital facilities than to physician offices or ASCs for
furnishing the same service to similar patients. The scope of the payment differential varies,
depending on the procedure, and in some cases may be difficult to ascertain because units of
payment differ across payment systems. Furthermore, the payment differential may extend beyond
primary services to entire episodes of care. One analysis found that payments for cardiovascular
imaging, colonoscopy, and evaluation and management services are higher when furnished in
HOPDs, and that the higher payments extend to related services provided to patients as part of
episodes of care associated with these procedures. The variations in payment persisted after
controlling for patient demographic and severity differences, thereby attributing a substantial
portion of the pay disparities to the payment systems themselves.

The Council previously studied aspects of the site-of-service differential—and confirmed that
Medicare payments for many procedures are higher when furnished in HOPDs—during the
Council Report 3-A-13 compared Medicare payments for five common procedures performed
across outpatient settings, and built upon the AMA’s substantial policy supporting site neutrality by
encouraging private payers to incentivize outpatient care delivery in lower-cost settings. Council
Report 3-A-14 found that existing Medicare payment formulas have contributed to growth in the
volume of outpatient services provided in hospitals and hospital-owned facilities, even when these
services can be safely performed in lower-cost settings. Council Report 3-A-14 focused primarily
on equalizing payments between HOPDs and ASCs because payments to these settings are based
on the same Medicare payment system (OPPS), with ASCs paid at lower rates. Developing policy
addressing payment disparities between hospital-owned facilities and independent physician
practices is more complex because, under current statute, the rate-setting for items and services in
these outpatient sites is based on separate Medicare payment systems that calculate payments for
different units of service.

Medicare Payment Rates for Off-Campus Provider-Based Hospital Departments

For many years, higher payments to HOPDs likely incentivized the sale of physician practices and
ASCs to hospitals because acquired facilities meeting certain criteria (eg, located within 35 miles
of the hospital) were routinely converted to HOPDs and allowed to charge higher OPPS rates for
services performed at these off-campus facilities. However, a provision in the Bipartisan Budget
Act of 2015 (BBA) disallowed provider-based billing by hospitals for newly acquired physician
practices and ASCs. The Congressional Budget Office estimated in 2015 that this provision would
save $9.3 billion over 10 years. Beginning in 2017, off-campus entities acquired after enactment
of the BBA—in November 2015—were no longer permitted to bill for services under the OPPS,
and instead required to bill under the applicable payment system (PFS). Since 2017, CMS has paid
for services at non-excepted off-campus provider-based hospital departments using a PFS relativity
adjuster that is based on a percentage of the OPPS payment rate. Currently, CMS regulations
stipulate that these services be paid 40 percent of OPPS payment rates, although provider-based
departments acquired prior to November 2015 continue to bill under the OPPS. In July 2018, CMS
proposed extending site-neutral payments to include clinic visits provided at off-campus provider-
based hospital departments acquired prior to November 2015, that were excepted from the BBA
provision. CMS proposed to reduce payment rates for clinic visits at hospital-owned physician
practices located off the hospital campus from $116 with $23 cost-sharing to $46 with $9 cost-sharing. At the time this report was written, the CMS proposal had not been finalized.

Hospital Employment of Physicians

It is possible that Medicare payment reductions for services provided at off-campus provider-based hospital departments acquired after November 2015 have contributed to a leveling off of hospital acquisitions of physician practices. Data from the AMA’s 2012, 2014, and 2016 Physician Practice Benchmark Surveys, which yield nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week, demonstrate recent stability in the ownership structure of physician practices. Analyses of the surveys found that the share of physicians who worked directly for a hospital or in practices that were at least partially owned by a hospital remained unchanged between 2014 and 2016—at 33 percent. This percentage represented an increase from 29 percent in 2012. Although detailed information on practice ownership structure is not available for years prior to 2012, research suggests that in 2007-2008, only 16 percent of physicians worked directly for a hospital or in practices that were at least partially owned by a hospital.

Medicare Payment Systems for Outpatient Services

The separate methodologies used for rate-setting under the OPPS and the PFS are at the root of the outpatient site-of-service differential (see Table 1). Under current law, Medicare’s payment systems do not account for the fact that many outpatient services can be provided safely and at lower cost to Medicare and patients outside of the hospital setting. Because there is no linkage between OPPS and PFS payment systems, Medicare may pay dramatically different rates for the same services based on whether they are provided in hospital facilities or physician offices.

<table>
<thead>
<tr>
<th>Site</th>
<th>Physician Office</th>
<th>Hospital Outpatient Department</th>
<th>Ambulatory Surgical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment System</td>
<td>Physician fee schedule (non-facility rate)</td>
<td>Physician fee schedule (facility rate) plus OPPS rate</td>
<td>Physician fee schedule (facility rate) plus ASC payment system (based on relative weight under the OPPS)</td>
</tr>
<tr>
<td>Basis for Updates</td>
<td>Medicare Access and CHIP Reauthorization Act (MACRA)</td>
<td>Hospital market basket</td>
<td>Consumer price index for all urban consumers</td>
</tr>
<tr>
<td>Unit of Payment</td>
<td>Individual service</td>
<td>Ambulatory payment classification</td>
<td>Ambulatory payment classification</td>
</tr>
</tbody>
</table>

For services furnished in physician and other practitioner offices, Medicare pays for units of service billed under the PFS. There is a single payment for each service which amounts to 80 percent of the PFS rate, with the patient responsible for cost-sharing that covers the remaining 20 percent. For procedures provided in hospital outpatient departments, Medicare pays a reduced physician fee under the PFS plus a facility fee established under the OPPS. Patients are responsible for cost-sharing associated with both the physician fee and the facility fee. Whereas providers generally receive separate payments for each service under the PFS, services paid under the OPPS
are grouped together into ambulatory payment classifications based on clinical and cost
similarities.

Formulas unique to each payment system are then used to annually adjust payment rates for
inflation, which may actually widen existing payment disparities. HOPD updates are based on the
hospital market basket, and annual updates to the PFS were established by MACRA. The Medicare
program currently uses the consumer price index for all urban consumers (CPI-U) to annually
update ASC payment rates, although—consistent with AMA policy—CMS recently proposed
updating ASC rates using the hospital market basket instead of the CPI-U for a five-year period. If
this proposal is finalized, CMS will examine whether the change incentivizes a migration of
services to lower-cost ASC settings over the five-year period.

Medicare Physician Payment Updates Compared to Inflation

Medicare payments for physician services have for many years failed to keep pace with the actual
costs of running a practice. From 2001 to 2017, Medicare physician pay rose just six percent
(0.4 percent per year on average), although Medicare’s index of inflation in the cost of running a
practice increased 30 percent (1.7 percent per year on average). Economy-wide inflation, as
measured by the Consumer Price Index, has increased 39 percent over this time period.9 Adjusted
for inflation in practice costs, Medicare physician pay has declined 19 percent from 2001 to 2017,
or by 1.3 percent per year on average.

During the same time period, Medicare hospital pay has increased roughly 50 percent, with average
annual increases of 2.6 percent per year for inpatient services, and 2.5 percent per year for
outpatient services. Medicare skilled nursing facility pay has increased 51 percent between 2001
and 2017, or 2.6 percent per year.10 There are some significant differences between hospitals and
physician practices that may lead to higher costs of providing care in HOPDs. For example,
hospitals maintain operations 24/7, and also standby capacity for handling emergencies, although
payment for standby costs is included in Medicare’s payment for emergency department services.11

Uncompensated/Inadequately Compensated Physician Practice Expenses

The need for sustainable physician payments under the Medicare program is compounded by
numerous uncompensated administrative tasks that are extremely costly to practices and reduce
time spent with patients, yet increase the work necessary to provide medical services. CMS alone
publishes thousands of pages of regulations affecting physician practices every year, including
rules governing the reporting of quality measures, the Recovery Audit Contractor (RAC) Program,
MACRA implementation, and Medicare’s numerous payment systems. Utilization management has
become so burdensome that in 2017 the average physician reported completing 29 prior
authorizations per week, a process that required 14.6 hours of work or the equivalent of two
business days.12 In addition to navigating a plethora of payer protocols and utilization management
requirements, physician practices have to purchase, manage and update electronic health records
(EHRs) to document the care they are providing. Incorporating EHR technology into practice
workflows is costly and consumes a significant amount of physician time that could otherwise be
spent with patients. Notably, a 2016 Annals of Internal Medicine study found that, for every hour
of clinic time spent with patients, physicians spend approximately two hours per day during office
hours, and another one to two hours outside of office hours, on EHR and desk work.13 According to
a 2016 Health Affairs study, physician practices across four common specialties spend over $15.4
billion annually to report quality measures, with physicians on average spending 2.6 hours per
week on these measures.14 Many physician practices also provide high-technology outpatient
services (ie, infusions and/or imaging) that were once the domain of hospitals and for which practices are not adequately compensated under the PFS.

Hospitals that treat a disproportionate share of low-income patients receive additional payments to offset the financial effects of treating these patients. Traditionally, disproportionate share hospital (DSH) payments were based on hospitals’ share of Medicaid patients and Medicare patients with Social Security Disability Insurance. Beginning in 2014, DSH payments were calculated as 25 percent of that payment amount, and hospitals also began receiving uncompensated care payments from a pool of funds equal to 75 percent of the DSH payment received under the traditional formula, minus an amount that increases in proportion to decreases in the uninsured population. Part of this pool is distributed to hospitals based on the share of uncompensated care they provide. Physician practices are not eligible for either DSH or uncompensated care payments, despite the fact that most physicians (89 percent) treat Medicare patients and, in 2016, most also had Medicaid (82.6 percent) and uninsured (75.6 percent) patients. There have been questions as to whether Medicare DSH and uncompensated care payments are appropriate proxies for the amount of uncompensated care provided by hospitals, and Medicare Payment Advisory Commission (MedPAC) has recommended that uncompensated care payments to hospitals be based on actual uncompensated care data.

Expert Policy Recommendations for Reducing Payment Variations

To address shifts in outpatient care to higher cost sites-of-service (eg, hospital-owned facilities), which increase costs to the Medicare program and its patients, several policy options have been proposed to equalize payments across settings for certain services. After the MedPAC found that payments to HOPDs for 15-minute evaluation and management visits were 80 percent higher than payments to physician offices for the same service, it recommended in 2012 that HOPD payments for these services be reduced to physician office rates. In 2014, MedPAC recommended that differences in payment rates between HOPDs and physician offices be eliminated by reducing HOPD rates for 66 ambulatory payment classifications. These groups of services were selected by MedPAC based on patient severity being similar in HOPDs and physician offices, and because they are frequently furnished in physician offices.

A 2011 RAND Health analysis examined several policy options for addressing Medicare payment differentials across outpatient sites, such as increasing uniformity in the units of service across payment systems, and basing payment rates on the least costly setting. This analysis concluded that basing payment differentials on justifiable cost differences would promote payment equity across outpatient sites-of-care and value-based care, but would also be administratively burdensome. Determining justifiable cost differences would also be impractical.

The Office of the Inspector General (OIG) has also recommended reductions in HOPD payment rates to those of less costly settings, and has even recommended pursuing legislative changes to OPPS budget neutrality provisions so that payment rates to HOPDs could be reduced without offsetting those reductions with payment increases. Several administrations have also proposed equalizing payment variations via budget proposals, and President Trump’s budget published in February 2018 proposed applying physician office rates to all hospital-owned physician offices located off the hospital campus. As stated previously, CMS has proposed extending site-neutral payments to include clinic visits provided at off-campus hospital-owned facilities.

It is clear that most of the policy options identified to date have recommended leveling the site-of-service playing field by reducing payment rates to the amounts payable in the least costly outpatient setting. Although CMS has not implemented the MedPAC or OIG recommendations,
2014 the agency identified approximately 200 services for which physician office payments were higher than HOPD or ASC rates and proposed lowering physician fees for these services. Most experts, including MedPAC, believe that Medicare payments to physician offices, HOPDs and ASCs will continue to be based on the program’s current payment systems for the foreseeable future. The combined payment system called for in the second resolve of Resolution 817-I-17 would require legislative changes that would face significant obstacles in a Congress that is hamstrung by partisanship and budgetary concerns. Opponents, including hospitals and other stakeholders whose payment rates would be affected, are likely to counter that physicians’ facility costs are already covered through the practice expense component of the PFS.

Moreover, convincing Congress to redesign Medicare’s payment systems would be extremely difficult. Given existing pressures to reduce health care costs, there is also a risk that advocating for a combined payment system could encourage Congress or CMS to design a system that lowers payments to all providers and/or does not provide relief for independent physician practices. CMS could also choose to impose the OPPS payment system, on which HOPD and ASC payments are based, on physician practices. Doing so would mean that units of service currently paid separately under the PFS would be grouped together into an ambulatory payment classification, which is the unit of payment under the OPPS.

**Updating Physician Practice Expenses Paid under the PFS**

Alternatively, the Council considered requesting that CMS update the inputs used to calculate the indirect practice expense component of the PFS, which is analogous to OPPS facility fees and which is based in part on 10-year-old survey data that no longer reflect current practice arrangements or the relative costs of running a practice. Updated data are urgently needed to ensure that practice expenses under the PFS more accurately reflect the costs to physician practices of furnishing office-based services. However, it is important to recognize that any practice expense changes under the current system will need to be budget neutral.

Payments under the PFS are required by statute to be based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service. In brief, RVUs are established for work, practice expense, and malpractice expense categories, which are adjusted for geographic cost variations. These values are multiplied by a conversion factor to convert the RVUs into payment rates. Statutory budget neutrality provisions require that annual adjustments to the RVUs that increase by more than $20 million must be offset by cuts in other RVUs or through a cut in the conversion factor.23

CMS establishes separate facility-and nonfacility-based practice expense RVUs for services furnished in facility settings (eg, HOPD or ASC) and in nonfacility settings (eg, physician offices). Facility-based RVUs are generally lower than nonfacility-based RVUs, so that HOPDs and ASCs receive facility payments under the OPPS whereas physician offices receive a facility fee under the PFS. Nonfacility practice expense RVUs are intended to reflect all of the direct and indirect practice expenses associated with furnishing a service in a physician office.

Direct expenses include cost inputs related to clinical labor, medical equipment and supplies. Indirect expenses include administrative labor, rent, billing services, and other office-related expenses that cannot be directly attributed to a service. In its proposed rule for CY 2019, CMS proposed updated pricing recommendations for 2,017 supply and equipment items currently used as direct practice expense inputs. The proposal is based on a report from a CMS contractor that used market research resources and methodologies to determine the updated prices. As described in the following section, survey data are used by CMS to determine the indirect practice expenses
incurred per hour worked. Each procedure is then assigned practice expense RVUs that are supposed to reflect the practice expenses required to provide the service relative to those required to provide other procedures.

The need for accurate data on practice costs is significant, considering many of the points raised in Resolution 817-I-17. Physician practices have experienced significant increases in practice expenses due to cumbersome regulations, quality measure requirements, EHRs (purchases, software upgrades, ongoing support and maintenance), complex payment and utilization management protocols, costly equipment used to provide, for example, imaging or infusions, and other costs that have changed dramatically since practice expense survey data was collected a decade ago. It may also be challenging for many independent and small group practices to accurately determine their total practice expenses when completing surveys about the costs of running a practice.

**The Physician Practice Information Survey (PPI Survey)**

In 2010, CMS began basing indirect practice expenses on the PPI Survey, a multispecialty, nationally representative survey of both physicians and non-physician practitioners paid under the PFS that was administered by the AMA over a period of time in 2007 and 2008. The PPI Survey collected data from 3,656 respondents across 51 medical specialties and health care professional groups. Participating practices were asked to fill out expense worksheets that itemized expenses such as payroll, supplies and equipment. They were also asked about the costs of managing a practice, charity care, time spent on quality improvement activities, and the acquisition, operating and maintenance costs associated to EHRs. PPI Survey data were used by CMS to confirm the accuracy of PFS practice expense data. As required by statute, CMS uses medical oncology supplemental survey data from 2003 for practice expenses per hour for oncology drug administration services. For specialties that did not participate in the PPI Survey, CMS develops proxy practice expense values by crosswalking practice expense data from specialties providing similar services.

Section 220 of the Protecting Access to Medicare Act of 2014, allocates funds for CMS “…to collect and use information on physicians’ services in the determination of relative values in the formulae for setting physician’s fees.” The AMA/Specialty Society RVS Update Committee and other entities have encouraged CMS to use these funds to conduct an updated survey on practice expense data. Even CMS has expressed concerns regarding the accuracy of the outdated data used to determine practice expense RVUs but, lacking other sources, the agency continues using PPI Survey data to inform physician payments under the PFS. The collection of physician practice expense data is a necessary first step which will enable comparisons to hospital cost and payment metrics and provide insight into the costs of care provided in hospital-owned and independently-owned practices.

AMA POLICY

The AMA has substantial and long-standing policy supporting equitable payments across outpatient sites of service. Policy H-240.993 calls for equity of payment between services provided by hospitals on an outpatient basis and similar services in physicians’ offices. AMA policy also supports defining Medicare services consistently across settings and encouraging the CMS to adopt payment methodologies that assist in leveling the playing field across all sites of service (Policy D-330.997).
Policy H-330.925 encourages CMS to fairly pay physicians for office-based procedures and adopt a site-neutral payment policy for hospital outpatient departments and ambulatory surgical centers; advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; advocates that in place of the CPI-U, CMS use the hospital market basket index to annually update ASC payment rates; and encourages the use of Current Procedural Terminology (CPT) codes across all sites of service as the only acceptable approach to payment methodology.

Policy H-400.957 encourages CMS to expand the extent and amount of reimbursement for procedures performed in the physician office, to shift more procedures from the hospital to the office setting, which is more cost effective, and to seek to have practice expense RVUs reflect the true cost of performing office procedures. Policy H-400.966 directs the AMA to aggressively promote the compilation of accurate data on all components of physician practice costs, and the changes in such costs over time, as the basis for informed and effective advocacy concerning physician payment under Medicare.

Policy D-240.994 directs the AMA to work with states to advocate that third-party payers be required to assess equal or lower facility coinsurance for lower-cost sites of service; publish and routinely update pertinent information related to patient cost-sharing; and allow their plan’s participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient. Furthermore, AMA policy urges private third-party payers to implement coverage policies that do not unfairly discriminate between hospital-owned and independently owned outpatient facilities with respect to payment of facility costs (Policy H-240.979). Policy H-390.849 directs the AMA to advocate for the adoption of physician payment reforms that promote improved patient access to high-quality and cost-effective care, do not require budget neutrality within Medicare Part B, and are based on payment rates that are sufficient to cover the full cost of sustainable medical practices.

AMA ACTIVITY

Enhancing Practice Efficiency and Promoting Physician Satisfaction

A strategic focus area within the AMA is working diligently to help physicians succeed in a rapidly changing health care environment. From advancing health care delivery and payment reforms that promote affordable care to restoring and preserving physician professional satisfaction, the AMA is driving practice transformation by translating regulatory requirements into actionable information; developing and disseminating practice improvement strategies and tools; establishing national benchmarks for physician burnout, leading to organizational level changes; and producing evidence-based research. To accelerate advancements in—and support for—physician and care team well-being, the AMA sponsors conferences that bring top investigators and thought leaders together to debate and advance health policies.

Encouraging Value-Based Payment

The AMA has been working for several years to encourage the development and implementation of Medicare payment models that will improve the financial viability of physician practices in all specialties, and help independent practices of all sizes remain independent; give physicians more resources and greater flexibility to deliver appropriate care to their patients; minimize administrative burdens that do not improve the quality of patient care; enable physicians to help control aspects of health care spending that they can influence, rather than having Medicare use inappropriate mechanisms to control costs such as payment cuts, prior authorization or non-
coverage of services. Since the passage of MACRA, the AMA has been accelerating its efforts to help national medical specialty societies and other physician organizations to develop, refine and implement alternative payment models (APMs) that will achieve these goals. Ideally, payment under these models should extend across sites of care.29 AMA policy (Policy H-385.913) recognizes that APMs should provide adequate resources to support the services physician practices need to deliver to patients. The AMA has urged the US Department of Health and Human Services to reconsider testing a number of APMs as recommended by the Physician-Focused Payment Model Technical Advisory Committee.30

Improving Price Transparency

As the health care market evolves, patients are increasingly becoming active consumers of health care services rather than passive recipients of care in a market where price is often unknown until after the service is rendered. Achieving meaningful price transparency can help lower costs and empower patients to make informed care decisions, including decisions about where to receive certain outpatient services. Many patients may not be able to readily distinguish between hospital-owned and independent practices, and may not understand how choice of outpatient setting impacts their cost-sharing expenses. The AMA supports measures to expand the availability of health care pricing information that allows patients and their physicians to make value-based decisions when patients have a choice of provider or facility.

DISCUSSION

The AMA has long supported and advocated for fair, equitable and adequate Medicare payments across outpatient sites of service, as well as payment policies that support value-based care and encourage use of the most cost-effective care setting. The policy priority established by the Council in previous reports addressing the site-of-service differential has been to ensure patient access to services in the most clinically appropriate setting, depending on their needs and the severity of their conditions. While an HOPD may be the appropriate setting for certain medically complex patients, the migration of many services from physician offices to hospital-owned facilities is of significant concern not only because of increased costs to the Medicare program, but also because it has become increasingly difficult for practices in certain specialties to remain competitive or even sustain operations because of declining payment rates and the increased costs to practices of dealing with regulatory and administrative burdens. The Council continues to be concerned for independent physician practices, and for Medicare patients who incur higher cost-sharing expenses for outpatient services provided in hospital facilities whose care could have been safely provided in lower-cost settings. The Council believes that policy proposals addressing the site-of-service differential must be patient-centric and ensure adequate payment that supports the costs of providing high-quality, high-value physician services.

Accordingly, the Council recommends reaffirming four existing policies that guide AMA advocacy regarding the site-of-service differential: Policy H-240.993, which calls for equity of payment between services provided by hospitals and similar services provided in physician offices; Policy D-330.997, which supports defining Medicare services consistently across settings and encouraging CMS to adopt payment policies that assist in leveling the playing field across all sites of service; Policy H-400.957, which encourages CMS to expand the extent and amount of payment for procedures performed in physician offices, to shift more procedures from the hospital to the office setting, and to seek to have practice expense RVUs reflect the true cost of performing office procedures; and Policy H-400.966, which promotes the compilation of accurate physician practice cost data as the basis for informed and effective advocacy concerning Medicare physician payment.
Building on these policies, the Council recommends that the AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. This policy recommendation enables ongoing AMA advocacy in support of site-neutral payments while at the same time seeking solutions that do not simply lower payments for services to amounts paid to the least costly setting. The Council is mindful that there is the potential for physicians to be adversely affected as Congress and the Administration promote site-neutrality based solely on cost as a means of reining in health care spending.

The site-of-service differential impedes the provision of high-value care because it incentivizes payment based on the location where a service is provided. Payment should be based on the service itself, and not the location where it is provided. Accordingly, the Council recommends that the AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting.

After extensive exploration of the “combined health care payment system” described in the second resolve of Resolution 817-I-17, the Council concludes that the practice expense component of the PFS is analogous to the facility fee paid under the OPPS, and that the valuation of the practice expense component needs to be updated to accurately reflect the costs of running a practice. The Council further believes that if physicians are paid a facility fee as called for in the second resolve, that fee is likely to be smaller than the current one and might not make up for the probable elimination of the practice expense differential in the current system. Rather than seeking the statutory changes to implement a combined payment system that pays facility fees for both hospital-owned and independent physician practices—which would be extremely challenging to accomplish in a Congress hamstringed by partisanship and a trillion-dollar deficit—the Council recommends urging CMS to update the data used to calculate the practice expense component of the PFS. The Council believes that CMS should conduct a survey similar to the PPI Survey to confirm the accuracy of practice expense data, given the many changes that have occurred since the survey was administered in 2007 and 2008, and that this survey should be administered every five years to ensure that timely data are used to inform PFS calculations. The Council believes that CMS should collect data to ensure that all physician practice costs are captured. Examples of data that must be collected by CMS include administrative and other costs that cannot be directly attributed to a service, costs of managing the practice, costs of providing uncompensated care, costs of navigating payer protocols and utilization management requirements, costs of purchasing, managing and updating EHRs, and costs related to quality measures and improvements.

Advocating for regular ongoing collection of physician practice expense data that more accurately reflect the costs of sustaining a practice is a viable option that could be impactful in the nearer term although, under Medicare’s current system, PFS payments would be redistributed rather than increased overall. The updated data could be used to help measure differences in the costs of providing services in physician offices and hospital settings, and would inform future AMA advocacy on broader payment reforms.

To address concerns regarding the methodology used for DSH and uncompensated care payments to hospitals and the care provided by many physicians for which they are not fully compensated, the Council recommends that the AMA encourage CMS to both: a) base DSH and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care.

While the focus of this report is the site-of-service differential, the Council recognizes the need to address broader physician payment issues. The Council further recognizes that achieving site-
neutral payments for outpatient procedures will require increases in Medicare payment for
physician services so that physician practices can be sustained and patient choice of care setting is
safeguarded. To help build the case for future Medicare payment reforms, the Council recommends
that the AMA collect data and conduct research both: a) to document the role that physicians have
played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the
Medicare budget allocated to physician services that more accurately reflects practice costs and
changes in health care delivery.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution
817-I-17, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-240.993, which urges more
   aggressive implementation by the US Department of Health and Human Services of existing
   provisions in federal legislation calling for equity in payment between services provided by
   hospitals on an outpatient basis and similar services in physician offices. (Reaffirm HOD
   Policy)

2. That our AMA reaffirm Policy D-330.997, which encourages the Centers for Medicare &
   Medicaid Services (CMS) to define Medicare services consistently across settings and adopt
   payment methodology for hospital outpatient departments (HOPDs) and ambulatory surgical
   centers (ASCs) that will assist in leveling the playing field across all sites-of-service. (Reaffirm
   HOD Policy)

3. That our AMA reaffirm Policy H-400.957, which encourages CMS to expand the extent and
   amount of reimbursement for procedures performed in the physician office, to shift more
   procedures from the hospital to the office setting, which is more cost effective, and to seek to
   have practice expense relative value units reflect the true cost of performing office procedures.
   (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-400.966, which directs the AMA to aggressively promote the
   compilation of accurate data on all components of physician practice costs, and the changes in
   such costs over time, as the basis for informed and effective advocacy concerning physician
   payment under Medicare. (Reaffirm HOD Policy)

5. That our AMA support Medicare payment policies for outpatient services that are site-neutral
   without lowering total Medicare payments. (New HOD Policy)

6. That our AMA support Medicare payments for the same service routinely and safely provided
   in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on
   sufficient and accurate data regarding the real costs of providing the service in each setting.
   (New HOD Policy)

7. That our AMA urge CMS to update the data used to calculate the practice expense component
   of the Medicare physician fee schedule by administering a physician practice survey (similar to
   the Physician Practice Information Survey administered in 2007-2008) every five years, and
   that this survey collect data to ensure that all physician practice costs are captured. (New HOD
   Policy)
8. That our AMA encourage CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care. (New HOD Policy)

9. That our AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery. (Directive to Take Action)

Fiscal Note: $100,000 to $200,000
REFERENCES


2 Ibid.

3 Congressional Budget Office. Estimate of the Budgetary Effects of HR 1314, the Bipartisan Budget Act of 2015, as reported by the House Committee on Rules on October 27, 2015. Available at: https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr1314.pdf.

4 Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medicare program; Revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2019; Medicare shared savings program requirements; Quality payment program; and Medicaid promoting interoperability program. Federal Register. July 27, 2018.


10 Ibid.


16 Ibid.


21 Office of Inspector General. Medicare and Beneficiaries Could Save Billions if CMS Reduces Hospital Outpatient Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates. April 2014.
22 Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2017. Medicare program; Revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2018; Medicare shared savings program requirements; and Medicare diabetes prevention program. Final rule. Federal Register 82, no. 219 (November 15).
23 Ibid.
24 Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2018. Medicare program: Revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2019; Medicare shared savings program requirements; Quality payment program; and Medicaid promoting interoperability program. Federal Register. July 27, 2018.
25 Ibid.
27 Ibid.
Whereas, Copayments (copays) for emergency department services have been shown to create a significant barrier to necessary emergency care for Medicaid enrollees\(^1\); and

Whereas, Many Medicaid programs utilize the current federally allowed copay up to eight dollars for emergency department services determined to be non-emergent\(^2\); and

Whereas, For the purposes of determining non-emergency, and therefore imposition of copays for Medicaid enrollees, many states use the Emergency Severity Index (ESI) triage levels or final diagnoses rather than the Prudent Layperson Standard\(^3\) as directed in the CMS guidance for implementation of such copays\(^4\); and

Whereas, Our AMA Policy H-130.970 opposes implementation of policies that violate the Prudent Layperson Standard of determining when to seek emergency care\(^5\); and

Whereas, States are using Section 1115 Medicaid waiver demonstrations to implement emergency department copays of increasing amounts and to apply such emergency department copays even for emergent services; and

Whereas, Medicaid programs that have copays for non-emergent use of the emergency department do not decrease such non-emergent use\(^6\) and do not decrease overall Medicaid costs\(^7\); and

Whereas, The calculated effect of Indiana’s increased Medicaid emergency department copay ($25), allowed by a 2015 CMS Medicaid waiver demonstration, used a retrospective definition of “emergency,” disregarding the federal Prudent Layperson Standard; and

Whereas, Copays requested at the time of registration in the emergency department could intimidate patients from receiving a mandated medical screening exam, thus placing the hospital at risk for an EMTALA violation\(^8\); therefore be it

RESOLVED, That our American Medical Association oppose imposition of copays for Medicaid beneficiaries seeking care in the emergency department. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 10/10/18
RELEVANT AMA POLICY

Access to Emergency Services H-130.970

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:

(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(C) All health plans should be prohibited from requiring prior authorization for emergency services.

(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third party payer whether it is retrospectively determined that an emergency existed or not.

(G) States should be encouraged to enact legislation holding health plans and third party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(I) In instances in which no private or public third party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the prudent layperson standard of determining when to seek emergency care.


References:


8 Emergency Medical Treatment and Labor Act - 42 United States Code (U.S.C.) 1395dd
Whereas, The harm to patients caused by delayed implementation of prescribed treatment or compromise in treatments or testing prompted by payers that result in switching for reasons other than efficacy or toxicity cannot be quantified because its role cannot be coded by our current ICD system; and

Whereas, Other contributors to patient and public health harm are identified by the mining of data from ICD administrative codes, including but not limited to infections, poisons, assaults, insect bites, trauma, infections and lifestyle factors; therefore be it

RESOLVED, That our American Medical Association support the creation and implementation of an ICD code(s) to identify administrator or payer influence that affects treatment and leads to or contributes to, directly or indirectly, patient harm. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 10/10/18
Whereas, Medical providers and hospitals were successful in the 2018 Indiana legislative session in getting some prior authorization (PA) relief through HEA 1143 (P.L.77-2018); and

Whereas, That bill addressed only PA hassles and inconsistencies in commercial health plans; and

Whereas, The same hassles and burdensome PA requirements are routinely applied in Medicaid and Medicaid managed care plans, as well as Medicare Advantage plans; and

Whereas, There is a need to request relief equally from all health plans; therefore be it

RESOLVED, That our American Medical Association support legislation that would apply the following legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:

• Listing services that require a PA on a website.
• Notifying providers of any changes at least 45 days prior to change.
• Standardizing a PA request form.
• Not denying payment for PA that has been approved unless fraudulently obtained or ineligible at time of service.
• Defining a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans (New HOD Policy); and be it further

RESOLVED, That our AMA apply these same legislative processes and parameters to PA for Medicaid and Medicaid managed care plans and Medicare Advantage plans, to include:

• Medications already working when a patient changes health plans cannot be changed by the plan without discussion and approval of the ordering physician.
• Minimizing PA requirements as much as possible within each plan.
• Making an easily accessible and reasonably responsive direct communication tool available to resolve disagreements between plan and ordering provider. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/09/18
RELEVANT AMA POLICY

Prior Authorization and Utilization Management Reform H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18

Prescription Drug Plans and Patient Access D-330.910
Our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare and Medicaid Services and other appropriate organizations to resolve them.
Citation: (Res. 135, A-14)

https://policysearch.ama-assn.org/policyfinder/search/medicare%20advantage/relevant/1/
Whereas, USA Today has reported on seriously deleterious physician hiring practices in the Veterans Health Administration; and

Whereas, These deleterious hiring practices include subjecting our nations’ veterans to care by physicians who have faced dozens of malpractice cases, and who have been sanctioned and, in some cases, have lost their licenses to practice in at least one state; and

Whereas, The U.S. Government Accountability Office has recently reported that the U.S. Department of Veterans Affairs failed to report 90 percent of potentially dangerous medical providers in recent years to a national database; and

Whereas, USA Today has found that oversight of the Veteran’s Administration is so lax that the Veterans Administration had no idea how many medical workers had been reported or if they had been reported at all; and

Whereas, The U.S. Government Accountability Office has discovered that at one facility, officials failed to report six providers to the national practitioner database because the officials were unaware that they had been delegated responsibility for reporting; and

Whereas, Patients receiving care in non-Veterans Health Administration institutions would not be subjected to similar substandard care; therefore be it

RESOLVED, That our American Medical Association amend policy H-510.986, “Ensuring Access to Care for our Veterans,” by addition to read as follows:

Ensuring Access to Safe and Quality Care for our Veterans H-510.986
1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the
registry be made available to the veterans in their community and the local Veterans Administration.

5. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains first-rate, competent, and ethical physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.

6. Our AMA will engage the Veterans Health Administration in dialogue on accreditation practices by the Veterans Health Administration to assure they are similar to those of hospitals, state medical boards, and insurance companies.

(Modify Current HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/10/18

RELEVANT AMA POLICY

Ensuring Access to Care for our Veterans H-510.986
1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.
Citation: (Res. 231, A-14; Reaffirmation A-15; Reaffirmed: Sub. Res. 709, A-15)

Expansion of US Veterans' Health Care Choices H-510.983
1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans.
2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program.
3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways.
4. Our AMA will support consolidation of all the VA community care programs.
5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care.
6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission.
7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.
8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care.

9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.

10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.

Citation: CMS Rep. 06, A-17

Fixing the VA Physician Shortage with Physicians D-510.990
1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.

2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility.

3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.

Citation: Res. 1010, A-16

Support for VA Health Services for Women Veterans H-510.981
Our AMA recognizes the disparity in access to care for women veterans, and encourages research to address this population's specific needs to improve patient outcomes.

Citation: Res. 825, I-17

Access to Health Care for Veterans H-510.985
Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.

Citation: Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17

Health Care for Veterans and Their Families H-510.989
Our AMA supports the recommendations of the President's Commission on Care for America's Wounded Warriors report "Serve, Support, Simplify."

Citation: BOT Rep. 6, A-08; Reaffirmed: BOT Rep. 09, A-18
Health Care for Veterans and Their Families D-510.994
Our AMA will: (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration.
Citation: (BOT Rep. 6, A-08; Reaffirmed: Sub. Res. 709, A-15)

Health Care Policy for Veterans H-510.990
Our AMA encourages the Department of Veterans Affairs to continue to explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).
Citation: (Sub. Res.115, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)

Veterans Administration Health System H-510.991
Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.
Citation: (CMS Rep. 8, A-99; Reaffirmed: CMS Rep. 5, A-09)

Requiring The Joint Commission to Conduct Root-Cause Analysis to Determine How its Surveys Allowed Veterans Administration Hospitals to Cause Delay in Treatment and Harm Veterans D-510.991
Our AMA supports The Joint Commission making public its findings following its resurveying of Veterans Health Administration (VHA) facilities to ensure quality of care and patient safety.
Citation: (Sub. Res. 709, A-15)

Budgetary and Management Needs of the Veterans Health Administration H-510.995
Our AMA urges Congress and the President to provide the VHA: (1) with funding sufficient to allow its hospitals and clinics to provide proper care to the patients the VHA is mandated to treat; and (2) with maximum flexibility in eliminating unneeded or duplicative services and in closing clinics or hospitals.
Citation: (BOT Rep. EE, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10)
At its 2018 Annual Meeting, the OMSS Assembly referred Resolution 1, “Emeritus Membership Category,” to the Governing Council for report. Resolution 1 asked the OMSS Governing Council to pursue amendment of the AMA Bylaws and OMSS Internal Operating Procedures as necessary to establish a new category of Section membership as follows:

Emeritus members of the Organized Medical Staff Section

1. Membership criteria -- An emeritus member must:
   1. Be an active member of the AMA;
   2. Have previously been an OMSS representative; and
   3. Be retired from medical practice and no longer in a position to represent a medical staff in the OMSS.

2. Membership rights -- An emeritus member shall have the right to speak and debate, but shall not have the right to introduce business, make motions, vote, or run for election to the OMSS Governing Council.

3. Certification -- The Governing Council shall establish a process, which shall be codified in the Internal Operating Procedures, for certifying emeritus members. The AMA to:

Testimony revealed significant confusion about current requirements for OMSS representation, as well as disagreement about which rights should be granted to members of the proposed emeritus category. There was also a suggestion that the Section should not approve this proposal without first explicating the process by which emeritus status would be granted. Resolution 1 was therefore referred to the Governing Council for report to clarify these and other ambiguities.

BACKGROUND

AMA Bylaw 7.41 limits membership in the OMSS to physicians, including residents and fellows, selected by physician members of the medical staffs of hospitals and other delivery systems. This current membership model does not permit formal continued involvement in the Section by OMSS representatives who have retired from medical practice and are no longer affiliated with a medical staff. In recognizing that many of these retired/former OMSS representatives possess a specialized knowledge and unique expertise, and continue to demonstrate a genuine interest in current medical staff affairs, the Governing Council sought to expand membership to include these retired OMSS representatives in a non-voting capacity.
DISCUSSION

Expanding the Section’s membership through the creation of an emeritus member category would allow former OMSS representatives who have since retired to formally participate in OMSS business meetings. However, we note that designating the title of “emeritus” to describe this new category of membership has created confusion—particularly among OMSS representatives and alternative representatives who are currently affiliated with their hospital or health care organization through honorary or emeritus categories of medical staff membership.

It is important to clarify that this new category of membership is separate and distinct from those OMSS representatives who are currently affiliated with their organization through such honorary or emeritus staff categories. Specifically, this new category of Section membership was narrowly-tailored to expand membership opportunities only to those OMSS members who have since retired and are no longer affiliated (i.e., former OMSS representatives) with their medical staff in any formal capacity. We recommend changing the title of this new membership category to eliminate any further confusion.

Concerns have also been raised by Section members regarding the granting of voting rights to those retired/former OMSS representatives that would make up this new category of membership. Most notably, Section members cautioned that extending such voting rights to individuals who are no longer affiliated with a medical staff would diminish the foundational essence of the Section’s representative model.

After careful consideration, we agree that representation at OMSS business meetings should remain grounded in the fundamental unit of the medical staff. Further, we note that nothing would preclude any of the members within this new category of membership from certifying as a current OMSS representative if they re-affiliate with a medical staff in the future. We therefore recommend that voting rights remain limited to those physicians who have been selected in part to represent the interests and concerns of their medical staff peers at biannual OMSS meetings.

RECOMMENDATION

The OMSS Governing Council recommends that the following be adopted in lieu of Resolution 1-A-18, and that the remainder of this report be filed:

1. That our Organized Medical Staff Section (OMSS) Governing Council pursue amendment of the AMA Bylaws and OMSS Internal Operating Procedures as necessary to establish a new category of Section membership as follows:

   Unaffiliated members of the Organized Medical Staff Section

   1. Membership criteria -- An unaffiliated member of the OMSS must:
      a. Be a member of the AMA;
      b. Have previously served as an OMSS representative;
      c. Be fully retired from medical practice; and
      d. Have no formal membership on any medical staff.

   2. Membership rights -- An unaffiliated member of the OMSS shall have the right to speak and debate, but shall not have the right to introduce business, make motions, vote, or run for election to the OMSS Governing Council.
Appendix: Relevant AMA Policy

AMA Bylaws 7.4 Organized Medical Staff Section

7.4 Organized Medical Staff Section. The Organized Medical Staff Section is a delineated Section.

7.4.1 Membership. Membership in the Section shall be open to all active physician members of the AMA who are members of a medical staff of a hospital or a medical staff of a group of practicing physicians organized to provide healthcare. Active resident and fellow members of the AMA who are selected by their medical staffs as representatives to the Business Meeting also shall be considered members of the Section.

7.4.2 Representatives to the Business Meeting. Each medical staff of a hospital and each medical staff of a group of practicing physicians organized to provide healthcare may select up to two active physician AMA member representatives to the Business Meeting. The president or chief of staff of a medical staff may also attend the Business Meeting as a representative if he or she is an active physician member of the AMA. The representatives must be physician members of the medical staff of a hospital or group of practicing physicians organized to provide healthcare or residents/fellows affiliated with the medical staff of a hospital or group of practicing physicians organized to provide healthcare. All representatives to the Business Meeting shall be properly certified in accordance with procedures established by the Governing Council and approved by the Board of Trustees.

7.4.2.1 When a multi-hospital system and its component medical staffs have unified the medical staffs, those medical staff members who hold specific privileges to practice at each separate entity within the unified system may select up to two representatives to the Business Meeting, so long as they are active physician members of the AMA. The president or chief of staff of a unified medical staff also may attend the Business Meeting as a representative if he or she is an active physician member of the AMA.

7.4.3 Cessation of Eligibility. If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.4.1 or ceases to be credentialed as a representative consistent with Bylaw 7.4.2 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant.

7.4.4 Member Rights and Privileges

7.4.4.1 An OMSS member who is certified as a representative in accordance with 7.4.2 has the right to speak and debate, and has the right to introduce business, make motions, vote, and run for office to the OMSS Governing Council.

7.4.4.2 An OMSS member who is not certified as a representative in accordance with 7.4.2 has the right to speak and debate, but does not have the right to introduce business, make motions, vote or run for office to the OMSS Governing Council.

7.4.4.3 A physician who is not an AMA member may attend one Business Meeting as a guest, without the right to speak or debate, introduce business, make motions, vote or run for office to the OMSS Governing Council.

7.4.4.4 At the discretion of the Governing Council, a non-physician may attend the Business Meetings as a guest. (2016)
Subject: OMSS Position on Board of Trustees Report 9-I-18: Hospital Closures and Physician Credentialing
(Submitted in response to OMSS-sponsored Resolution 716-A-18)

Presented by: David Welsh, MD, Chair

Referred to: OMSS Reference Committee
(Vimal Nanavati, MD, Chair)

INTRODUCTION FROM BOARD OF TRUSTEES REPORT 9

At the 2018 Annual Meeting, the House of Delegates (HOD) referred Resolution 716, “Hospital Closures and Physician Credentialing.” Resolution 716 was sponsored by the Organized Medical Staff Section and asked the AMA to:

“work with appropriate stakeholders—such as the AMA Organized Medical Staff Section and National Association Medical Staff Services (NAMSS)—to produce an AMA credentialing repository that would allow hospitals and other organizations that credential physicians to access verified credentialing information for physicians who were on staff at a hospital (or one of its departments) at the time of closure, and report back at the 2018 Interim Meeting.”

RECOMMENDATION OF BOT REPORT 9

The Board of Trustees recommends that the following be adopted in lieu of Resolution 716-A-18 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-230.956, which states that the governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility should be responsible for making arrangements for the disposition of physician credentialing records upon the closing of a facility and should make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, and medical staff status. (Reaffirm HOD Policy)

2. That our AMA develop model state legislation and regulations that would require hospitals to: (a) implement a procedure for preserving medical staff credentialing files in the event of the closure of the hospital; and (b) provide written notification to its state health agency and medical staff before permanently closing its facility indicating whether arrangements have been made for the timely transfer of credentialing files and the exact location of those files. (Directive to Take Action)
3. That our AMA: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations; and (b) explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information as it relates to physician practice and affiliation history, and report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take Action)

GOVERNING COUNCIL RECOMMENDATION

The Governing Council recommends that the OMSS Delegate be instructed to support the intent of the recommendations of BOT Report 9-I-18.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-I-18

Subject: Hospital Closures and Physician Credentialing
(Resolution 716-A-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates (HOD) referred Resolution 716-A-18, “Hospital Closures and Physician Credentialing.” Resolution 716 was sponsored by the Organized Medical Staff Section and asked the AMA to:

work with appropriate stakeholders–such as the AMA Organized Medical Staff Section and National Association Medical Staff Services (NAMSS)–to produce an AMA credentialing repository that would allow hospitals and other organizations that credential physicians to access verified credentialing information for physicians who were on staff at a hospital (or one of its departments) at the time of closure, and report back at the 2018 Interim Meeting.

Testimony largely supported the intent of Resolution 716. However, some members noted that not only would the cost of implementing Resolution 716 be significant, but there are also many unanswered questions about the demand for such a service and how it would work. Other members were concerned as to whether the AMA is the organization best positioned to take up this issue.

DISCUSSION

Resolution 716 suggests that a lack of institutional policies for preserving medical staff credentialing files when a hospital closes can lead to undue delays in future credentialing efforts due to inaccessibility of historical credentialing information. To minimize the potentially devastating impact this shortcoming may have on physicians and other displaced medical staff members, Resolution 716 asks that the AMA create a centralized repository to facilitate the verification of credentialing information as it relates to a physician’s hospital affiliation history.

Existing AMA policy supports the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities. Policy H-230.956, “Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records” states that, where in accordance with state law and regulations, “…[t]he governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility…” and “…make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.” Policy H-230.956 also states that the closing facility “…shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information.”
Notwithstanding this comprehensive policy, a thorough review of existing law reveals few requirements for the retention of physician credentialing records when a hospital closes. While some states require hospitals to implement policies for the preservation of medical staff credentialing files (e.g., Illinois and New York), most states have no specific law or regulations providing for the timely transfer of medical staff credentialing files and proper notification to physicians of the location of those files. As a starting point, the AMA should encourage emulation of appropriate existing laws and regulations by developing model state legislation that supports timely physician access to credentialing files following the closure of a hospital.

Even if closing hospitals were required by law to preserve credentialing files, it remains to be seen where and how this information would be most appropriately stored. Resolution 716 suggests the development of a comprehensive and centralized repository of credentialing files from closed hospitals. States, payors, and other stakeholders are already in the process of developing credentialing repositories for verification of physicians’ current and past hospital affiliations. For example, Oregon passed legislation to establish a centralized credentialing database from which medical staff professionals, hospitals, health plans, and other organizations can get up-to-date information on every licensed physician in the state. Additionally, the National Association Medical Staff Services (NAMSS) has launched an online repository to provide medical staff offices a place to quickly find and upload physician affiliation history. Either of these efforts could be expanded to address the problems raised by closed facilities. Recognizing the value that the AMA could provide alongside expert leaders in the credentialing industry, the AMA should continue to monitor these efforts and explore the feasibility of developing a universal clearinghouse that centralizes the verification of physician practice and affiliation history.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 716-A-18 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-230.956, which states that the governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility should be responsible for making arrangements for the disposition of physician credentialing records upon the closing of a facility and should make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, and medical staff status. (Reaffirm HOD Policy)

2. That our AMA develop model state legislation and regulations that would require hospitals to:
   (a) implement a procedure for preserving medical staff credentialing files in the event of the closure of the hospital; and (b) provide written notification to its state health agency and medical staff before permanently closing its facility indicating whether arrangements have been made for the timely transfer of credentialing files and the exact location of those files. (Directive to Take Action)

3. That our AMA: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations; and (b) explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information as it relates to physician practice and affiliation history, and report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take Action)

Fiscal Note: Modest – Between $1,000 and $5,000
Relevant AMA Policy

H-230.956, “Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records”

1. AMA policy regarding the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities, where in accordance with state law and regulations is as follows:

   A. Governing Body to Make Arrangements: The governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility.

   B. Transfer to New or Succeeding Custodian: Such a facility shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information. In the alternative, the facility shall seek to make arrangements with a reputable commercial storage firm. The new or succeeding custodian shall be obligated to treat these records as confidential.

   C. Documentation of Physician Credentials: The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.

   D. Maintenance and Retention: Physician credentialing information and CME information transferred from a closed facility to another hospital, other entity, or commercial storage firm shall be maintained in a secure manner intended to protect the confidentiality of the records.

   E. Access and Fees: The new custodian of the records shall provide access at a reasonable cost and in a reasonable manner that maintains the confidential status of the records.

2. Our AMA advocates for the implementation of this policy with the American Hospital Association.
2018 Interim Meeting Education Guide

Friday, November 9, 2018

Identifying victims of sex trafficking: The role of the physician

* Direct contracting with large employers: Is your organization an appealing partner?

* Can system-level and individual medical staff needs coexist? Spoiler: Yes!

* Coalition building: Fundamental steps for success

* Don’t just survive, thrive: Wellness for young physicians

Providing care for child and adolescent refugees

2019 Medicare payment policy: Everything you need to know

Alternative privileging criteria: Evaluating competency without MOC

Health care think tank: Members moving medicine

The forgotten Americans: An introduction to US-Mexico border colonias

The FDA: What do they do for physicians and patients?

Opioid rehabilitation and care coordination: What physicians in training need to know

Mergers, acquisitions and partnerships in health care: Why is New York – Presbyterian in the Florida Keys?

Advocacy in action: Enacting change at a grassroots level

Sessions certified by the AMA for CME credit are indicated by an asterisk (*)

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American Medical Association designates each live activity for the maximum number of AMA PRA Category 1 Credits™ reflected with each session. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Saturday, November 10, 2018

Scope of practice: How the AMA protects physicians’ role in providing patient-centric care

Design thinking in health care

* Communications: Perfecting your elevator speech and your personal brand

Our turn to serve: How to improve health care for veterans

Caring for vulnerable populations: What can you can do to support LGBTQ+ youth

Train the trainer: Empowering your community to combat the opioid crisis

* Mind the gap: Improving undocumented patients’ access to care

Is there a vaccine for burnout? Building resilience in the medical student community

Difficult conversations: End of life care

* Older and wiser: Assessing competency of elder physicians

How will the November elections affect LGBTQ patients and physicians?

* Acculturation: Continuous immersion and improvement for IMGs

The more things change: Issues facing senior women physicians

The business of improving workforce diversity

Sunday, November 11, 2018

Busharat Ahmad, MD leadership development program: How to earn an AMA leadership position

Sessions certified by the AMA for CME credit are indicated by an asterisk (*)

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The American Medical Association designates each live activity for the maximum number of AMA PRA Category 1 Credits™ reflected with each session. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Identifying victims of sex trafficking: The role of the physician

8:30 a.m.- 9:15 a.m. | Friday, November 9 | Chesapeake G & H | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

8:30 - 9:15 a.m.  Identifying victims of sex trafficking: The role of the physician

Each year, 100,000-300,000 international and domestic minors in the United States are at risk of being trafficked for sex. Physicians can help reduce the risk of harm to victims by knowing what to look for and how to offer help. Become empowered with the knowledge needed to better identify, interview, and assist patients who are victims of sex trafficking.
Direct contracting with large employers: Is your organization an appealing partner?

8:45 a.m. - 10:45 a.m. | Friday, November 9 | Potomac 1 & 2 | Gaylord National Resort and Convention Center

INTEGRATED PHYSICIAN PRACTICE SECTION

8:45 a.m. - 10:45 a.m. Direct contracting with large employers: Is your organization an appealing partner? (2.0 AMA PRA Category 1 Credits™)

Recently, Henry Ford Health System (HFHS) and General Motors (GM) announced a direct contracting partnership in which HFHS provides a wide range of services to 24,000 GM employees. Join senior executives from both organizations to learn more about this venture and more broadly, how you can prepare your system to partner with large employers.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 2.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Can system-level and individual medical staff needs coexist? Spoiler: Yes!

9:30 a.m.–10:30 a.m. | Friday, November 9 | Potomac D | Gaylord National Resort and Convention Center

ORGANIZED MEDICAL STAFF SECTION

9:30–10:30 a.m. Can system-level and individual medical staff needs coexist? Spoiler: Yes! (1.0 AMA PRA Category 1 Credit™)

Multi-hospital systems are seeking standardization across their medical staffs to improve care and efficiency. While unification of all staffs under a single, system-wide medical staff organization is an option, this approach can overlook the unique needs of individual staffs and hospitals. Join the Organized Medical Staff Section to learn how systematization—creating uniformity in select medical staff governance and operations areas without formal unification—can benefit your medical staff.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Coalition building: Fundamental steps for success

Noon - 1 p.m. | Friday, November 9 | Chesapeake D / E / F | Gaylord National Resort and Convention Center

Coalition building: Fundamental steps for success
(1.0 AMA PRA Category 1 Credit™)

Physician-led health care coalitions can play an important role in promoting health on a local, state or national level. With a strong coalition, you can effect positive change through events, outreach, and engagement with the media, healthcare community, policymakers, and the public. If you are a physician leader interested in community advocacy and tapping into the power of a coalition, this program will help equip you with the knowledge and skills necessary to build and sustain a successful coalition.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Don’t just survive, thrive: Wellness for young physicians

Noon - 1:30 p.m. | Friday, November 9 | Potomac C | Gaylord National Resort and Convention Center

YOUNG PHYSICIANS SECTION

Noon-1:30p.m. Don’t just survive, thrive: Wellness for young physicians
(1.5 AMA PRA Category 1 Credits™)

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Providing care for child and adolescent refugees

1 p.m. - 2 p.m. | Friday, November 9 | Chesapeake G & H | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

1 - 2 p.m. Providing care for child and adolescent refugees

The World Health Organization estimates that there are 258 million international migrants in the world today, many of whom lack adequate access to medical resources. With this statistic, it is likely that you will encounter individuals who fit this definition, including children and adolescent refugees. Explore what physicians are doing to care for this vulnerable population and learn what you can do to support these patients in your practice.
2019 Medicare payment policy: Everything you need to know

1 p.m.- 2:20 p.m. | Friday, November 9 | Potomac 1 & 2 | Gaylord National Resort and Convention Center

INTEGRATED PHYSICIAN PRACTICE SECTION

1 - 2:20p.m. 2019 Medicare Payment Policy: Everything You Need to Know

Join Medicare payment policy experts to learn about the key changes in 2019 Medicare payment policies and the Quality Payment Program. A reaction panel with physician leaders from a variety of settings (urban, rural, private practice IPA, academic) will explore how the new rule could potentially impact integrated organizations.
Alternative privileging criteria: Evaluating competency without MOC

1:45 p.m.– 2:45 p.m. | Friday, November 9 | Potomac D | Gaylord National Resort and Convention Center

ORGANIZED MEDICAL STAFF SECTION

1:45–2:45 p.m. Alternative privileging criteria: Evaluating competency without MOC

Medical staffs typically employ a combination of board certification, maintenance of certification (MOC), outcomes data, and other measures as proxies for physician competency. But with many physicians opting out of MOC, many physicians no longer practicing in hospitals, and other changes, medical staffs are increasingly looking to find alternative ways to evaluate applicants and members. Join the Organized Medical Staff Section to learn about and discuss holistic approaches to measuring competency for credentialing and privileging.
Health care think tank: Members moving medicine

2 p.m.- 3 p.m. | Friday, November 9 | Magnolia 3 | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

2 – 3 p.m.    Health care think tank: Members moving medicine

TED Talk-style ideas presented by medical students that highlight their passion for medicine. Each 10-minute presentation will be on a hot topic in medicine with recommendations for action. Come for the passionate students, stay for the innovative solutions to pressing problems in health care, and leave feeling inspired.
The forgotten Americans: An introduction to US-Mexico border colonias

3 p.m.– 3:30 p.m. | Friday, November 9 | Chesapeake G & H | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

3 - 3:30 p.m. The forgotten Americans: An introduction to US-Mexico border colonias

Border colonias are rural border communities that exist along the US-Mexico border. These communities lack basic health resources, like clean water and access to medical care and as such, poverty and disease are rampant. Physicians can help the people living in these areas by providing health care services and through advocating for change. Learn about these communities and how you can make an impact and save lives.
The FDA: What do they do for physicians and patients?

3:30 p.m. - 4:15 p.m. | Friday, November 9 | Magnolia 3 | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

3:30 - 4:15 p.m. | The FDA: What do they do for physicians and patients?

The Food and Drug Administration influences what drugs and medical devices are available to patients. While review processes seem lengthy, they are necessary to ensure that drugs and medical devices are safe for Physicians to prescribe to their patients. Learn about the FDA and its role in protecting Physicians and their patients.
Opioid rehabilitation and care coordination: What physicians in training need to know

4 p.m. - 4:45 p.m. | Friday, November 9 | Chesapeake G & H | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

4 - 4:45 p.m.  Opioid rehabilitation and care coordination: What physicians in training need to know

Physicians are critical to overcoming the opioid epidemic. Patients in recovery require focused care and their physicians apply a team-based care model to manage their care and recovery. Learn how physicians leverage this care model to provide care to this patient population.
Mergers, acquisitions and partnerships in health care: Why is New York-Presbyterian in the Florida Keys?

4:30 p.m. - 5 p.m. | Friday, November 9 | Magnolia 3 | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

4:30 - 5 p.m. Mergers, acquisitions and partnerships in health care: Why is New York-Presbyterian in the Florida Keys?

Hospitals and health systems are merging into multi-state networks. These networks include traditional and nontraditional players and the partnerships are transforming care delivery and the physician experience. Join the AMA-MSS to review this trend and discuss how it will shape care delivery and the physician experience.
Advocacy in action: Enacting change at a grassroots level

5 - 5:45 p.m. | Friday, November 9 | Chesapeake G & H | Gaylord National Resort and Convention Center

**MEDICAL STUDENT SECTION**

5 - 5:45 p.m. **Advocacy in action: Enacting change at a grassroots level**

Physician advocates play a vital role in influencing policymakers on matters that health policy and patient care. Despite serving in this important role, physicians rarely receive training on how to conduct advocacy activities and enact change at a grassroots level. Learn about what you need to influence change.
Scope of practice: How the AMA protects physicians’ role in providing patient-centric care

7:30 - 8:30 a.m. | Saturday, November 10 | Potomac D | Gaylord National Resort and Convention Center

The AMA is partnering with state and specialty societies to protect the physician role in providing patient centered care. Learn how the AMA is partnering with state and specialty societies to protect the physician role in providing patient centered health care.
As the leaders of the health care team, physicians are responsible for providing the best care possible and ensuring that errors are corrected before they harm any patient. Applying Design Thinking principles to solve issues ensures that creativity is used when developing solutions to the identified problems. Learn about this way of thinking and how you can apply these steps to improve care outcomes.
Communications: Perfecting your elevator speech and your personal brand

8:10 a.m. - 9:15 a.m. | Saturday, November 9 | Woodrow Wilson B | Gaylord National Resort and Convention Center

ACADEMIC PHYSICIANS SECTION

8:10 a.m. - 9:15 a.m.  Communications: Perfecting your elevator speech and your personal brand
(1.0 AMA PRA Category 1 Credit™)

Effective communication skills are a central clinical and professional function for physicians. As leaders in both the clinical and academic arenas, physicians need to be able to identify their audience, develop, and deliver a clear, audience-focused message. Join the AMA-APS to learn how you can maximize your communication efficacy.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
There are more than 20 million veterans in the United States. This large patient population has its own unique set of physical and mental wellness challenges that are not addressed in medical training, but greatly influence the care outcomes for veterans. Join us to learn what you can do to improve care for this important population.
According to the National Alliance on Mental Illness, LGBTQ+ individuals are almost three times more likely than their cisgender, heterosexual counterparts to experience a mental health condition. While acceptance of LGBTQ+ individuals has increased within the medical profession and society, many LGBTQ+ patients still encounter stigmatization, discrimination, and violence based on their sexual orientation and/or gender identity. Learn what you can do to improve the mental health of LGBTQ+ youth.
Train the trainer: Empowering your community to combat the opioid crisis

9:30 a.m. - 10 a.m. | Saturday, November 10 | Potomac 6 | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

9:30 - 10 a.m.  
Train the trainer: Empowering your community to combat the opioid crisis

Timely administration of naloxone has saved thousands of lives. While physicians and other health and safety professionals receive training in overdose detection and naloxone administration, laypeople do not receive such training. As a physician or physician in training, you can reduce the number of lives claimed by opioid overdose by training local community members how to identify an opioid overdose and administer naloxone to reverse the effects. Learn how you can reverse the epidemic.
Mind the gap: Improving undocumented patients’ access to care

10 a.m. - 11 a.m. | Saturday, November 10 | Potomac D | Gaylord National Resort and Convention Center

10-11 a.m. Mind the gap: Improving undocumented patients’ access to care
(1.0 AMA PRA Category 1 Credit™)

In our current political and social climate, a patient’s access to care is influenced by their citizenship status. Physicians can improve care outcomes for patients, regardless of their citizenship status, by creating an inclusive care environment and decreasing barriers to accessing care. Join us to learn what you can do to improve care for members of this vulnerable population.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Is there a vaccine for burnout?
Building resilience in the medical student community

10 a.m. - 11 a.m. | Saturday, November 10 | Exhibit Hall C | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

10 - 11 a.m.  Is there a vaccine for burnout? Building resilience in the medical student community

The pressures of medical school can have a major impact on students’ mental health and wellness. Now more than ever, medical students need to be able to identify the appearance of burnout in themselves and their peers. In having this knowledge, students will be able to support one another and build resilient peer networks. Learn how you can solve the burnout epidemic and build resiliency among your peers.
Difficult conversations: End of life care

11 a.m. - Noon | Saturday, November 10 | Potomac 6 | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

End of life discussions are a difficult and necessary part of medicine. While important, physicians do not learn how to compassionately and comprehensively discuss death with patients and their families during their training. Learn how to effectively facilitate these important conversations with your patients and their families.
Older and wiser: Assessing competency of elder physicians

Noon - 1:30 p.m. | Saturday, November 10 | Woodrow Wilson A | Gaylord National Resort and Convention Center

SENIOR PHYSICIANS SECTION & COUNCIL ON MEDICAL EDUCATION

Noon - 1:30 p.m. Older and wiser: Assessing competency of elder physicians
(1.5 AMA PRA Category 1 Credits™)

Current research suggests that physician competency and practice performance decline with increased years in practice (Hawkins, 2016). Knowing when to give up practice is an important decision for most physicians, but many physicians lack information and education regarding the effects of aging on practice. This program will review current evidence and research regarding the assessment of senior/late career physicians to help attendees understand the uncertain and variable influences of aging on clinical and cognitive competency.

The AMA’s Council on Medical Education worked in collaboration with the Senior Physicians Section to identify organizations to work together on the AMA Work Group on Assessment of Senior/Late Career Physicians over the last three years. Council on Medical Education Report 1-I-18 will be the product, in part, of these discussions.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
How will the November elections affect LGBTQ patients and physicians?

5:00 p.m.–7:00 p.m. | Saturday, November 10 | Potomac 2 | Gaylord National Resort and Convention Center

ADVISORY COMMITTEE ON LGBTQ ISSUES

5:00–7:00 p.m. How will the November elections affect LGBTQ patients and physicians?

How will the November elections affect LGBTQ patients and physicians? The Advisory Committee on LGBTQ Issues will host a townhall to explore how the November elections could impact LGBTQ health policy.
Acculturation: Continuous immersion and improvement for IMGs

5:15 p.m.- 5:45 p.m. | Saturday, November 10 | Potomac 3 & 4 | Gaylord National Resort and Convention Center

INTERNATIONAL MEDICAL GRADUATE SECTION

5:15-5:45 p.m. Acculturation: Continuous Immersion and Improvement for IMGs (0.5 AMA PRA Category 1 Credit™)

International Medical Graduates (IMGs) face challenges navigating American culture and societal norms when practicing medicine in the United States. These differences influence how IMGs engage with their patients, their colleagues and other members of the care team. Acculturation can help with navigating these differences and empower you with the tools and knowledge needed to navigate American culture and avoid common misunderstandings. Join the AMA- IMG Section to learn about acculturation and resources that are available to help you improve your interactions with others.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 0.5 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
The more things change: Issues facing senior women physicians

6:00 p.m.- 6:30 p.m. | Saturday, November 10 | Woodrow Wilson D | Gaylord National Resort and Convention Center

**WOMEN PHYSICIANS SECTION**

6:00-6:30 p.m.  
**The more things change: Issues facing senior women physicians**

Come hear cutting edge research by our 2017 Joan F. Giambalvo Fund for the Advancement of Women grant winners.
The business of improving workforce diversity

6 p.m.– 7 p.m. | Saturday, November 10 | Potomac 6 | Gaylord National Resort and Convention Center

MINORITY AFFAIRS SECTION

6 – 7 p.m. The business of improving workforce diversity

Immediately following the HOD Opening Session at 6pm on Saturday, November 10, MAS will hold its business meeting, which will feature a panel discussion on physician entrepreneurs and their efforts to improve the pipeline of, and career development for underrepresented minorities in medicine. All are welcome.
Busharat Ahmad, MD
leadership development program:
How to earn an AMA leadership position

2:30 p.m.– 4:00 p.m. | Sunday, November 11 | Potomac 4 & 5 | Gaylord National Resort and Convention Center

INTERNATIONAL MEDICAL GRADUATES SECTION

2:30-4:00 p.m. Busharat Ahmad, MD leadership development program: How to earn an AMA leadership position

Join the AMA-IMG Section to learn how to become a leader within the AMA.
During the last several months, the AMA has been involved in the following cases that concern medical staff issues:

1. **Brugaletta v. Garcia** (N.J. S.Ct.)

   **Issue**

   The issue in this case was whether the New Jersey Patient Safety Act, N.J.S.A. §§ 26:H-12:23 to -12.25 (NJ PSA), created a privilege against legal discovery of a hospital’s self-critical report of a patient’s care.

   **AMA interest**

   The AMA supports the protection of peer review information from litigation discovery.

   **Case summary**

   The plaintiff, Janelle Brugaletta, alleged that she reported to the emergency room at Chilton Medical Center, complaining of persistent abdominal pain and a fever. She had also reported body aches, weakness, and a phlegmatic cough. She was incorrectly diagnosed with pneumonia. In fact, she had appendicitis and pelvic abscess.

   Brugaletta sued Chilton for medical malpractice. She also sued Calixto Garcia, D.O., Steven D. Richman, M.D., and Patrick J. Hines, M.D., three of the physicians who had allegedly misdiagnosed her.

   During pre-trial preparation, Brugaletta learned that Chilton had prepared an analysis of her care, entitled “Event Detail History with all Tasks” (Event Detail). She demanded production of the Event Detail. Chilton, however, refused to produce it, claiming the NJ PSA privileged it from discovery.
The trial court ordered production of a redacted version of the Event Detail. It found that Chilton had not reported Brugaletta’s alleged misdiagnosis to the New Jersey Department of Health, and such reporting was a precondition to a claim of privilege under the NJ PSA.

Chilton appealed to the Appellate Division, the intermediate appellate court in New Jersey. The Appellate Division found that the Event Detail included a “self-critical analysis” of Brugaletta’s care. It held that such self-critical analyses are privileged from discovery under the NJ PSA. Further, although the NJ PSA requires that certain patient care events be reported to the New Jersey Department of Health, reporting is not a precondition to a privilege claim. The Appellate Division reversed the trial court production order.

Brugaletta appealed to the New Jersey Supreme Court. In a split decision on July 25, 2018, the Supreme Court affirmed the appellate court ruling, finding that where an entity meets the procedural requirements, the NJ PSA “unconditionally” protects the process of self-critical analysis. However, the Court reversed on a separate issue relating to Chilton’s disclosure obligations under New Jersey’s Patient Bill of Rights.

Litigation Center involvement

The Litigation Center and the Medical Society of New Jersey filed an amicus brief in the New Jersey Supreme Court to support Chilton’s privilege claim under the NJ PSA.

2. Daley v. Teruel and Ingalls Memorial Hospital (Ill. App.Ct.)

Issue

The issue in this case was whether the Federal Patient Safety and Quality Improvement Act of 2005, 42 USC §§ 299b1-21 et seq. (PSQIA), protects hospital incident reports from discovery in litigation.

AMA interest

The AMA supports the protection of peer-review information from litigation discovery.

Case summary

Terri Daley is the Independent Administrator of the Estate of Rosalie Jones. Daley alleged that Ms. Jones was admitted to Ingalls Memorial Hospital (Ingalls) for renal failure on November 6, 2013. Ingalls staff, including nurses Kevin Teruel and Victoria Hall, was responsible for monitoring Ms. Jones’ blood glucose levels. On the night of November 17, 2013, her blood glucose level was 203. She was then given insulin.

At 3:32 am on November 18, 2013 a nurse drew Ms. Jones’ blood for a comprehensive test. The results of this test showed a blood glucose level of 16, which generated a “panic low.” However, Ms. Jones’ treatment team was not made aware of this test result. At approximately 6:20-6:30 am
on the same day, Ms. Jones was found to be unresponsive. She then suffered irreversible brain damage, and she later died from these injuries.

Ingalls had contracted with the Clarity Patient Safety Organization (Clarity PSO), a federally and state certified PSO, in 2009. Ingalls maintained a patient safety evaluation system—Healthcare SafetyZone Portal—to collect and report information to Clarity PSO. Ingalls personnel submitted incident reports to Clarity PSO through the Healthcare SafetyZone Portal in relation to Ms. Jones’ treatment. Ingalls did not retain copies of these reports.

Daley sued Teruel, Hall, and Ingalls for medical malpractice. As part of discovery, Daley’s attorneys requested the incident reports that had been submitted to Clarity PSO. Ingalls objected to this request, citing PSQIA. After a hearing on Daley’s motion to compel production of the incident reports, the trial judge deemed them discoverable under Illinois law and ordered their production.

Ingalls filed a motion to reconsider, which the trial judge denied. Ingalls refused to produce the incident reports and asked to be held in “friendly contempt,” which would allow an interlocutory appeal. The trial court obliged.

Ingalls appealed the production and contempt orders to the Illinois Appellate Court, First District. In June of 2018, the court found that the PSQIA pre-empted Illinois law and that the incident reports constituted privileged work product under the PSQIA. The appellate court reversed the trial court ruling and remanded the case for further proceedings.

Litigation Center involvement

The Litigation Center, along with the Illinois State Medical Society and the Illinois Health and Hospital Association, filed an *amicus* brief to support Ingalls.

3.  **Desai v. Lawnwood Medical Center** (FL Dist.Ct.App.4th Dist.)

**Issue**

The issue in this case is whether a hospital could lawfully refuse to renew the medical staff privileges of a physician, after the medical staff itself had approved that renewal.

**AMA interest**

The AMA supports medical staff self-governance, and it opposes retribution against physicians who advocate on matters regarding the profession or regarding medical staff self-governance.

**Case summary**

Anil Desai, MD, is a strong advocate of medical staff self-governance and a fervent supporter of the AMA. He has urged other members of the Lawnwood Medical Center medical staff to join the AMA. In fact, he offered $10,000 from his own pocket to pay the membership dues of
Lawnwood physicians who would join the AMA. Unfortunately, only a few of the physicians took him up on the offer, and he ended up donating most of the money to the AMA Foundation.

Dr. Desai spoke at a Litigation Center Open Meeting about a lawsuit involving Lawnwood. He was also featured prominently, with his picture, in the AMA’s 2007 Annual Report.

Dr. Desai had held medical staff privileges at Lawnwood since approximately 1990. His privileges had never been questioned until 2009, when he routinely applied for their renewal.

The medical staff recredentialing committee (RC) and the medical executive committee (MEC) both recommended that his renewal application be granted. The hospital administration, however, protested that recommendation. Purportedly based on its own investigation of Dr. Desai’s record, including reports from outside consultants, the hospital claimed several examples of deficiencies in his patient care and also instances of “disruptive behavior.” The administration may have been motivated by a desire to exact retribution against Dr. Desai on account of his advocacy for medical staff self-governance.

The RC and MEC reconsidered Dr. Desai’s application for recredentialing in light of the hospital’s claims, but they found those claims factually unconvincing. The RC and MEC renewed their recommendation in favor of recredentialing. The hospital administration again protested the RC/MEC recommendation.

As a result, the renewal request was brought to the attention of the hospital board of trustees for decision. The board of trustees rejected Dr. Desai’s application, based on the same charges which the RC and MEC had found unconvincing.

Subsequent to its rejection of Dr. Desai’s renewal application, the hospital offered him what it characterized as a “fair hearing.” Dr. Desai was required to notify the hospital within 30 days to accept the fair hearing offer, but he declined to do so.

Dr. Desai sued the hospital to have his privileges renewed, asserting that the hospital had violated his right to be recredentialing under the procedures of the medical staff bylaws. He maintained that he was not obliged to accept the hospital’s fair hearing procedure because that procedure was not contemplated under the medical staff bylaws. He argued that both the hospital and he were bound under the medical staff bylaws, under which he had been found suitable for recredentialing.

The trial court dismissed Dr. Desai’s lawsuit, because he had not exhausted the administrative remedies available to him under the fair hearing procedure. Dr. Desai appealed that dismissal to the Florida District Court of Appeal, Fourth District, which affirmed the dismissal.

Dr. Desai appealed to the Florida Supreme Court. Oral argument has been heard and the case is under advisement.
AMA involvement

The AMA filed an *amicus* brief to support Dr. Desai. The principal argument in the brief was that the hospital’s “fair hearing” procedure was, in fact, unfair.

4. **Florida Health Sciences Center, Inc. v. United States Dep’t. of HHS** (M.D. Fla.)

Issue

The issue in this case is whether the Federal Patient Safety and Quality Improvement Act of 2005, 42 USC §§ 299b1-21 *et seq.* (PSQIA), protects hospital incident reports from litigation discovery.

AMA interest

The AMA supports the protection of peer-review information from litigation discovery.

Case summary

In 2004, the State of Florida amended its constitution to state that, “patients have a right to have access to any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident.”

Recently, the Florida Supreme Court interpreted Amendment 7 to require disclosure of hospital incident reports and records prepared for submission to both (1) Florida’s hospital licensure authority and (2) a Patient Safety Organization (PSO). *S. Baptist Hosp. of Fla., Inc. v. Charles*, 209 So.3d 1199 (Fla. 2017).

In this case, Lawrence Brawley, a former patient of Florida Health Sciences Center, Inc. (the hospital), allegedly suffered injuries during the placement of a spinal cord stimulator. He sued the hospital in a Florida state court for medical malpractice.

As part of ordinary pre-trial discovery, Brawley asked the hospital to produce all analyses and records related to adverse medical events involving his care. In response to this request, the hospital identified (but did not produce to Brawley) various adverse event reports that were prepared for and reported to the hospital’s PSO, PSO of Florida. The hospital has concluded, based on *Baptist Hosp. of Fla., Inc. v. Charles*, that the Florida state court will require it to produce at least some of the adverse event reports.

The state court case remains pending. As far as we know, the state court has not yet ordered production of the adverse event reports.

The hospital sued HHS and Brawley in federal court. It alleged that it confronted a dilemma. On the one hand, if it refused to obey the anticipated state court order for document production, it could be in contempt of that order and would incur various penalties. On the other hand, if it did produce the documents it might be fined by HHS for “knowing … violation” of PSQIA’s confidentiality provisions. The hospital requested that the court declare that: 1) the adverse event
reports are privileged and confidential under the PSQIA, and 2) Florida’s Amendment 7 is preempted by the federal PSQIA (and thus, at least by inference, *Baptist Hosp. of Fla., Inc. v. Charles* was wrongly decided). It further requested that the court enjoin HHS from assessing a fine against the hospital if it “knowingly” complies with a state court order requiring production of information deemed confidential under PSQIA.

HHS moved to dismiss for a variety of technical reasons, including an argument that the hospital’s objection to production should be made in state court, rather than in federal court. The federal court denied this motion, observing that the hospital was between “a rock and a hard place.” The court also allowed PSO of Florida to intervene as a plaintiff in the case, which means that PSO of Florida is a party in the federal suit, aligned with the hospital.

The parties anticipate that a motion for summary judgment will be filed shortly.

**Litigation Center involvement**

At the appropriate time in the proceedings, the Litigation Center will file a brief in support of the hospital.

5. **Miranda v. Laredo Specialty Hospital** (Webb Cnty. Tex. Dist.Ct.)

**Issue**

The principal issue in this case, still at the trial court level, is whether two hospitals violated Texas antitrust laws by suspending Dr. Eduardo Miranda’s medical staff privileges without due process. Secondary issues are based on claims of tortious interference with prospective business relations, defamation, business disparagement, and civil conspiracy.

**AMA interest**

The AMA opposes the loss of medical staff privileges without due process.

**Case summary**

Dr. Miranda lives and works in Laredo, Texas. He is board certified in internal medicine, oncology, and hematology, and he owns and operates an oncology/hematology clinic. Since 1999 and until the incidents described below, he had medical staff privileges at Laredo Specialty Hospital and at Laredo Medical Center (different institutions).

In 2007 and 2008, Dr. Miranda purchased cancer treatment medications from a pharmaceutical supplier, which he believed was located in the United States. In fact, however, the supplier was a Canadian company. Although the medications were chemically identical to medicines available from American companies, the FDA had not inspected the drug company’s manufacturing operations. Furthermore, the labeling and package inserts for these drugs were not FDA approved.
Dr. Miranda used the medications on his patients in violation of “strict liability” statutes. Accordingly, his belief that he was ordering from an FDA-approved American company was not a defense to the crime. Likewise, his knowledge or lack of knowledge of FDA requirements was not an element of the crime.

In 2013, the United States government brought a criminal suit against Dr. Miranda. Dr. Miranda agreed to plead guilty to a misdemeanor under a plea agreement. He was placed on five years’ probation and was required to make restitution of approximately $1 million in Medicare and Medicaid amounts paid to him. He was also restricted from participation in federal healthcare programs, including Medicare and Medicaid. However, these restrictions did not apply to Dr. Miranda’s practice in Webb County, Texas, which included Laredo.

In August 2015, Laredo Medical Center summarily terminated Dr. Miranda’s medical staff privileges, ostensibly based on his criminal conviction and federal healthcare program exclusion (or restriction). His request for a peer review hearing was denied.

In February 2016, Laredo Specialty Hospital also terminated Dr. Miranda’s medical staff privileges. As before, he was not afforded a peer review hearing.

Dr. Miranda and his clinic sued Laredo Specialty Hospital and Laredo Medical Center in the Webb County, Texas District Court, alleging a violation of the Texas Free Enterprise and Antitrust Act of 1983, which roughly tracks the provisions of the federal Sherman Act in outlawing monopolistic behavior. Plaintiffs contend that Laredo Medical Center, which recently built a cancer infusion center through which it could provide chemotherapy drugs in a hospital setting, became a competitor of the plaintiffs and terminated Dr. Miranda’s staff privileges in order to eliminate a dangerous competitor (in that plaintiffs could provide similar chemotherapy treatment in a less expensive, non-hospital setting).

Plaintiffs further allege that Laredo Medical Center induced the termination of Dr. Miranda’s medical staff privileges at Laredo Specialty Hospital to advance its anti-competitive plans. In other words, plaintiffs contend that the misdemeanor conviction and the limitation on participation in federally funded healthcare programs were not the basis for termination, but were simply pretexts to justify this anti-competitive scheme. The plaintiffs are also alleging tortious interference with prospective business relations, defamation, business disparagement, and civil conspiracy.

Litigation Center involvement

The Litigation Center contributed funds to the Texas Medical Association, which, in turn, used the money, plus funding of its own, to pay a portion of Dr. Miranda’s legal fees and expenses.
6. **Tulare Hospital Medical Staff v. Tulare Local Healthcare District**  
   (Tulare Cnty. Cal. Super. Ct.)

**Issue**

The issue in this case was whether Tulare Regional Medical Center (Tulare Hospital), a publicly owned hospital in Tulare, California could unilaterally dissolve its medical staff and form a new medical staff, with the same members as the previous one but with medical staff officers of the hospital’s choosing and without affording the medical staff an opportunity to approve or reject the new medical staff bylaws.

**AMA interest**

The AMA supports medical staff self-governance.

**Case summary**

Tulare Hospital claims it was compelled to create a new medical staff governance structure because the medical staff leadership had acted antagonistically to the hospital’s interests. Both the Joint Commission and the Centers for Medicare and Medicaid Services cited Tulare Hospital for deficiencies relating to its medical staff.

On January 26, 2016, Tulare Hospital, at a closed meeting of its board of trustees, abruptly terminated its relationship with the organized medical staff then in existence. In place of the former medical staff, the hospital created a new medical staff, under new medical staff bylaws. All members of the former medical staff were provisionally credentialed on the new medical staff. Except for a select few, members of the old medical staff had no opportunity to approve their new bylaws or vote on their new officers. Also, the old medical staff had funds, from which the hospital blocked access.

The medical staff maintains that any failures associated with the relationship between the medical staff and the hospital should be attributed primarily or fully to the ineptitude of the Tulare Hospital administration. Furthermore, the former medical staff was investigating the professional competence of three of the newly handpicked medical staff officers, and this may have motivated the hospital’s precipitous action. On February 10, 2016, the former medical staff sued Tulare Hospital for its usurpation of the medical staff’s self-governing prerogative.

The case has been tried. However, before the court rendered a decision, the hospital filed for bankruptcy. This automatically stayed all litigation pending against the hospital, including the suit of the former medical staff.

The parties settled the case on July 18, 2018. Under the settlement, the hospital agreed (a) not to recognize the replacement staff, its leaders or bylaws, (b) to reinstate the original medical staff and its duly-elected officers, with all the privileges, rights and status that existed before the hospital terminated the previous bylaws, (c) to reinstate the pre-existing medical staff bylaws, rules and policies, and (d) to pay $300,000 for the medical staff’s attorneys’ fees and costs.
Litigation Center involvement

The Litigation Center, along with the California Medical Association, the Tulare County Medical Society, and numerous individual physicians throughout the State of California, helped to defray the medical staff legal expenses.

Further information about these cases and about the Litigation Center can be found at: http://www.ama-assn.org/go/litigationcenter.
About the OMSS

Our People

- Committees
- State Chairs
- Governing Council

Documents

- OMSS Representative duties and responsibilities
- OMSS Internal Operating Procedures

Contact information

AMA Department of Organized Medical Staff Services
330 N Wabash Ave, Suite 39300
Chicago, IL 60611
Phone: (312) 464-4539
Fax: (312) 464-2450
Email: omss@ama-assn.org
Website: ama-assn.org/go/omss
OMSS Committees

Thank you to the following OMSS members for their contributions to the Section!

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<td>Vimal Nanavati, MD, Chair</td>
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<td>Ricardo Correa, MD</td>
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<td>James Guo, MD</td>
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<td>Alice Coombs, MD, Vice Chair</td>
<td>Raj Lal, MD</td>
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<td>Nancy Fan, MD</td>
<td>Nestor Ramirez, MD</td>
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<td>Catherine Ferguson, MD</td>
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OMSS State Chairs

If you notice an error, or would like to fill a vacancy, please email: omss@ama-assn.org.

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OMSS Governing Council

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<th>Name</th>
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<tr>
<td>David Welsh, MD</td>
<td>Chair</td>
<td><a href="mailto:djwelsh_1980@yahoo.com">djwelsh_1980@yahoo.com</a></td>
<td>Dr. Welsh is a general surgeon in solo practice in Batesville, Ind., and the OMSS representative for Margaret Mary Health and Decatur County Memorial Hospital.</td>
</tr>
<tr>
<td>John Spurlock, MD</td>
<td>Vice Chair</td>
<td><a href="mailto:jonthebold@aol.com">jonthebold@aol.com</a></td>
<td>Dr. Spurlock is a gynecologist in solo practice in Bethlehem, Penn., and the OMSS representative for St. Luke’s Hospital.</td>
</tr>
<tr>
<td>Nancy Church, MD</td>
<td>Secretary</td>
<td><a href="mailto:nancyrgchurch@gmail.com">nancyrgchurch@gmail.com</a></td>
<td>Dr. Church is an obstetrician and gynecologist in solo practice in Chicago, Ill., and the OMSS representative for Advocate Christ Medical Center.</td>
</tr>
<tr>
<td>Matthew Gold, MD</td>
<td>Delegate</td>
<td><a href="mailto:mdgold@massmed.org">mdgold@massmed.org</a></td>
<td>Dr. Gold is a neurologist in solo practice in Winchester, Mass., and the OMSS representative for Highland Healthcare Associates.</td>
</tr>
<tr>
<td>Raj Lal, MD</td>
<td>Alternate Delegate</td>
<td><a href="mailto:r_lal@ix.netcom.com">r_lal@ix.netcom.com</a></td>
<td>Dr. Lal is a cardiovascular thoracic surgeon in Oakbrook, Ill., and the OMSS representative for Loyola-Gottlieb Memorial Hospital.</td>
</tr>
</tbody>
</table>
| **John Flores, MD, Member at-Large**  
| **johnjala66@verizon.net**  
| Dr. Flores is an internist with Little Elm Medical Clinic in Little Elm, Texas, and the OMSS representative for UT Southwestern Clinically Affiliated Physicians. |

| **Lawrence Monahan, MD, Member at-Large**  
| **lkmonahan@jimed.roacoxmail.com**  
| Dr. Monahan is an internist with Jefferson Internal Medicine in Roanoke, Va., and the OMSS representative for LewisGale Medical Center. |
AMA Organized Medical Staff Section
Representative Information
Updated September 2017

Qualifications & Selection

OMSS representatives must be physician members of the AMA.

Representatives are selected by their medical staffs, using whatever process the medical staff deems appropriate. Each medical staff may select up to two representatives; additionally, the president or chief of staff may serve as a third representative if he or she is a physician member of the AMA.

The medical staff’s choice of representative(s) must be certified in writing by the medical staff president or secretary.

Duties & Responsibilities

1. Serve as a liaison between members of your medical staff and the OMSS:
   a. Represent the concerns of your medical staff at OMSS Annual/Interim meetings and other events, schedule permitting, and otherwise contribute to the AMA’s understanding of the challenges facing medical staffs and their members.
   b. Distribute information about OMSS meetings, events, and resources to members of your medical staff and other hospital/health system leaders, ideally providing semi-annual reports to your medical staff executive committee or full medical staff.
   c. Maintain contact with OMSS leadership and staff.

2. Advocate for and educate/mentor other physicians, including residents/fellows and young physicians, on the significance of medical staff governance and on the role of physicians in improving patient outcomes and enhancing physician experience.

3. Serve as a local expert on medical staff-related matters, answering questions from your medical staff and other stakeholders. Refer questions/concerns to OMSS as necessary.

4. Participate in OMSS meetings and events, schedule permitting. Where feasible, seek hospital and/or medical staff financial support for OMSS representative attendance at OMSS meetings and events.

5. Assist in OMSS member recruitment efforts at the local level.
American Medical Association Organized Medical Staff Section
Internal Operating Procedures

I. Mission and Vision Statement

A. Mission Statement. AMA Bylaw 7.01 defines the mission of the AMA Sections as follows:

1. **Involvement.** To provide a direct means for membership segments represented in the Sections to participate in the activities, including policy-making, of the AMA.

2. **Outreach.** To enhance AMA outreach, communication, and interchange with the membership segments represented in the Sections.

3. **Communication.** To maintain effective communications and working relationships between the AMA and organizational entities that are relevant to the activities of each Section.

4. **Membership.** To promote AMA membership growth.

5. **Representation.** To enhance the ability of membership segments represented in the Sections to provide their perspective to the AMA and the House of Delegates.

6. **Education.** To facilitate the development of information and educational activities on topics of interest to the membership segments represented in the Sections.

B. Mission specific to the OMSS. The AMA Organized Medical Staff Section (OMSS) provides a direct and ongoing relationship between the AMA and medical staff organizations. The Section debates issues and develops policy that influences the complex and rapidly changing environment within which our nation's hospitals and other delivery systems operate. Specifically, the OMSS:

1. Develops and nurtures medical staff leadership within the policy-making structure of the AMA, as well as state and county medical associations.

2. Provides a forum to discuss timely and often controversial issues, solve problems, and avoid polarization of medical staffs.

3. Identifies the implications of future trends, and the role of medical staffs individually and collectively.

4. Serves as a clearinghouse for issues pertinent to medical staffs.

5. Works to strengthen the self-governing medical staff.

6. Provides medical staff leaders with a contact point to receive timely information, as well as AMA source materials and services.
II. Membership

A. AMA Bylaw 7.41 limits membership in the Section to physicians, including residents and fellows, selected by physician members of the medical staffs of hospitals and other delivery systems.

III. Officers/Governing Council

A. Officer Designations. In addition to the Chair and Vice Chair identified in AMA Bylaw 7.04 there shall be a Secretary.

B. Governing Council. There shall be seven voting members of the Governing Council, consisting of the officers, delegate, alternate delegate and two members at-large elected at the Business Meeting of the Section as provided in AMA Bylaw 7.03. In addition, the Immediate Past Chair shall serve, ex officio, as a voting member of the Governing Council for one year only, to provide continuity in the leadership of the Section.

C. Eligibility. AMA Bylaw 7.40 defines eligibility and cessation of eligibility for those elected to the OMSS Governing Council.

D. Duties and Privileges. The Governing Council shall direct the programs and activities of the OMSS including the creation of OMSS committees, subject to the approval of such programs and activities, when required, by the Board of Trustees or House of Delegates of the AMA. Time commitments will include 5 days each for the Annual and Interim Meetings with the exception of the Delegate and Alternate Delegate whose commitment will be 7 days for the Annual Meeting and 6 days for the Interim Meeting and 4 weekend days associated with 2 Governing Council Meetings plus conference calls and other meetings on request.

1. Chair. The Chair shall:

   a. Preside at all meetings of the Section and meetings of the Governing Council.

   b. Represent the Section on all matters of policy.

2. Vice Chair. The Vice Chair shall:

   a. Assist the Chair and preside at meetings in the absence of the Chair or at the Chair's request.

   b. Act as liaison for the OMSS Outreach Program.

3. Secretary. The Secretary shall:

   a. Prepare summary minutes of Governing Council meetings in coordination with Department of Organized Medical Staff Services.
b. Work with staff of the Department of Organized Medical Staff Services in the production of communication materials.

c. Serves as Chair of the Credentials Committee

4. Delegate. The Delegate shall:

a. Present testimony on OMSS resolutions in the AMA House of Delegates.

b. Act as advocate for the OMSS in the AMA House of Delegates.

c. Monitor issues not directly commented on by the OMSS Assembly.

5. Alternate Delegate. The Alternate Delegate shall:

a. Present testimony on OMSS resolutions in the AMA House of Delegates.

b. Act as advocate for the OMSS in the AMA House of Delegates.

c. Monitor issues not directly commented on by the OMSS Assembly.

6. Members at-Large. The Members at-Large shall:

a. Complete special OMSS projects assigned by the Chair or Governing Council.

7. Immediate Past Chair. The Immediate Past Chair shall:

a. Provide continuity in the leadership of the Section.

b. Serve as an ex-officio member of the Governing Council.

E. Terms. Governing Council members, including the delegate and alternate delegate, shall serve a term of 2 years, beginning at the conclusion of the Annual Meeting at which they were elected and ending at the conclusion of the second Annual Meeting after their election. These provisions shall not be applicable to the Immediate Past Chair, whose term is one year.

F. Tenure. Governing Council members shall serve for no more than 2 consecutive terms in the same position on the Governing Council, except that the delegate and alternate delegate shall serve no more than three consecutive terms. A member elected to serve an unexpired term shall not be regarded as having served a term. These provisions shall not be applicable to the Immediate Past Chair, whose total tenure is limited to one year.

G. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next Business Meeting of the Section.
Members of the OMSS Governing Council shall be elected as follows:

**A. Time of the Election.** Elections shall be conducted at annual OMSS Business Meetings.

**B. Vacancies.** A deadline of 60 days prior to the OMSS Business meeting shall be established for the notification of a vacant position to be filled on the Governing Council. If a vacancy occurs on the Governing Council during the 60 days prior to the Business meeting, or during the Business meeting, the vacancy shall remain open until the next Business meeting when a formal election to fill the balance of the vacant position's term of office shall be held.

**C. Nominations.** A deadline of 30 days shall be established for the receipt in the Department of Organized Medical Staff Services of the nomination application from individuals declaring their candidacy for a position on the Governing Council. Any nomination form not received 30 days prior to the meeting will not be included in the advance OMSS Handbook. All candidates for office shall be urged to provide adequate information regarding their background, experience and qualifications for office by completing the application form adequately and meeting the deadline for including the application form in the advance OMSS Handbook. Nominations from the floor shall be allowed to assure to the fullest the democratic nature of the selection process.

**D. Eligibility.** Each candidate for a position on the Governing Council shall offer his/her name for only one position in any given election.

**E. Campaign Materials.** Candidates shall submit a sample of their election campaign materials to the OMSS staff before distribution.

**F. Method of Election.**

1. Nominations for election shall occur at the Business Meeting on Friday morning. If elections are uncontested, the Chair shall solicit nominations from the floor. If there are no nominations from the floor, candidates shall be elected by acclamation. The total minutes allocated to each candidate for nomination, seconding and addressing the Assembly shall be 4 minutes. Candidates for office shall be encouraged to address the Assembly during that 4-minute period.

2. Contested elections shall occur at polling places outside the Business meeting room on Saturday morning. Election results shall be announced as soon as they are available. If no candidate receives a majority of votes, the run-off election will occur between the two candidates receiving the most votes. Tellers will distribute ballots to the Assembly. Run-off election results will be announced as soon as they are available.

3. The Tellers Committee shall oversee the election process, assuring that credentials are verified and ballots are appropriately distributed, collected and tallied. The chair of the Tellers Committee will verify and transmit the election results to the Chair of the Governing Council.
V. OMSS Assembly Meeting

A. AMA Bylaw 7.06 provides for a Business Meeting of each Section on a day prior to each Annual and Interim Meeting of the House of Delegates.

B. AMA Bylaw 7.061 specifies the purpose of the Business Meeting as follows:

1. Hear such reports as may be appropriate.

2. Consider other business and vote upon such matters as may properly come before the meeting.

3. Adopt resolutions for submission by the Section to the House of Delegates.

4. Hold elections.

C. Meeting Procedure. AMA Bylaw 7.062 sets forth the general Meeting Procedure for the Sections. Additional procedures specific to the OMSS are:

1. OMSS representatives shall be seated with the representatives from their respective states at OMSS meetings. Some states hold regional caucus meetings in conjunction with the Assembly meeting. As part of their leadership responsibilities, state OMSS section chairs and caucus chairs shall be requested to:

   a. Assist in educating their representatives regarding the purposes of the reference committee hearings and OMSS business session.

   b. Appoint representatives from their state to each reference committee hearing and testify on the issues.

   c. Advise representatives that repetitious testimony during the business session should be limited;

   d. Review OMSS rules and procedures which will be used to conduct the business of the Assembly during their caucus meetings;

   e. Invite neighboring states that do not have a section to meet with their caucus;

   f. During caucus meetings review the reference committee's reasons for recommendations;

   g. Advise all representatives that they have an obligation to remain through the entire meeting; and

   h. Remain for the HOD Reference Committee hearings on Sunday and Monday, since an important purpose of the OMSS is to have the HOD adopt policies that are responsive to the needs of organized medical staffs, their representatives and the patients they serve.
D. Representatives and Alternate Representatives

1. Representatives to the Business Meeting. AMA Bylaw 7.43 states: The physician members of the medical staff of each hospital and delivery system meeting the requirements established by the Governing Council may select one or more representatives to the Business Meeting. The representatives must be physician members of the medical staff or residents/fellows affiliated with the hospital or delivery system. Selected physicians who are not AMA members may participate in the Business Meeting as provisional representatives without the right to vote. Provisional representatives may attend a maximum of 2 Business Meetings. Selected representatives to the Business Meeting shall be properly certified by the President or Secretary of the medical staff. AMA Bylaws 7.431 and 7.432 speak to ex officio participation in OMSS Business Meetings.

a. Per AMA Bylaw 7.41, selected physicians who are not AMA members may participate in the Section’s Business Meeting as provisional members without the right to vote. Provisional members may attend a maximum of 2 Business Meetings.

2. Delivery System. A delivery system is defined as any formalized medical staff organization whose purpose is to deliver health care, including group practices with 3 or more physicians.

E. Registration/Credentialing Process.

1. Before being seated at any Assembly meeting, all OMSS representatives and alternate representatives must be duly certified as the representative for his/her organized medical staff in order to be credentialed to vote at the meeting.

2. A credentialed representative may transfer his/her credentials to an alternate representative from the same hospital or other delivery system by notifying the Credentials Committee that the individual meets the criteria for serving as an OMSS representative. Upon approval of the Credentials Committee, the credentialed representative shall transfer the official badge with the credentialing ribbon and label to the alternate representative.

F. Rules of Order.

1. The Assembly meeting shall be conducted pursuant to the established rules of procedure presented by the OMSS Chair and adopted by the Assembly. These rules stem from AMA Bylaws, Procedures of the OMSS Representative Assembly approved by the Board of Trustees, decreed by its presiding officer and generally pursuant to the current edition of the Standard Code of Parliamentary Procedures (Sturgis). These include the following procedures:
a. The Chair shall preside over the Business Meeting.

b. Representative must wear his/her official badge with a credentialing ribbon at all times.

c. A representative of the Assembly wishing to obtain the floor shall approach the nearest microphone, wait to be recognized, address the Chair, and give his/her name and affiliation before speaking on the issue.

d. No one representative or recognized official observer shall speak more than once on any issue or separate motion until all who wish to speak have been heard, nor more than twice, without permission of the Chair or upon approval by a majority of the Assembly.

e. Debate shall be limited based on the recommendation of the Chair and the approval of the Assembly.

f. Any major amendments shall be submitted to the OMSS headquarters office before they are placed on the floor for discussion and action.

g. Reference committee reports, the order of business for consideration of reference committee reports, and OMSS amendment forms shall be available on Saturday morning at a specific time designated by the Chair.

h. Individual OMSS representatives and/or state delegations that wish to introduce amendments during the business session shall print or clearly write their amendment(s) on the OMSS amendment form. The completed amendment form shall be submitted to the OMSS staff office as soon as possible, but at least one hour before the Assembly convenes. Amendments shall be accepted after this time; however, state delegations and OMSS Representatives shall be encouraged to submit their amendments by the designated time.

i. To facilitate the OMSS Business Meeting, substantive amendments to reference committee reports shall be typed and projected. Amendments, which are not substantive, shall be written on the OMSS amendment form and presented to the Chair before they are placed on the floor for discussion and action.

j. Voting shall be by voice, that is the “ayes” and “nays,” except where the Chair or a delegate calls for a division of the Assembly, in which case a standing vote will be taken.

G. Quorum. Fifty percent (50%) of the credentialed, registered representatives at any business meeting of the OMSS shall constitute a quorum for the conduct of business at that meeting.
H. Resolutions.

1. Resolutions may be submitted by individual representatives or state OMSS sections.

2. Resolutions must be submitted to the AMA Department of Organized Medical Staff Services no later than 40 days prior to commencement of the Business Meeting to be considered as regular business. State OMSS Sections that adjourn during or one week preceding this 40-day period, shall be allowed 7 days after the close of their meeting, but no less than 10 days prior to the OMSS meeting, to submit resolutions to the OMSS Chicago office.

3. Late resolutions (received after the 40-day and 7-day deadlines and before 4:00 p.m. on the day before the Business Meeting convenes) shall be submitted to the Committee on Late Resolutions. The Committee is not a reference committee. It shall not hold open hearings but shall provide sponsors of late resolutions an opportunity to explain the reasons for their submission. Sponsors shall be notified of the time and location of the meeting. The Committee on Late Resolutions shall then make its recommendations to the Assembly on their acceptance and the Assembly shall vote on the acceptance of each recommendation. A two-thirds affirmative vote shall be required for acceptance as official business of the Assembly.

4. An emergency resolution may be introduced by an individual representative or state sections after 4:00 p.m. on the day before the Assembly convenes and until the Assembly adjourns. The Chair and Vice Chair shall report to the Assembly as to whether the matter involved is or is not of an emergency nature. If the Chair and Vice Chair rule that the matter is of an emergency nature, it shall be presented to the Assembly and shall require a ¾ affirmative vote by the Assembly for acceptance as emergency business. The author shall have the right to appeal the chair’s ruling, but a ¾ affirmative vote of the Assembly shall be required to overrule the chair. If time permits, the emergency resolution shall be assigned to a reference committee, otherwise it shall be presented directly to the Assembly. If the emergency resolution fails to receive a ¾ affirmative vote, the Chair shall defer its introduction until the next meeting of the Assembly.

5. Authors of resolutions shall be responsible for making certain that their resolutions are received by the Department of Organized Medical Staff Services.

6. Resolutions must be submitted in official format, either via e-mail or computer disk. Authors are encouraged to call the Department to confirm receipt of their resolution. Late resolutions, submitted after Tuesday the week of the Assembly meeting, shall be e-mailed to the Department of Organized Medical Staff Services at omss@ama-assn.org to assure receipt by AMA staff.

7. Resolutions that meet the deadline date shall be included in the OMSS Handbook, and shall be considered as items of business for the Assembly. Sponsors/authors of resolutions may make changes to their own resolutions, or withdraw them without a vote. When a resolution is withdrawn the report of the reference committee shall note the event.
8. Late resolutions accepted as official business of the Assembly shall be distributed to the Assembly and introduced by the Chair of the Committee on Late Resolutions.

9. Resolutions that appear to reaffirm AMA policy shall be reviewed by the Committee on Late Resolutions. Information supporting reaffirmation shall be provided to both the Committee and the author. If the Committee determines that the resolution reaffirms policy, it shall be placed on the Reaffirmation Consent Calendar. Resolutions reaffirming policy shall be cited in the Report of the Committee on Late Resolutions. An OMSS representative shall have the ability to extract a resolution from the Reaffirmation Calendar.

10. When a resolution presents a legal problem, AMA staff shall contact the author/sponsor and discuss the problem with the resolution as prepared. If the author/sponsor is able to remedy the situation, then the resolution shall be distributed in a routine manner. If the legal problem cannot be resolved, the Chair shall designate it a "deferred" resolution. It shall not be distributed in the OMSS Handbook. Rather, it will be referred to the Committee on Late Resolutions for consideration.

I. Reports.

The Governing Council shall issue reports in response to referred resolutions or directives stemming from adopted resolutions.

1. The Governing Council also shall have the ability to initiate reports on topics, which it believes should be brought to the Assembly's attention.

2. The Governing Council also shall have the ability to issue reports on “green” paper to discuss the disposition of OMSS resolutions that have been referred by the House of Delegates to the Board of Trustees or appropriate Council. The “green” reports shall be an item of business to allow the Assembly to fully participate in the policy-making process and to inform representatives of the outcome of their resolution.

3. Reports shall be referred to reference committees and shall be subject to discussion at the reference committee hearing. After hearing testimony, the reference committee shall make recommendations to adopt, amend, not adopt, file, or refer back to the Council for further consideration. Reports of an informational nature with no specific proposal for action may be filed.

VI. OMSS Committees

A. Credentials Committee.

1. The Credentials Committee is chaired by the Secretary of the Governing Council with assistance from other Governing Council members or state chairs when needed. The number to serve on the Credentials Committee will be determined by the Chair of the Governing Council based on meeting attendance.
2. The Committee is responsible for consideration of all matters relating to the
registration and credentialing of all representatives.

B. Committee on Late Resolutions.

1. The Committee on Late Resolutions is composed of 5 representatives selected by
the Chair to meet with authors of late resolutions prior to the opening of the
Assembly.

2. This Committee does not hold open hearings, but provides the sponsors of all late
resolutions an opportunity to explain the reasons for submitting them.

3. The Committee considers the emergency nature of each late resolution. If the
resolution is not of an emergency nature, it is recommended that the resolution be
resubmitted to the next regular business meeting of the OMSS.

4. The Committee then submits its recommendations to the Assembly. The
Assembly votes on the acceptance of each resolution. A two-thirds affirmative
vote is required for acceptance of any item as official business of the Assembly.

5. The Committee also reviews resolutions that may be a reaffirmation of AMA
policy. The Committee provides a reaffirmation calendar to the Assembly. A
representative can extract a resolution from a reaffirmation calendar for referral to
a reference committee. The Committee shall cite the current policy which the new
resolution reaffirms in their report to the Assembly.

C. Reference Committee(s).

1. Reference committees shall consist of 5 representatives, who are selected by the
Chair in consultation with the Governing Council. The committees shall conduct
open hearing on all items of business before the Assembly. Based on testimony
and their deliberations, the reference committee shall develop a report and make
recommendations on the disposition of all referred items of business.

2. Reference committee reports shall comprise the bulk of the Business Meeting.
They shall be constructed swiftly and succinctly after completion of the hearings in
order that they may be processed and made available to the representatives as far in
advance of formal presentation as possible.

3. Reference committees shall have wide latitude in their efforts to facilitate the will
of the participants on the matters before them. They shall be able to amend
resolutions and consolidate similar resolutions by constructing substitutes. They
also shall be able to recommend the usual parliamentary procedure for disposition
of the business before them, such as adopt, not adopt, amend and refer.
Resolutions and reports, which are grouped together, shall be carefully reviewed to
verify that they are similar.

4. All reference committee members shall review and sign the final report. The
OMSS Chair and Vice Chair shall review, with the reference committee chairs, the
final reference committee reports for parliamentary procedure and clarity.
5. The entire report of the reference committee shall be presented on a Consent Calendar, with the items of business grouped together according to the committee’s recommended courses of action. When the reference committee moves adoption of the consent calendar, the Chair shall ask if any member of the Assembly wishes to extract any item from it to be considered separately. Upon request of any representative, the item shall be withdrawn from the calendar and shall be considered as a separate item after the remainder of the consent calendar is acted upon.

6. The Chair shall open for discussion the matter that is the immediate subject of the reference committee report. The effect is to permit full consideration of the business at hand, unrestricted to any specific motion for its disposal. The reference committee report shall not contain a direct motion, and any appropriate motion shall be made from the floor. If the reference committee recommendation is to refer to the Governing Council, opportunity will be given prior to the discussion for referral for an alternative motion. In the absence of such a motion, the Chair shall state the question in accordance with the recommendation of the reference committee.

7. Reference committee hearings shall be open to all AMA members, OMSS representatives, guests and interested persons. The reference committee chair shall be privileged to call upon anyone attending the hearing if, in the chair's opinion, the individual has information helpful to the committee. A reference committee hearing is the proper forum for discussion of controversial items of business. In general, representatives who do not take advantage of the hearing process to present their views on an issue shall be discouraged from doing so on the floor of the Assembly.

8. Equitable hearings shall be the responsibility of the reference committee chair, and the committee may establish its own rules on the presentation of testimony with respect to limitations of time, repetitive statements and the like. The chair shall also have the jurisdiction over such matters as photography, television filming and the introduction of recording devices. If, in the Chair's estimation, these actions would be or become undesirable in order to conduct an orderly hearing, the Chair can prohibit them.

9. The reference committee chair shall not query those in attendance or take an informal vote on matters before the reference committee. Committee members shall be free to ask questions of those at the microphone in order for clarification or understanding of a statement. They also shall have the ability to answer questions if a member seeks clarification on an issue, but never shall engage in a debate with speakers or express opinions during the hearing. It shall be the charge of the committee to listen carefully and evaluate all opinions presented so that the recommendations in the reference committee report reflect thoughtful consideration.

10. After an open hearing, the reference committee members shall meet separately in executive session to deliberate and prepare a report. The committee shall have the ability to call into the executive session anyone who it wishes to hear from or question.
D. **Tellers Committee.**

1. The Tellers Committee is composed of 15 representatives, one of whom serves as chair. At the request of the Governing Council Chair, members of this committee are responsible for taking a count of votes in a designated section of the Assembly during the Business Meeting.

2. The Committee is selected by the Governing Council Chair.

3. The Committee is also responsible for distributing, collecting, and counting ballots during the elections.

VII. **Miscellaneous**

A. **Conflict of Interest.** OMSS Representatives or other individuals providing testimony at a reference committee hearing or speaking on the floor at the Business Meeting who have a personal interest or a substantial financial interest in a commercial enterprise which interest will be materially affected by a matter before the Assembly, including any pending litigation, must publicly disclose that interest before speaking.

B. **Testimony at House of Delegates Reference Committee Hearings.** Any member of the AMA has a right to testify before a HOD reference committee and share his/her views on any item of business. However, since the AMA Bylaws provide only for a Delegate and Alternate Delegate to represent the OMSS in the HOD and to minimize confusion at the HOD reference committee hearings, an OMSS Representative shall not introduce himself/herself as an OMSS representative unless the OMSS Delegate or Alternate Delegate has asked the representative to present testimony on behalf of the OMSS.

C. All material/information to be distributed to the Assembly must be cleared through the OMSS office.

D. Material relating to business of the OMSS shall be distributed during the Business Meeting. The Chair shall advise representatives and participants of this material.

E. Smoking shall be prohibited at all official business meetings of the OMSS including the Business Meeting, reference committees and workshops.

F. A credentialed representative may transfer his/her credentials to an alternate representative from the same entity by notifying the Credentials Committee that the individual meets the criteria for serving as an OMSS representative. Upon approval of the Credentials Committee, the credentialed representative shall transfer the official badge with the credentialing ribbon and label to the alternate representative.

G. The disposition of all new business or issues that are introduced by an OMSS educational speaker or at the open forum may be introduced as an emergency resolution by an OMSS representative.

H. A parliamentarian may be selected by the Chair prior to each meeting.