



MEMBERSHIP
MOVES
MEDICINE™

AMA Guides® Editorial Panel

Virtual Panel Meeting
Thursday, November 18th, 2021

Please Mute Your Computer to Prevent Background Noise

Participants will be placed in the waiting room until the meeting begins at 6:00 PM CT

Topics

- October Meeting Summary
- Proposals to update the AMA Guides:
 - ENT
 - fPROMs
- Closing of Public Meeting
- Executive Session

Attendance

- Attendance will be taken to establish a quorum.

Panel Members

Helene Fearon, PT
Steven Feinberg, MD
David Gloss, MD
Robert Goldberg, DO
Rita Livingston, MD, MPH

Doug Martin, MD
Kano Mayer, MD
Mark Melhorn, MD
Lylas Mogk, MD
Marilyn Price, MD

Noah Raizman, MD
Michael Saffir, MD
Jan Towers, PhD

Panel Advisors

Chris Brigham, MD
Hon. Shannon Bruno Bishop, JD
Barry Gelinas, MD, DC

Abbie Hudgens, MPA
Hon. David Langham, JD

Confidentiality/COI Reminders

- Confidentiality
 - It is at the discretion of the AMA, the publisher and convener, which topics, news items, or policy decisions resulting from this or any Editorial Panel meeting will be announced publicly at the appropriate time. Until and unless the AMA makes such a public announcement, all discussion and decisions made during AMA Guides® Editorial Panel Meetings are confidential.
 - Please refrain from tweeting or participating in podcasts, interviews, or news articles about Panel meetings, discussions, or deliberations. Recording devices by Panel members and co-chairs is strictly prohibited. The AMA will record all Panel meetings for reference materials and will be the only recording of Panel meetings allowed.
- Conflict of Interest (COI)
 - You are here because of your interest and/or experience with the AMA Guides®, but your affiliations could pose a potential conflict of interest. Please mention all of your disclosures if they are relevant to the topic being discussed or the opinions you hold and express.
 - While you were nominated by a society, remember that your Editorial Panel duty is to the AMA Guides®. You are not here to represent the interests of any society, profession, or employer.

Professional.

Ethical.

Welcoming.

Safe.

- Updated policy in early 2019.
- This is what we expect of our members and guests at AMA-sponsored events.
- We take harassment and conflicts of interest seriously. Read our policy or file a claim at **ama-assn.org/codeofconduct** or call **(800) 398-1496**.

Meeting Mechanics

- Webcams are optional but may be used if Panel Members and Advisors wish to do so
- Panel members and advisors are open-line participants and may speak at any time throughout the duration of the event.
 - Please consider muting your phone to prevent background noise and raising your hand to pose a question or comment.
- All other attendees are open line participants but have been auto-muted to prevent background noise.
- Hand raise or chat feature encouraged to indicate desire to speak. **Please unmute yourself prior to speaking.**

Meeting Mechanics (con't)

- Co-chairs will introduce proposals and presenters.
- Presenters will provide an overview of the proposal.
- Primary and secondary reviewers will be called upon first to lead discussion and recommend action.
- Editorial panel members and advisors are encouraged to contribute to discussion.
 - Oral disclosures are not required of panel members and advisors during the meeting but might be helpful when expressing a strong opinion.
- Public participants are invited to participate towards the end of discussion and are asked to disclose any conflicts of interest when introducing themselves.

October 14 Meeting Highlights

- **Three Newsletter articles** were **approved** by the Panel as **authoritative**. Authoritative articles reflect an official AMA interpretation, application or clarification. **Revisions to the AMA Guides are not made via the Newsletter**. These designated articles are in the process of being earmarked AMA Guides Digital.
- **Grade Modifiers:** Discussions of the **Spine 3-Grade modifier system** is based on current **best science** and will move the 3-Grade to the other musculoskeletal chapter when appropriate. Further discussion on this topic within the spine proposal is anticipated at the upcoming December 16th meeting.
- Discussion on **Editorial Priorities** to determine new topics to **prioritize** for advancement. Topics under consideration include telemedicine, long-haul COVID, pain and more. Further discussion and **finalization** of new topics to occur at the upcoming December 16th meeting.
- **AMA Guides Sixth 2022** is now available on **AMA Guides Digital!** Education Module will be available on **December 9th** on the **AMA Ed Hub™**.

ENT Proposal

Dr. Robert Sataloff, MD, DMA, FACS

American Academy of Otolaryngology - Head and Neck Surgery

Lase Ajayi, MD
Member since 2013

ENT Proposal - Summary

- Rotary Chair Testing (*slide 11*)
- Dysphagia
 - New Example (*slide 12*)
 - *Proposed additional Added to condition description:* Dysphagia may be caused by structural, neuromuscular, neoplastic and other maladies. Oropharyngeal tumors must be ruled out and may occur even in young people, especially in association with human papilloma virus (HPV) infection.
- Addition of videonystagmography (VNG) to subtitle and to accompany electronystagmography (ENG)

Proposed Language: Rotary Chair Testing

Rotary chair testing helps identify whether dizziness is due to dysfunction in the inner ear or brain. Caloric testing (ENG/VNG) generally is considered the gold standard for identifying unilateral vestibular dysfunction. Rotary chair testing is the gold standard for detection of bilateral vestibular dysfunction. ENG/VNG is performed to evaluate most people with suspected labyrinthine dysfunction. Rotary chair testing is obtained when bilateral disease is suspected, or when more sophisticated information is required. Rotational chair testing has no contraindications such as neck trauma, which is not the case with ENG/VNG. In rotary chair testing, rotation is computer controlled and extremely accurate. It is well-tolerated and even can be performed in children. Rotary chair testing has been used for decades, and there is extensive literature on the technique. In addition to bilateral semicircular canal paresis, common indications include equivocal or inconclusive ENG/VNG results, evaluation of vestibular compensation, ototoxicity management, and testing of special populations includes children and handicapped individuals. Rotary chair testing assesses the integrity of vestibuloocular reflex (VOR), and suppression of that reflex. The tests are complementary. Unlike caloric testing, rotary chair testing stimulates both ears simultaneously. Caloric testing assesses the vestibular system at a frequency of only 0.03 Hz; but rotary chair testing assesses from 0.01 Hz through 0.64 Hz. Common rotary chair tests include sinusoidal harmonic acceleration (SHA), VOR suppression, and the velocity step test. Other subtests may include slow harmonic (sinusoidal) testing in darkness, high-velocity or high-frequency sinusoidal rotation, rotation with fixation on head-fixed targets to evaluate suppression, optokinetic after-nystagmus, tilted-axis rotation (OVAR), rotation with fixation on earth-fixed targets, optokinetic testing, and others. Rotary chair testing allows monitoring of the VOR over time, which is important because the phase abnormality and symmetry in VOR recover in some patients following vestibular injury.

Proposed Example:

15% WPI; Subject 70-year-old man

- **History:** This 70-year-old male worked for approximately four decades in an industry in which he was exposed to carcinogens. He had no history of smoking cigarettes or consuming alcohol. At age 60, he was treated with surgery and radiation therapy for squamous cell carcinoma of the right side of the tongue and floor of mouth. Since that time, he had had dysphagia. He had to eat slowly, was unable to swallow food of some textures; and sometimes he coughed after drinking liquids, although he did not sense aspiration. He also had difficulty maintaining his body weight.
- **Current symptoms:** Dysphagia as described above.
- **Physical examination:** Partial restriction of tongue motion on the right. Dry, mildly erythematous mucosa of the oral cavity, pharynx and larynx consistent with radiation change. On stroboscopy, he had diffuse laryngeal edema and severe right vocal fold paresis.
- **Clinical studies:** Barium swallow showed silent aspiration. Modified barium swallow with a speech-language pathologist present revealed the following abnormalities:
- **Oral stage:** Mastication was effective. Lingual transfers were segmented. There was posterior bolus leakage prior to the initial swallow to the distal pharynx with thin liquids and to the proximal pharynx with all other textures.
- **Pharyngeal stage:** Delay of swallow initiation. Sluggish epiglottic displacement. Pharyngeal dysmotility with resultant bolus hold up in valleculae in pyriform sinuses. The residuals increased with thicker textures. Spontaneous second swallow cleared residuals only partially. A cued liquid chaser cleared most of the remaining residuals from the valleculae, but pyriform sinus residuals increased with thin liquid trials. Osteophytic spurs at C5-6 and C6-7 may have contributed to pyriform sinus residuals. There was transient laryngeal penetration of thin liquids to the level of the vocal folds. Sensation of the penetration was inconsistent. No aspiration was seen during the study, but the patient was felt to be at high risk for intermittent aspiration as had been identified on the previous barium swallow.



Kyle Edmonds, MD
Member since 2005

- 1. Primary / Secondary Reviewers**
- 2. Panel Members**
- 3. Public Participants**

Update on fPROM* Review for Guides 6th Edition

*Patient-reported outcome measures of function

Stephen Gillaspy, PhD

Kathryn Mueller, MD, MPH, FACOEM

Robert Glueckauf, PhD

Daniel Bruns, PsyD, FAPA

Kathryn L Mueller, MD, MPH, FACOEM

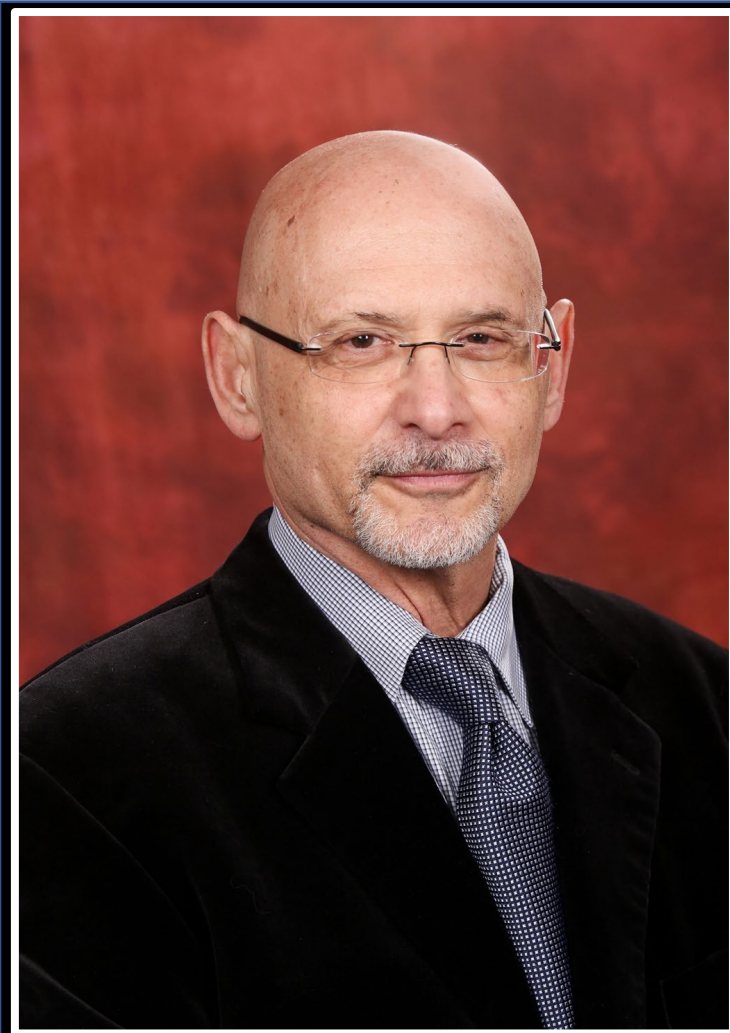
- Professor, University of Colorado, School of Public Health and School of Medicine – Department of Physical Medicine and Rehabilitation
- Prior Medical Director, Colorado Division of Workers Compensation – Currently a consultant
- Past President American College of Occupational Medicine
- Serves on Academic and International Advisory Boards for MedRisk and Workers Compensation Research Institute
- No relevant disclosures





Stephen R. Gillaspy, PhD

- Senior Director, Health Care Financing and the Center for Psychology & Health, American Psychological Association
- Licensed clinical psychologist, clinical scientist and senior administrator with extensive experience integrating psychological services into larger healthcare systems.
- Serves as the APA advisor to the American Medical Association's Relative Value Update Committee (RUC).
- Former professor and director of pediatric psychology in the department of pediatrics at the University of Oklahoma, College of Medicine
- Former President of the Oklahoma Psychological Association (OPA) in 2013 and chaired OPA's Division for Research, Academics, and Training from 2009 to 2011.
- No relevant disclosure



Rob Glueckauf, PhD
Florida State University
IHC Chair

IHC

Interdivisional Healthcare Committee

An APA Affiliated Think Tank

- APA Division 17 – Society of Counseling Psychology
- APA Division 22 – Rehabilitation Psychology
- APA Division 31 – State, Provincial and Territorial Affairs
- APA Division 38 – Society for Health Psychology
- APA Division 40 – Society for Clinical Neuropsychology
- APA Division 42 – Psychologists in Independent Practice
- APA Division 43 – Society for Couple & Family Psychology
- APA Division 54 – Society of Pediatric Psychology
- Also attended by APA leadership and ACOEM



Toni Vincent, MPH, PMP

- Director of Operations, Office of Health and Health Care Financing, American Psychological Association
- Master of Public Health, George Washington University
- Certified Project Management Professional (PMP)®
- Member American Public Health Association, Project Management Institute

Daniel Bruns, PsyD FAPA

Chair: Functional Outcome Assessment Task Force

- **American Psychological Association**
 - Member of Interdivisional Healthcare Committee (IHC)
- **American College of Occupational and Environmental Medicine**
 - Current chair of mental health treatment guidelines
- **State of Colorado**
 - Past chair of chronic pain treatment guidelines
 - Senior clinical instructor at University of Colorado Medical School
- **Principle investigator in 15-year longitudinal study of 29 million patients assessing the impact of biopsychosocial treatment guidelines**
- **Served as CMS Technical Expert for Medical Incentive Payment System**
- **2011 National Cancer Institute / Society for Behavioral Medicine Award: Data Harmonizing Pioneer**
- **Independent Pain Psychology Group Practice**
- **Disclosure**
 - Co-author of two standardized psychological tests designed for the assessment of patient risk for poor response to medical treatment



fPROM Project Organization

Kathryn Mueller, MD
Past ACOEM President

ACOEM

APA

Stephen Gillaspy, PhD
APA Senior Director

Interdivisional
Healthcare
Committee

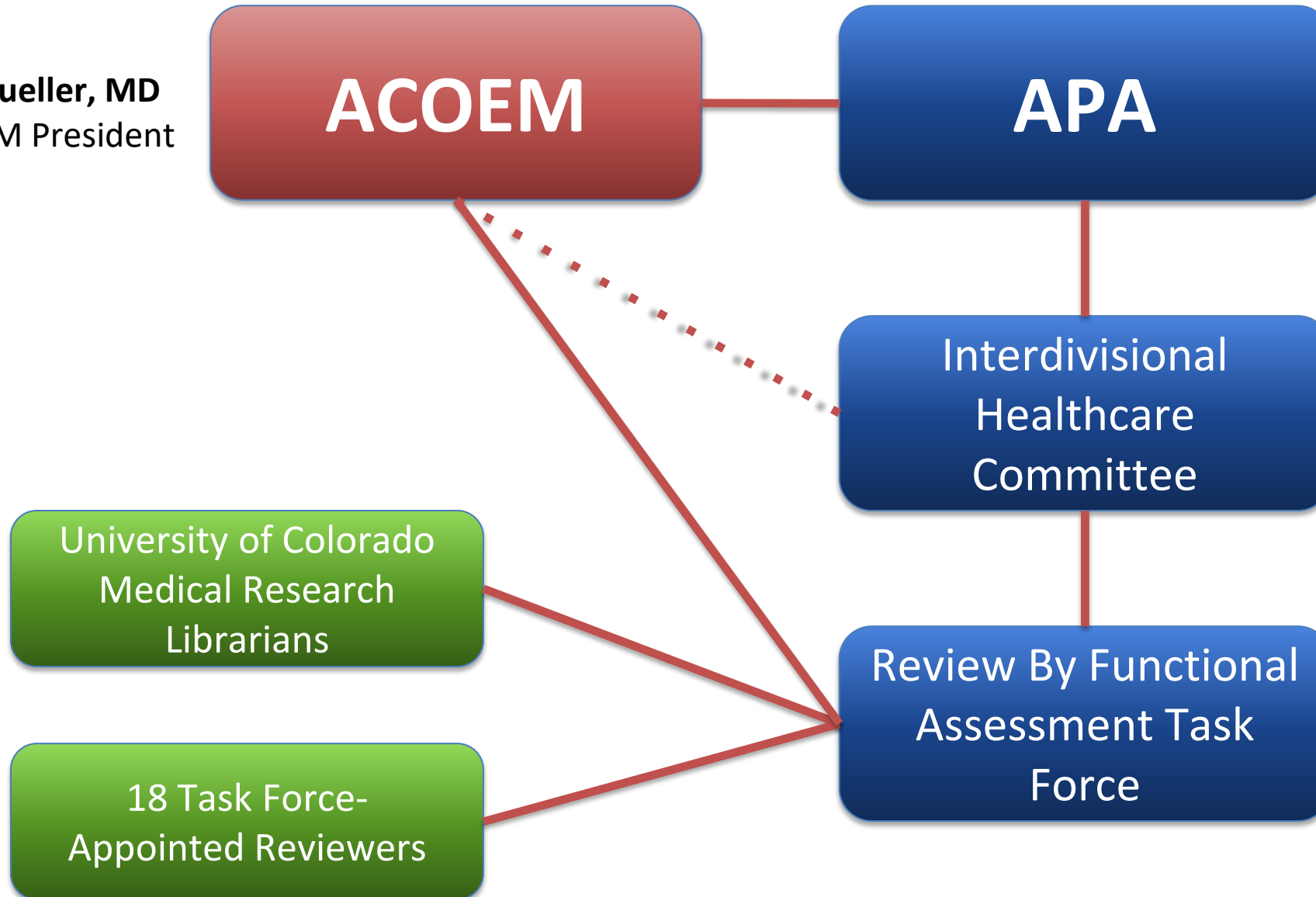
Robert Glueckauf, PhD
IHC Chair

University of Colorado
Medical Research
Librarians

18 Task Force-
Appointed Reviewers

Review By Functional
Assessment Task
Force

Daniel Bruns, PsyD
Task Force Chair



Criteria Considered in fPROM Review

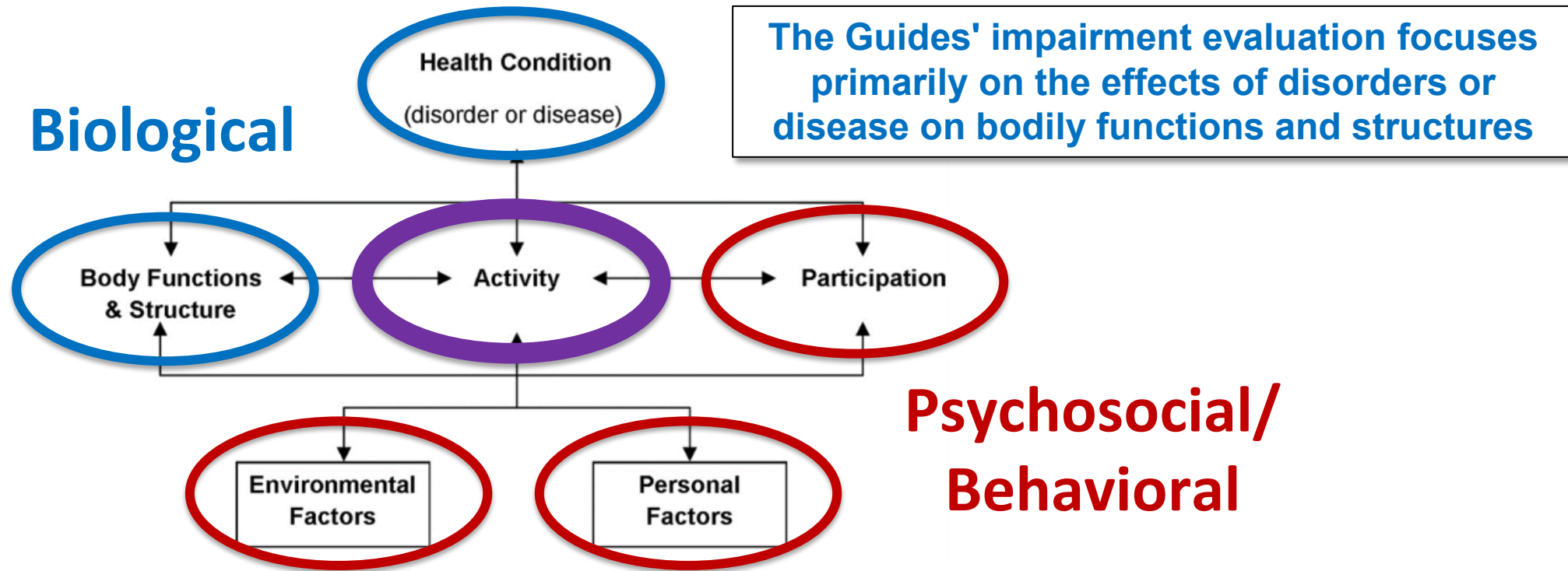
General psychometric standards

- Standardization
 - Validity (content and construct)
 - Reliability (internal and stability over time)
 - Norms (community and patient)
 - Fairness (no gender, race, ethnicity bias)
 - Harmonization (measures useful across groups and diagnoses)

AMA Guides standards

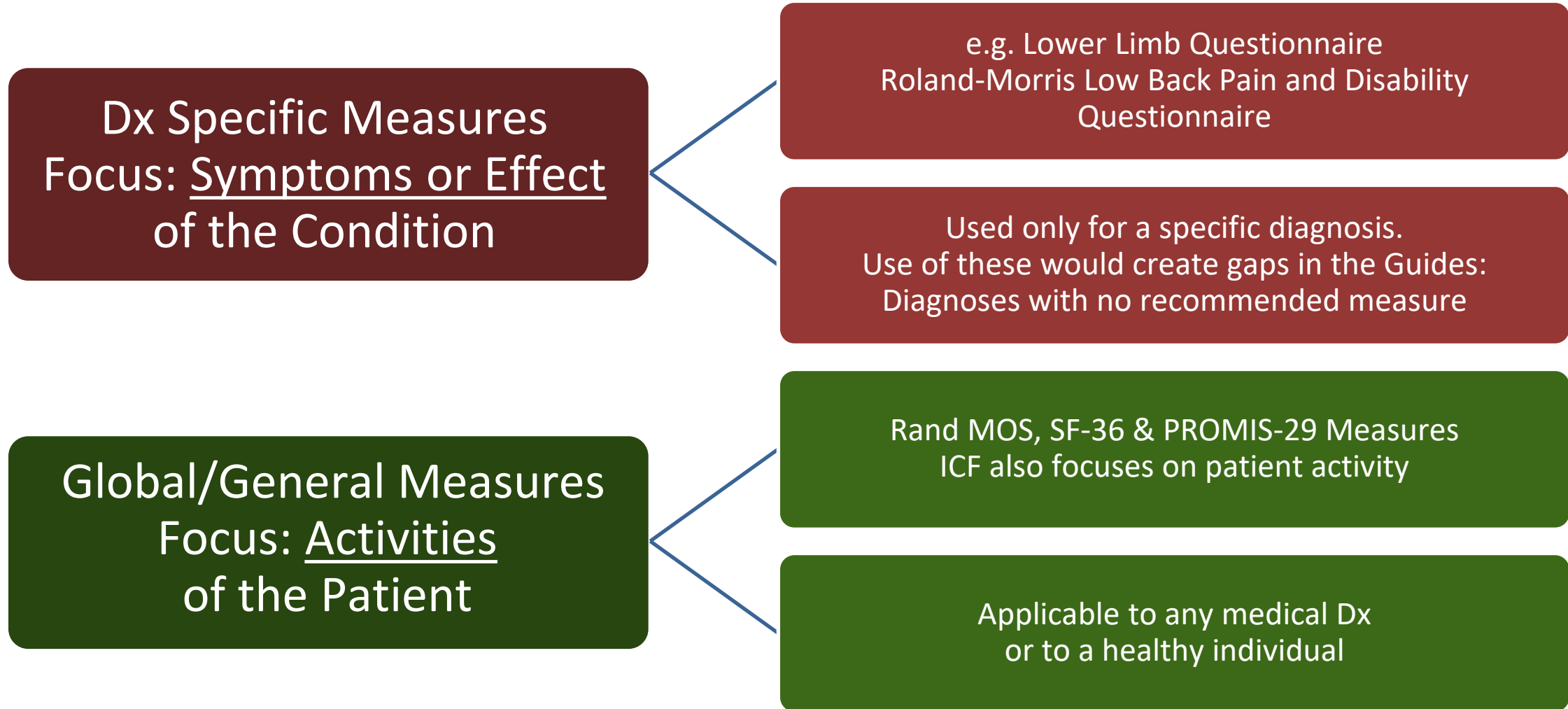
- Consistent with ICF
- Forensic defensibility
 - Rules of evidence (Frye, Daubert)
 - Regional regulations
- Practicality
- Guides internal consistency

Measures Should Be Consistent With the ICF and the Biopsychosocial Model



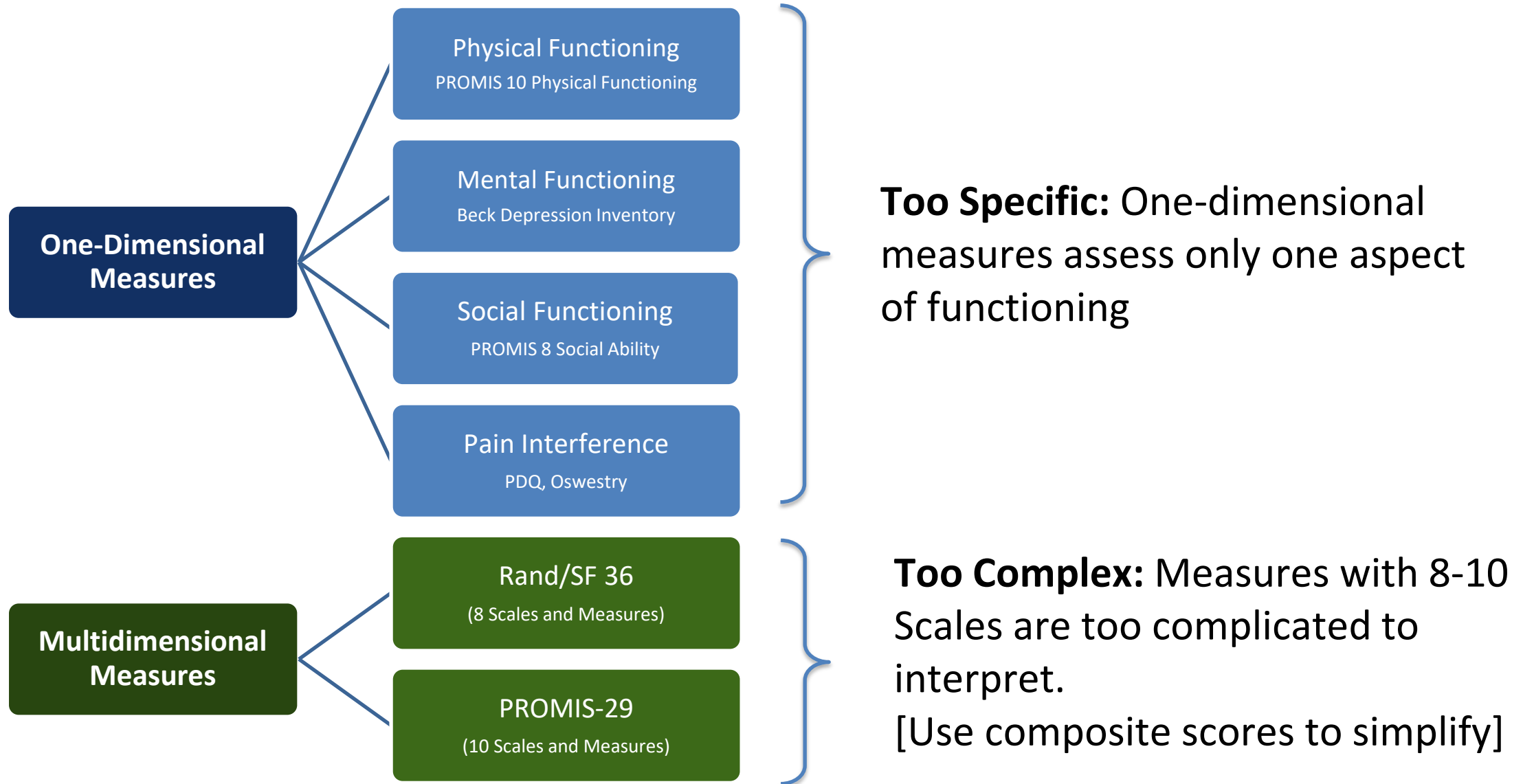
Activities play a central role in the ICF.
We found that most fPROMs
use ADL-type items to assess function

fPROMs and the “Swiss Cheese” Problem



Reviews of literature have not shown that specific measures are superior to general measures for outcome assessment (Chiarotto, 2018)

Evaluating Different Types of fPROMs



Measure Efficiency and Patient Burden

- **PROMIS Function on ambulating**
 - Are you able to go for a walk for at least 15 minutes ?
- **Oswestry uses 4.8 times more words to ask the same question**
 - Pain does not prevent me from walking any distance
 - Pain prevents me from walking more than one mile
 - Pain prevents me from walking more than a quarter of a mile
 - Pain prevents me from walking more than 100 yards
 - I can only walk using a cane or crutches
 - I'm in bed most of the time and have to crawl to the toilet

***Some measures are much more efficient at gathering information.
We felt this was an advantage***

What constitutes unusually high [or low] levels of functional impairment?

- **We found that most medical outcome measures are unable to make this determination**
 - They were developed for pre-post assessment
 - “Ipsative” measures
- **Standardized measures compare one score to a norm group**
 - Establishing what is high requires that the test be extensively studied with healthy persons in the community
 - “Normative” measures

We concluded that norm-based measures were superior for identifying high and low scores

Norm-Based T Score Output from PROMIS Physical Function Scale Offers More Information

Your T-score on the physical function measure is 37.
The average T-score is 50.

Your score indicates that your level of physical function is higher (better) than:

- 14% of people in the general population
- 10% of people age 35 to 45
- 11% of males

All PROMIS T-Scores of 50 = that of average community member
All PROMIS scales have a standard deviation of 10

Pre-post type measures do not provide this kind of information

NIH Patient Reported Outcome Measure System (PROMIS) Was Designed to Promote Data Harmonization

- There are a “cacophony” of fPROMs of varying quality, complexity, and response burden
 - *The goal was a system that could allow comparisons across studies or across conditions using a single metric*
 - Cella, 2010
- **Data harmonization:** The process of combining data from different sources to assemble a larger picture
 - PROMIS measures were designed to be used with individuals with any diagnosis, or no diagnosis

AMA Guides and Data Harmonization

Current Guides fPROMs Preclude Comparisons Across Chapters

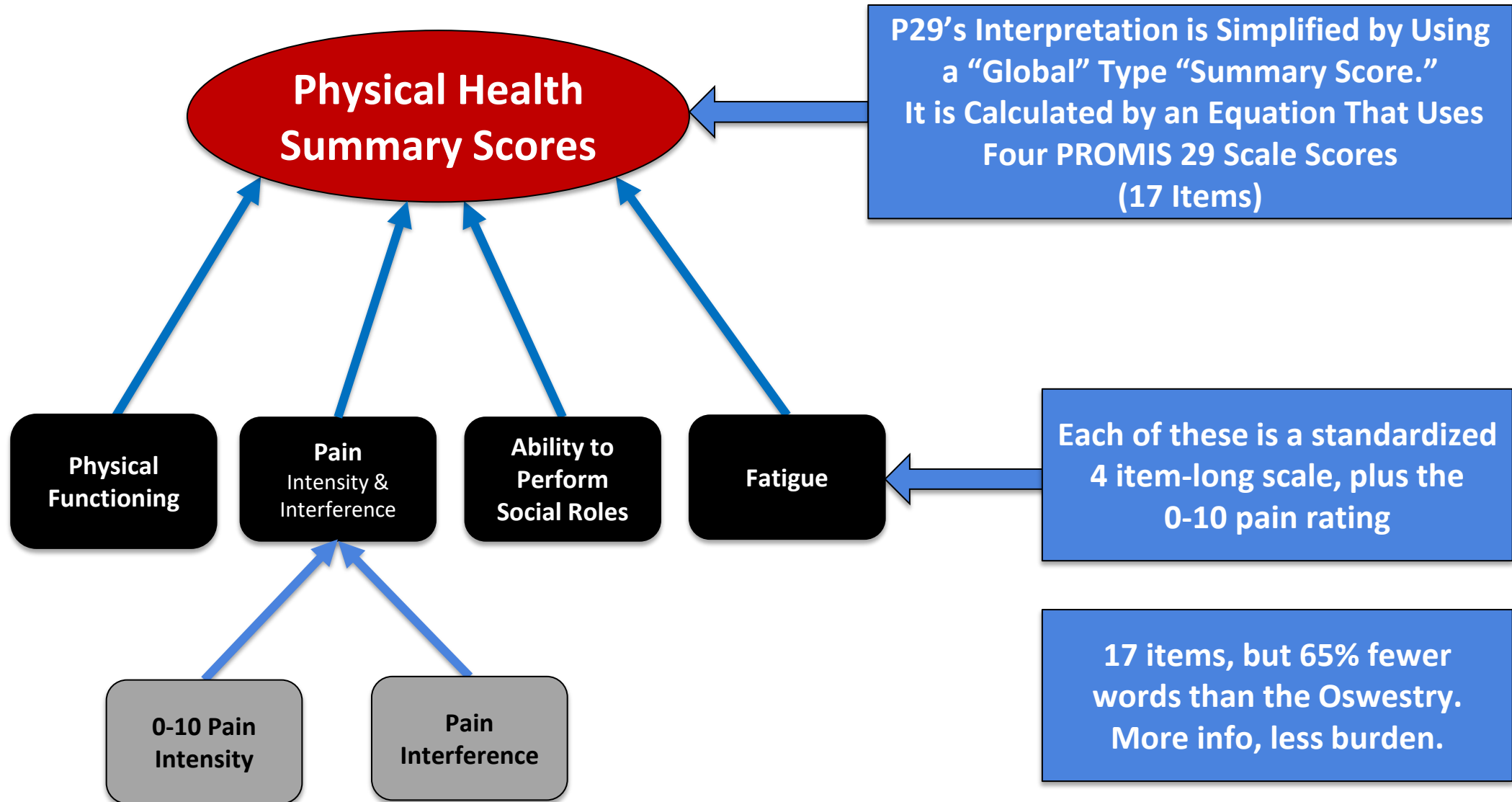
Measure	Percent of items on measure referring to:				Example items from these measures illustrate their nonequivalence
	Pain	Basic ADLs	Instru-mental ADLs	Advance d ADLs	
Lower Limb Questionnaire	43%	71%	0%	0%	How difficult is it for you to put on or take off socks?
QuickDASH	18%	27%	27%	27%	Has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors...
PDQ	100%	33%	7%	40%	Has your income declined since since your pain began? [Note: No impairments are rated unless due to pain]

Basic ADL: Ability to feed self, wash & dress self, walk, bowel and bladder control
Instrumental ADLs: Ability to use phone, travel to store, shop, use money, prepare food, clean up
Advanced ADLs: Ability to be productive at home or work, engage in recreation, and family/community activities
 (Dinken, 1951; Katz 1983; Reuban, 1989)

PROMIS 29's Physical Health Summary Score

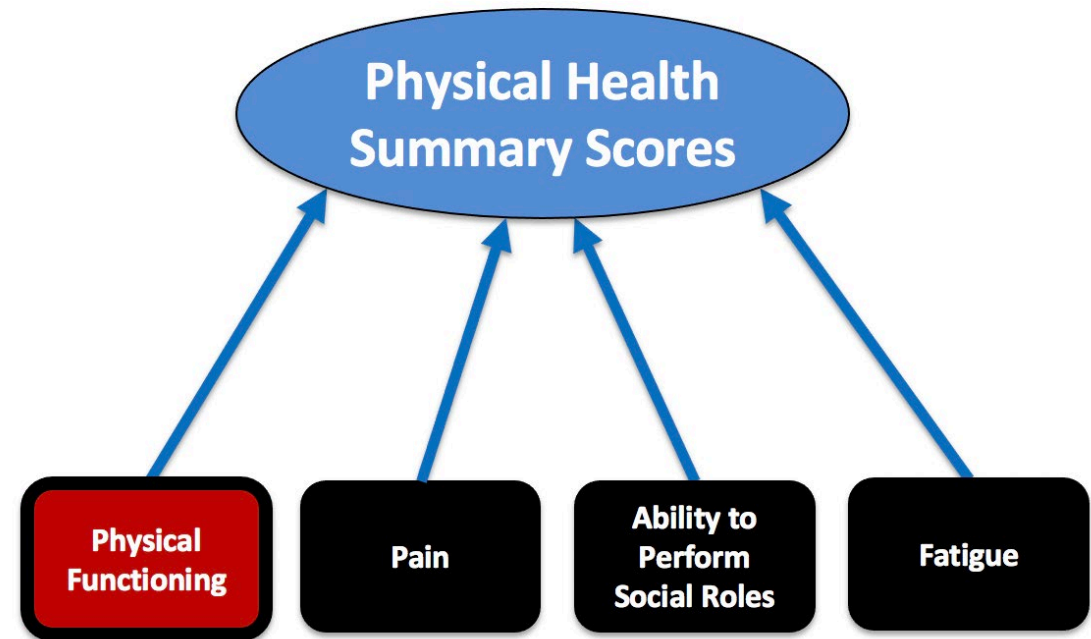
- **The PROMIS 29 measure generates:**
 - **7 scales**
 - **2 summary scores**
 - **Physical Health**
 - **Mental Health**
- **We concluded that the P29 Physical Health Summary Score is:**
 - **Supported by the strongest science**
 - **Offers the best answer to the AMA Guides questions**
 - **Would allow for data harmonization across chapters**

PROMIS 29's “Physical Health Summary Score”



Physical Functioning Is One of Four Components Of The PROMIS Physical Health Summary Score

- Development of Physical Functioning Scale
- Literature review identified 1728 items from 165 measures of physical functioning
- Expert review categorized and edited items
- Patient focus groups
 - What outcomes do patients value?
 - Sought patient feedback on item clarity and relevance
- (Rose, 2014; Dewalt 2007; Reeve, 2007)



Development of Physical Functioning Scale

- **Data:** 149 remaining items administered to 21,133 subjects
 - Both patients and community members
- **Analysis:** Extensive analysis of items
 - Biased items were eliminated
- **Results:** A four-item measure of Physical Functioning was developed and is used in the PROMIS 29
- To avoid bias, this scale was normed on a sample of community members matched to US census data
- (Rose, 2014; Dewalt 2007; Reeve, 2007)
- *Each scale on PROMIS 29 went through a similar process*

PROMIS 29 Physical Function: Items and Conversion Table

	<u>Physical Function</u>	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
PFA11	Are you able to do chores such as vacuuming or yard work?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
PFA21	Are you able to go up and down stairs at a normal pace?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
PFA23	Are you able to go for a walk of at least 15 minutes?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
PFA53	Are you able to run errands and shop?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1

Adult v1.0 - Physical Function 4a		
Short Form Conversion Table		
Raw Summed Score	T-score	SE*
4	22.9	3.9
5	26.9	2.7
6	29.1	2.4
7	30.7	2.2
8	32.1	2.2
9	33.3	2.1
10	34.4	2.1
11	35.6	2.1
12	36.7	2.1
13	37.9	2.2
14	39.1	2.2
15	40.4	2.2
16	41.8	2.3
17	43.4	2.4
18	45.3	2.6
19	48.0	3.1
20	56.9	6.7
*SE = Standard Error on T-score metric		

**T-scores Based on
Community Norms**
T50 = Average in community
Standard Deviation = 10

Following development of the 7 PROMIS 29 scales:

- **PROMIS 29 was tested on a diverse patient population**
 - Patient diagnoses included
 - Migraine, cancer, cardiac, pulmonary, neurological, injury, depression, drug abuse, etc.
 - Development research subjects in this phase n=5000
 - 51% female,
 - 60% non-Hispanic White,
 - 17% Hispanic,
 - 14% non-Hispanic Black,
 - 9% Asian
 - Hays, 2018
- **P29 interpretation was simplified by developing two summary scores**
 - **Physical Health Summary Score (recommended score)**
 - Mental Health Summary Score

PROMIS 29's “Physical Health Summary Score”

- **PHSS is a “global” measure that summarizes multiple aspects of physical health**
 - This score can be accepted as a “black box” for determining the patient reported level of function
 - For additional information, you can “unpack the box” and look at the scores of the four component scales, the way you might look at the item responses on a scale

Scoring the Physical Health Summary Score

- **The Physical Health Summary Score**
 - Is calculated by an equation using the component scales
 - $PHSS = [(Physical\ Health * 0.872) + (Pain * -0.094) + (Social * 0.113) + (Fatigue * -0.009)] * 10 + 50$
- **PROMIS measures are increasingly available in EHR**
- **AMA Spreadsheet or App?**
- **Other societies have already created web scoring for other PROMIS tests. See: <https://orthotoolkit.com/promis-10/>**

There Is Also a Hand scoring Workaround

- **If the rater does not have access to this software, physical and social scales account for majority of variance**
 - Physical Function scale assesses basic level of function
 - Social Function scale assesses more complex levels of function
- **These are the two biggest contributors to Physical Health Summary Score, and could be used as a substitute**

Methods of Literature Review

- **Univ Colorado Med School research librarians assisted lit review**
 - Identified both well-known & unfamiliar tests as candidates for review
- **There are easily over 1000 fPROM outcome measures**
- **38K studies on these measures:**
 - Rand/SF-36, PROMIS, Oswestry, Roland Morris
- **Developed a review system to rate measures for Guides**
 - 18 reviewers trained in the system were provided with articles and support line
- **Inter-rater reliability (agreement%) was calculated**
 - **Final overall inter-rater reliability was 82%**

Rating Process For Candidate fPROMs

- **Developed a review system to rate measures for Guides**
 - The *Guides* has unique needs – both clinical and forensic
 - A system tailored to the needs of the Guides was developed to rate measures
 - APA created a web-based system for gathering data from raters
- **Reviewers Were Recruited by IHC**
 - 18 reviewers (9 senior, 9 early career/fellowship training)
 - Reviewers trained in the system were provided with articles and support line
- **Inter-rater reliability (agreement%) was calculated**
 - Reliabilities calculated for each fPROM and for each item in the rating
 - **Final overall inter-rater reliability was 82%**
 - Rater reliability across measures: Std Dev = 10.15; Std Error = 3.4
- **These psychometric findings provided the empirical justification for further analyses**

Hypothetical Test of Strength: Precision vs Length

ACME Strength Test v6

How much weight can you lift from floor to waist?

- 1 pound
- 2 pounds
- 3 pounds
- 4 pounds
- 5 pounds

- 6 pounds
- 7 pounds
- 8 pounds
- ... 200 pounds

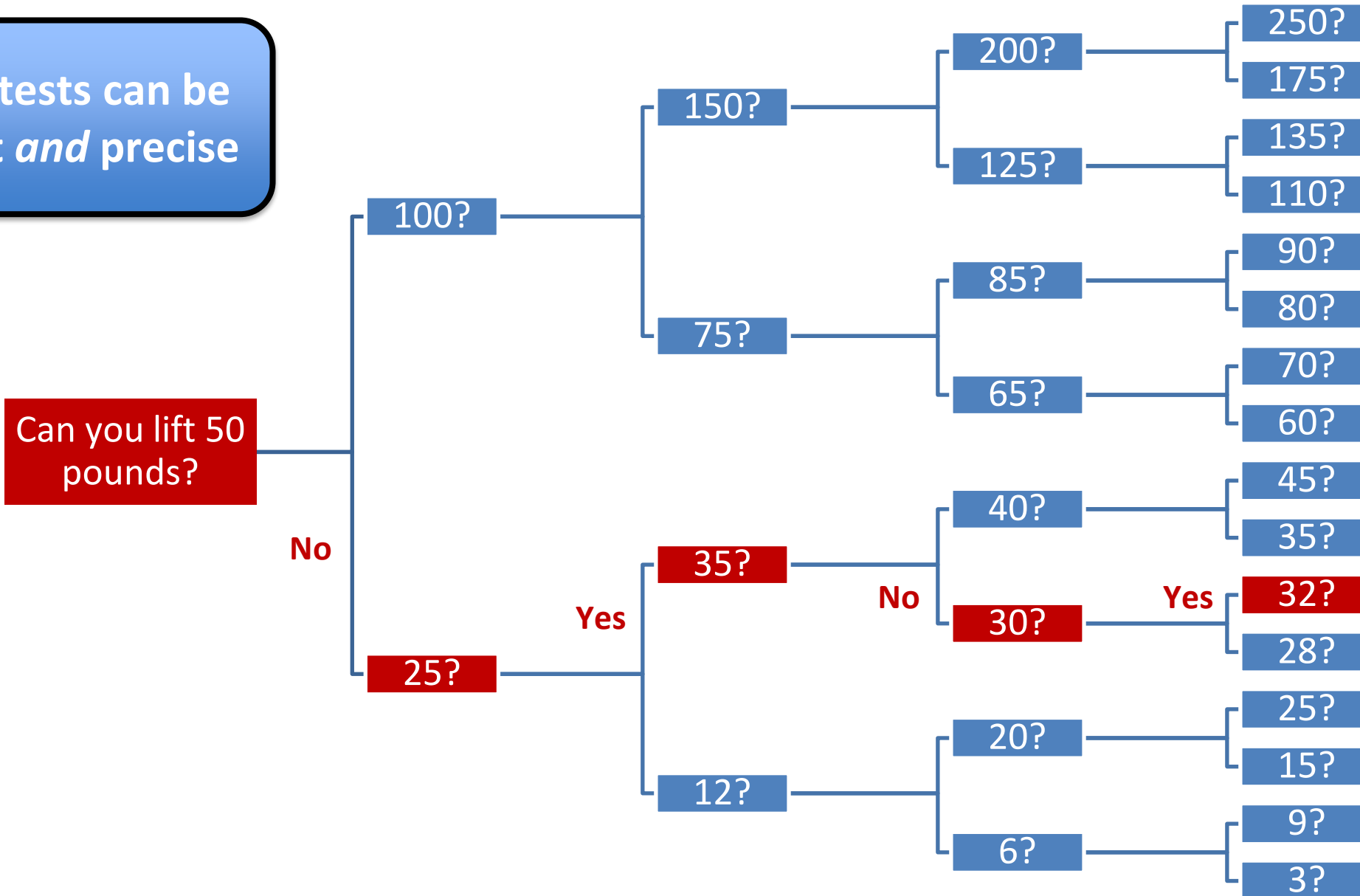


This test is precise
but very long!

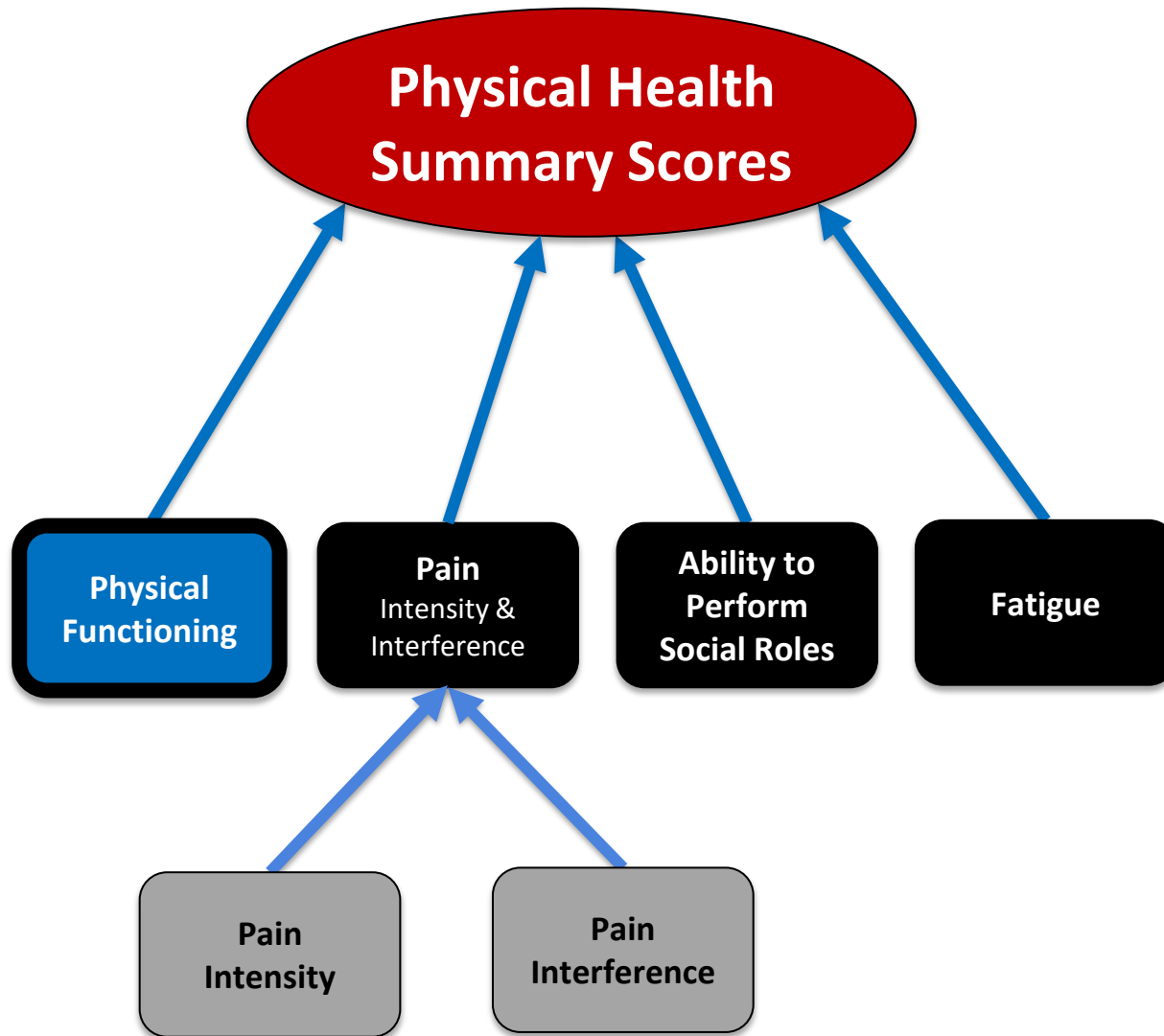
How can you have
a test that is short
and precise?

IRT: Computerized Adaptive Testing

CAT tests can be short *and* precise

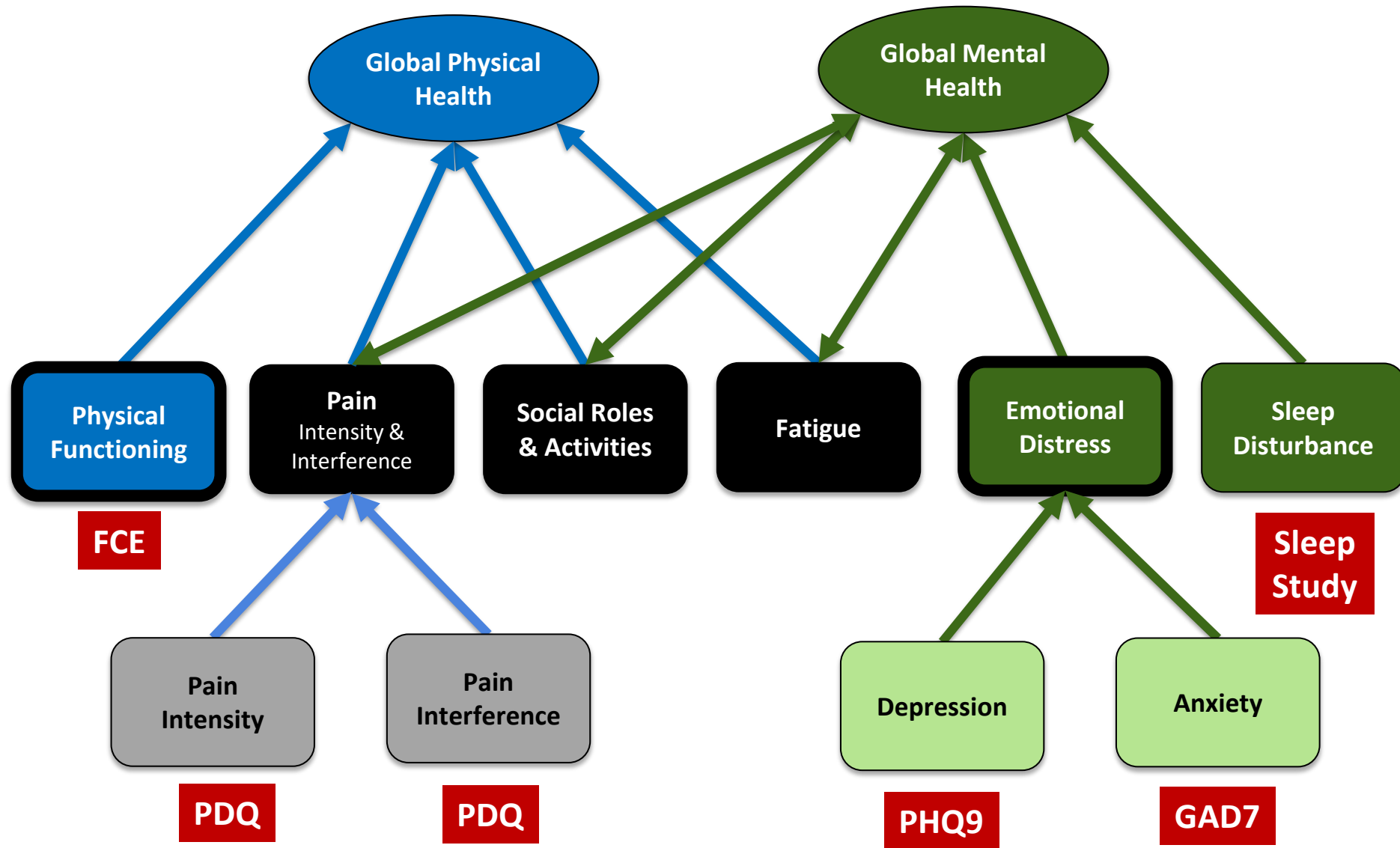


PROMIS 29 Overview

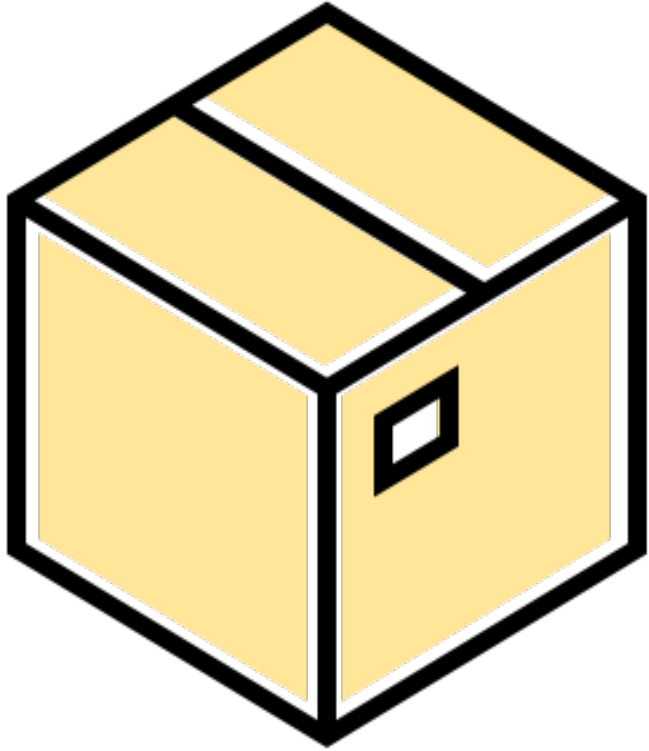


PROMIS 29 is like a “Russian Doll” system of tests where a “summary score” is calculated from several component scales. All component scales are independently valid and reliable, and are mathematically combined to create the overall score.

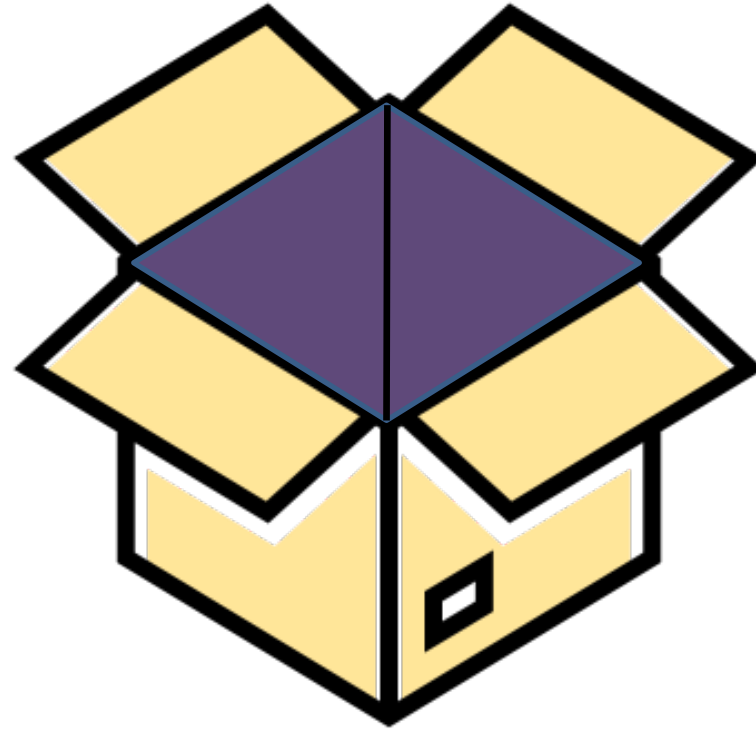
PROMIS 29 Overview



Both PROMIS 29 and SF 36 Use Summary Scores

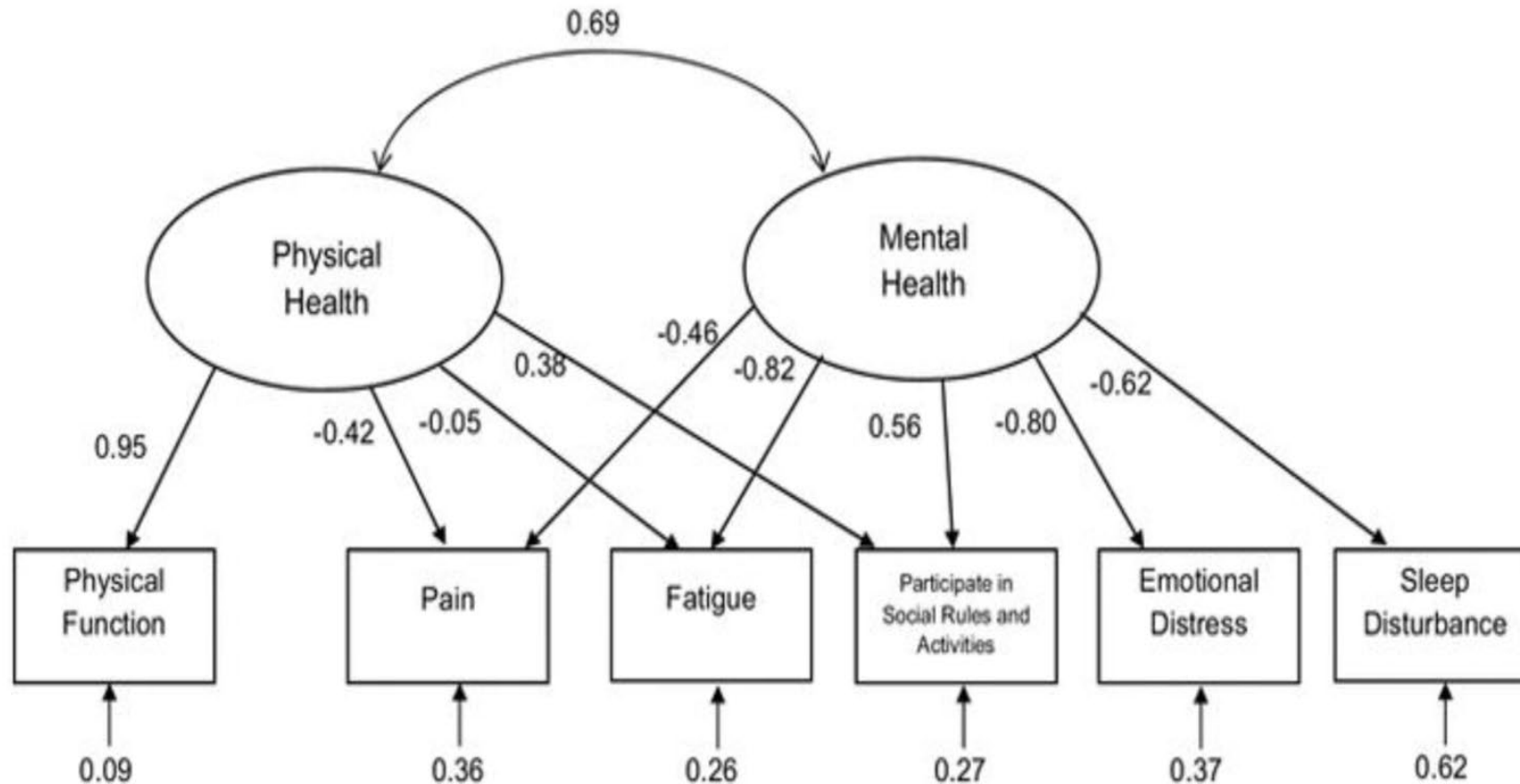


You can treat the
Physical Summary Score as a
closed box without consideration
for its inner workings



Alternately, you can unpack
the box and find more
information inside

PROMIS 29 Groups Functioning Into Two Broad Factors Based On Their Mathematical Relationships



Method: Confirmatory Factor Analysis

Scales previously developed using IRT

Principle components analysis of scales

Two factors extracted

Promax oblique rotation

Variance explained: Not reported

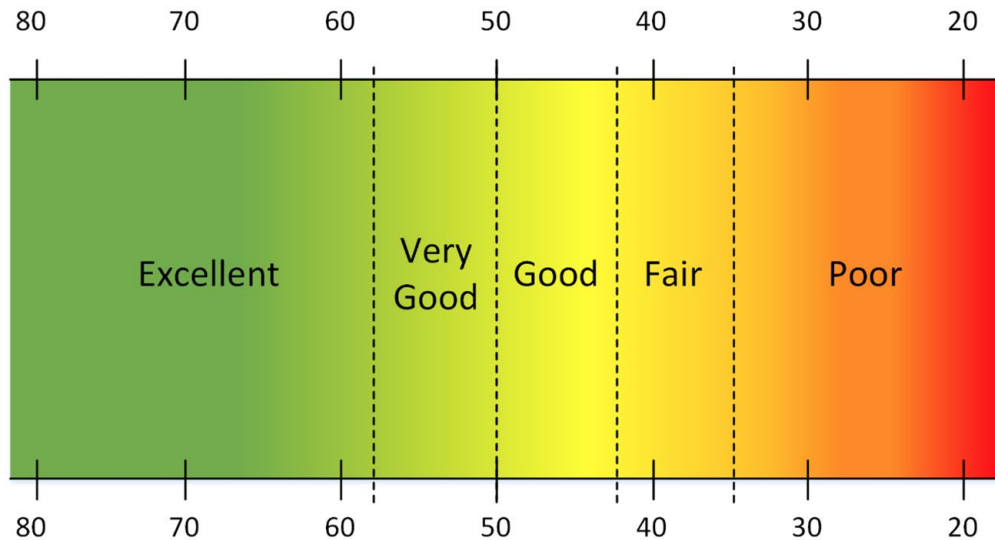
Correlation of physical and mental factors: **0.69**

PROMIS Uses Standardized T-Scores Based on Community Norms

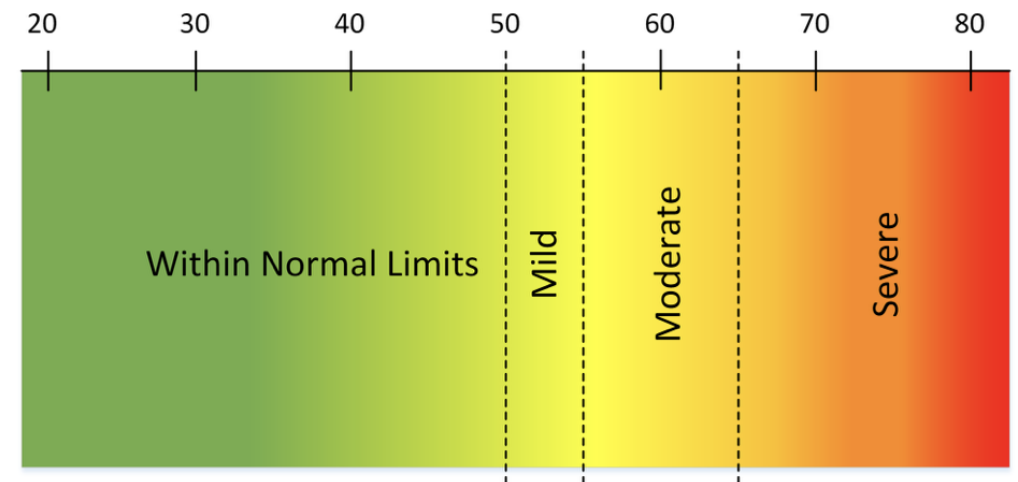
A High Score = A high Level of what the scale measures

Mean = 50; Std Dev = 10

Interpreting PROMIS® Global Physical Health T-Scores



Interpreting PROMIS® T-Scores* for Pediatric and Parent Proxy Anger, Anxiety, Depressive Symptoms, Fatigue, and Pain Interference




From HealthMeasures.net

PHSS

$$\text{PHSS} = (\text{Physical Health} * 0.872) + (\text{Pain} * -0.094) + (\text{Social} * 0.113) + (\text{Fatigue} * -0.009) + (\text{Sleep} * 0.002) + (\text{Emotion} * 0.003)$$

- 
- 1. Primary / Secondary Reviewers**
 - 2. Panel Members**
 - 3. Public Participants**



Theresa Phan, MD
Member since 2013

Closing

- Thank you to today's presenters. This now concludes the public meeting.
- Summary of Panel Actions will be posted on the AMA Guides website.
- The next public Editorial Panel Meeting will be held virtually on **December 16th at 6:00 pm CT.**
- Panel members and advisors will convene in Executive Session momentarily. Panel members please standby.

Executive Session

Siobhan Wescott, MD
Member since 2013

Quorum

- Attendance will be taken.

Panel Members

Helene Fearon, PT

Steven Feinberg, MD

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Panel Advisors

Chris Brigham, MD

Hon. Shannon Bruno Bishop, JD

Barry Gelinas, MD, DC

Abbie Hudgens, MPA

Hon. David Langham, JD

Meeting Mechanics: Executive Session

- Executive Session will resume for discussion and vote on the Editorial Change Proposal
 - **Staff sent voting instructions via email.**
- Co-chairs may call for a vote or panel members may motion to Approve, Reject, Revise or Table an Editorial Change Proposal.
- Qualtrics will be used to collect votes.
- Voting results shared in aggregate to inform the panel if the motion has passed. Only AMA staff will have a record of how each panel member voted.
- Disclose conflicts of interest as appropriate and maintain confidentiality

Potential Motions

Action	Description	Outcome
Approve	Proposed change is approved; Panel recommends AMA action to implement ECP.	Applicant(s) notified of Panel's decision, after AMA staff has determined early next steps toward deployment or implementation.
Reject	Proposed change is rejected; ECP might be out of scope, lacking evidence, premature, or not suitable for AMA Guides.	Applicant(s) notified and provided rationale for the decision (i.e., application criteria not met).
Revise	Revisions are requested in effort to make ECP more acceptable; application will be reconsidered at later Panel meeting following revisions.	Applicant(s) notified regarding decision, summary of suggested revisions, and provided rationale for the decision.
Table	Decision is postponed or suspended until further notice.	Applicant(s) notified and provided rationale for the decision.

ENT Proposal – Is there a Motion?

Motion to Accept (Seconded) – Approved.

Directive: Information on example to be embedded into the text of the Guides. (for review in December to approve)

fPROMs PROMIS 29 – Is there a motion?

Motion- Request applicants provide copies of the PROMIS 29 questions for review, and provide the crosswalk between the computer and paper scoring prior to making a decision on moving forward to incorporate the fPROM in the Guides. Acknowledge the effort of the proposing group. Express support for the PROMIS-29 as the best available, evidence-based science. – Approved.

Discussion:

Concerns w/ implementation and using a website

PROMIS-29 is open source; will look into licensing

Computer vs. Paper (paper application could lead to consistency issues); look at disclaimers as to why we are recommended PROMIS and rationale.

Suggested method; but can use another to get functional history

More defensible than other tools; look at our future outlook in terms of digital access.

How to apply the tool to each chapter and when; discuss implementation later. Move towards incorporating PROMIS-29 into the Guides

Next Steps

- AMA staff will recap the Executive Session decisions and rationale and share a summary with the Panel.
- AMA Guides leadership will inform Applicants of the Panel's decision in writing.
- Notice of the Panel's decision on the applications will be posted on the AMA Guides website.



Executive Session Closing

Saby Karuppiah, MD
Member since 2008