

Reference Committee G (medical practice)

YPS HOD Handbook Review Committee: Robert Melendez, MD, Chair; Sanjay Parikh, MD; and Gary Katz, MD, MBA

Note: The text of all resolutions and reports can be viewed at <http://www.ama-assn.org/ama/pub/category/18592.html>.

| HOD resolution/report | Action requested | Recommended AMA-YPS position | Final AMA-HOD actions |
|--|---|------------------------------|---|
| BOT Report 11: Tiering System for Third-Party Payers (Resolution 816, I-07) | <p>The Board of Trustees recommends that, in lieu of Resolution 816 (I-07), our American medical Association publish a National Health Insurers Report Card, and that the remainder of this report be filed. (Directive to Take Action)</p> <p>Fiscal Note: \$100,000.00 already budgeted.</p> | Monitor/Support | Adopted as amended; see http://www.ama-assn.org/ama1/pub/upl oad/mm/471/annotated g.doc for exact wording |
| BOT Report 12: Work of the Task Force on the Release of Physician Data | <p>1. That our American Medical Association adopt the following <i>Principles for the Public Release and Accurate Use of Physician Data</i>. (New HOD Policy)</p> <p style="text-align: center;"><i>Principles for the Public Release and Accurate Use of Physician Data</i></p> <p><i>The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data only when it preserves access and is used to provide accurate physician performance assessments in concert with the following Principles:</i></p> <ol style="list-style-type: none"> 1. <u><i>Patient Privacy Safeguards</i></u> <ul style="list-style-type: none"> • <i>All entities involved in the collection, use and release of claims data comply with the HIPAA Privacy and Security Rules (H-315.972, H-315.973, H-315.983, H-315.984, H-315.989, H-450.947).</i> • <i>Disclosures made without patient authorization are generally limited to claims data, as that is generally the only information necessary to accomplish the intended purpose of the task (H-315.973, H-315.975, H-315.983)</i> 2. <u><i>Data Accuracy and Security Safeguards</i></u> <ul style="list-style-type: none"> • <i>Effective safeguards are established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data (H-406.996, H-450.947, H-450.961).</i> • <i>Reliable administrative, technical, and physical safeguards provide security to prevent the unauthorized use or disclosure of patient or physician-specific health care data and physician profiles (H-406.996, H-450.947, H-450.961).</i> • <i>Physician-specific medical practice data, and all analyses, proceedings, records and minutes from quality review activities are not subject to discovery or admittance into evidence in any judicial or administrative proceeding without the physician's consent (H-</i> | Support | Referred |

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| | <p style="text-align: center;">406.996, H-450.947, H-450.961).</p> <p>3. <u>Transparency Requirements</u></p> <ul style="list-style-type: none"> • <i>When data are collected and analyzed for the purpose of creating physician profiles, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure (H-315.973, H-406.993, H-406.994, H-406.998, H-450.947, H-450.961).</i> • <i>The limitations of the data sources used to create physician profiles are clearly identified and acknowledged in terms understandable to consumers (H-406.994, H-450.947).</i> • <i>The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers (H-315.973, H-406.994, H-406.997, H-450.947, H-450.961).</i> • <i>Case-matched, risk-adjusted resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients (H-285.931).</i> <p>4. <u>Review and Appeal Requirements</u></p> <ul style="list-style-type: none"> • <i>Physicians are provided with an adequate and timely opportunity to review, respond and appeal the results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release (H-315.973, H-406.996, H-406.998, H-450.941, H-450.947, H-450.961).</i> • <i>When the physician and the rater cannot reach agreement, physician comments are appended to the report at the physician's request (H-450.947).</i> <p>5. <u>Physician Profiling Requirements</u></p> <ul style="list-style-type: none"> • <i>The data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians (H-406.994, H-</i> | | |

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| | <p>406.997, H-450.947, H-450.961).</p> <ul style="list-style-type: none"> • <i>When a single set of claims data includes a sample of patients that are skewed or not representative of the physicians' entire patient population, multiple sources of claims data are used (no current policy exists).</i> • <i>Physician efficiency of care ratings use physician data for services, procedures, tests and prescriptions that are based on physician utilization of resources so that the focus is on comparative physician utilization and not on the actual charges for services (no current policy exists).</i> • <i>Physician-profiling programs do not use the ranking of individual physician members of a medical group for placement in a network or for reimbursement purposes (no current policy exists).</i> <p>6. <u>Quality Measurement Requirements</u></p> <ul style="list-style-type: none"> • <i>The data are used to profile physicians based on quality of care provided — never on utilization of resources alone — and the degree to which profiling is based on utilization of resources is clearly identified (H-450.947).</i> • <i>Data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the Physician Consortium for Performance Improvement. (H-406.994, H-406.998, H-450.947, H-450.961).</i> • <i>These evidence-based measures are endorsed by the National Quality Forum (NQF) and/or the AQA and HQA, when available. When unavailable, scientifically valid measures developed in conjunction with appropriate medical specialty societies and practicing physicians are used to evaluate the data. (no current policy exists)</i> <p>7. <u>Patient Satisfaction Measurement Requirements</u></p> <ul style="list-style-type: none"> • <i>Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction be used by physicians to better meet patient needs particularly as they relate to favorable patient outcomes and other criteria of high quality care (H-450.982).</i> • <i>Because of the difficulty in determining whether responses to patient</i> | | |

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| | <p><i>satisfaction surveys are a result of the performance of a physician or physician office, or the result of the demands or restrictions of health insurers or other factors out of the control of the physician, patient satisfaction data is not used by payers in incentive or tiering mechanisms (no current policy exists).</i></p> <p>2. That our AMA adopt the following policy, <i>Release of Claims and Payment Data from Governmental Programs</i>. (New HOD Policy)</p> <p><i>Release of Claims and Payment Data from Governmental Programs</i></p> <p><i>The public's interest in disclosure of claims and payment data resulting from government health care programs must be balanced against the interest of physicians [and their practice entities] and patients in confidentiality and privacy. Moreover, steps should be taken to make sure that any data that are released are neither false nor misleading.</i></p> <p><i>In light of these considerations, claims and payment data resulting from government health care programs, including, but not limited to the Medicare and Medicaid programs, should only be released:</i></p> <ol style="list-style-type: none"> <i>1. on request to physicians [or their practice entities] to the extent the data involve services they have provided;</i> <i>2. to law enforcement and other regulatory agencies when there is reason to believe that a specific physician [or practice entity] may have violated a law or regulation, and the data is relevant to the agency's investigation or prosecution of a possible violation;</i> <i>3. to researchers/policy analysts for bona fide research/policy analysis purposes, provided the data do not identify specific physicians [or their practice entities] unless the researcher or policy analyst has (a) made a specific showing as to why the disclosure of specific identities is essential and (b) executed a written agreement promising to maintain the confidentiality of any data identifying specific physicians [or their practice entities];</i> <i>4. to others only if (a) the data do not identify specific physicians [or their practice entities] or (b) preparation, review, and release of the data are in accord with the AMA Principles for the Public Release and Accurate Use of Physician Data; or,</i> <i>5. if patient privacy is preserved via de-identified data aggregation or if written authorization for release of individually identifiable patient data</i> | | |

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| | <p><i>has been obtained from such patient in accordance with the requirements of the HIPAA regulations.</i></p> <ol style="list-style-type: none"> 3. That the Council on Legislation use the <i>Release of Claims and Payment Data from Governmental Programs</i> as a basis for draft model legislation. (Directive To Take Action) 4. That our AMA create additional tools to assist physicians in dealing with the release of physician data. (Directive To Take Action) 5. That our AMA continue to monitor the status of, and take appropriate action on, any legislative or regulatory opportunities regarding the appropriate release and use of physician data and the New York Attorney General's settlements with health insurers. (Directive To Take Action) 6. That our AMA continue to educate employers, healthcare coalitions and the public about concerns with physician profiling. (Directive To Take Action) <p>Fiscal Note: No significant fiscal impact</p> | | |
| <p>BOT Report 27: Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage at the Bedside</p> | <p>The Board of Trustees recommends that our American Medical Association adopt the following recommendations to create increased physician awareness of opportunities to address and resolve the RN shortage at the bedside and that the remainder of this report be filed.</p> <ol style="list-style-type: none"> 1. Support increased physician awareness of their role in solving the RN shortage at the bedside and the importance of physicians' participation in efforts to relieve the shortage. (Directive to Take Action) 2. Support increased awareness of opportunities for physician leadership and participation in efforts to solve the RN shortage at the bedside. (Directive to Take Action) 3. Support physician efforts to identify those models and strategies that are most applicable to their communities and hospitals and, additionally, will produce the best results. (Directive to Take Action) 4. Support national efforts to increase funding for bedside nursing education. (Directive to Take Action) <p>Fiscal Note: \$500</p> | <p>Support</p> | <p>Adopted</p> |

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| <p>CMS Report 1: Medical Care Outside the United States (Resolutions 711 and 732, A-07)</p> | <p>The Council on Medical Service recommends that the following be adopted in lieu of Resolutions 711 (A-07) and 732 (A-07), and that the remainder of this report be filed:</p> <ol style="list-style-type: none"> 1. That our American Medical Association reaffirm Policy D-475.997, which encourages the American public to become better informed about the need to coordinate postoperative care, especially in cases where the patient's site of recovery is a significant distance from where the initial surgery was performed. (Reaffirm HOD Policy) 2. That our AMA advocate that employers, insurance companies, and other entities that facilitate or incentivize medical care outside the US adhere to the following principles: <ol style="list-style-type: none"> (a) Medical care outside of the US must be voluntary. (b) Financial incentives to travel outside the US for medical care should not inappropriately limit the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options. (c) Financial incentives should only be used for medical care at institutions that have been accredited by recognized international accrediting bodies (e.g., the Joint Commission International or the International Society for Quality in Health Care). (d) Prior to travel, local follow-up care should be coordinated and financing should be arranged to ensure continuity of care when patients return from medical care outside the US. (e) Coverage for travel outside the US for medical care must include the costs of necessary follow-up care upon return to the US. (f) Patients should be informed of their rights and legal recourse prior to agreeing to travel outside the US for medical care. (g) Access to physician licensing and outcome data, as well as facility accreditation and outcomes data, should be arranged for patients seeking medical care outside the US. (h) The transfer of patient medical records to and from facilities outside the US should be consistent with HIPAA guidelines. | <p>Active Support</p> | <p>Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotatedg.doc for exact wording</p> |

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| | <p>(i) Patients choosing to travel outside the US for medical care should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities. (New HOD Policy)</p> <p>Fiscal Note: Staff cost estimated to be less than \$500 to implement.</p> | | |
| <p>CMS Report 2: Access to Psychiatric Beds and Impact on Emergency Medicine</p> | <p>The Council recommends that the following be adopted and the remainder of this report be filed:</p> <ol style="list-style-type: none"> 1. That our American Medical Association reaffirm Policy H-130.945[3], which supports the establishment of local, multi-organizational task forces with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physician on-call coverage and encourage the exchange of information among these groups. (Reaffirm HOD Policy) 2. That our AMA modify Policy H-185.974, which supports parity of coverage for mental illness, alcoholism and substance abuse <u>use</u>. (Modify HOD Policy) 3. That our AMA support efforts to facilitate access to both inpatient and outpatient psychiatric services, ameliorate the psychiatric workforce shortage, and provide adequate reimbursement for the care of patients with mental illness. (New HOD Policy) <p>Fiscal Note: Staff cost estimated to be less than \$500 to implement.</p> | <p>Support</p> | <p>Adopted as amended; see http://www.ama-assn.org/ama1/pub/upl oad/mm/471/annotated g.doc for exact wording</p> |
| <p>CMS Report 3: The Role of Cash Payments in All Physician Practices (Resolution 703, A-07 and Resolution 728, A-07)</p> | <p>The Council on Medical Service recommends that the following recommendation be adopted in lieu of Resolutions 703 (A-07) and 728 (A-07), and that the remainder of the report be filed:</p> <ol style="list-style-type: none"> 1. That the American Medical Association adopt the following as AMA policy: GUIDING PRINCIPLES FOR OPERATING A CASH-BASED PRACTICE <ol style="list-style-type: none"> (a) Prior to transitioning to or opening a cash-based practice, physicians should develop a business plan that includes the following: <ol style="list-style-type: none"> (i) An analysis of the target patient mix, and, if transitioning from a traditional practice, an analysis of how the target compares to the current patient population with | <p>Monitor</p> | <p>Adopted</p> |

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| | <p>respect to demographics such as age, income and health status.</p> <p>(ii) A description of the type(s) of care that will be offered by the practice.</p> <p>(iii) An evaluation of practice expenses to determine revenue requirements.</p> <p>(iv) A description of how the marketing, billing and collection needs of the practice will be met.</p> <p>(v) Consideration of the legal, regulatory and contractual implications of opening or transitioning to a cash-based practice.</p> <p>(b) Cash-based practices should develop and maintain an appropriate and transparent fee schedule that is understandable and easily accessible to patients.</p> <p>(c) Cash-based practices should have clearly defined payment policies that help patients understand their payment responsibilities. These policies should include guidance about how patients can coordinate health insurance benefits with cash-based physician services.</p> <p>(d) Cash-based practices should encourage patients to maintain health insurance coverage for more complex or catastrophic health care events. (New HOD Policy)</p> <p>Fiscal Note: Staff cost estimated to be less than \$500 to implement.</p> | | |
| <p>CMS Report 4: Policy Sunset Report for 1998 AMA Socioeconomic Policies</p> | <p>That our American Medical Association policies listed in the appendix to this report be acted upon in the manner indicated. (Directive to Take Action)</p> <p>Fiscal Note: No significant fiscal impact.</p> | <p>Monitor/Support</p> | <p>Adopted</p> |
| <p>CMS Report 7: Value-Based Decision- Making in the Health Care System</p> | <p>1. That our American Medical Association reaffirm Policy H-155.960[3], which supports adequate third-party payment for lifestyle counseling provided by physicians. (Reaffirm HOD Policy)</p> <p>2. That our AMA adopt the following principles to guide physician value-based decision-making:</p> | <p>Monitor</p> | <p>Adopted</p> |

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| | <p>a) Physicians should encourage their patients to participate in making value-based health care decisions.</p> <p>b) Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.</p> <p>c) Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.</p> <p>d) Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.</p> <p>e) Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.</p> <p>f) Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life. (New HOD Policy)</p> <p>3. That our AMA advocate for third-party payers and purchasers to make cost data available to physicians in a useable form at the point of service and decision-making, including the cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the respective patient. (Directive to Take Action)</p> <p>4. That our AMA encourage efforts by the Congressional Budget Office to more comprehensively measure the long-term as well as short-term budget deficit reductions and costs associated with legislation related to the prevention of health conditions and effects as a key step in improving and promoting value-based decision-making by Congress. (Directive to Take Action)</p> <p>Fiscal Note: Staff cost estimated to be less than \$500 to implement.</p> | | |

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| Resolution 701: Emergency Department Boarding | <p>RESOLVED, That our American Medical Association work with the American Hospital Association, The Joint Commission, and appropriate specialty societies including the American College of Emergency Physicians to (1) achieve efficient flow of patients through the emergency department (ED); (2) move admitted emergency patients out of the emergency department to hospital inpatient areas; (3) implement programs that will facilitate the timely discharge of patients from hospital inpatient areas; and (4) implement processes and procedures that mitigate crowding and boarding of patients in the emergency department (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA report annually on the effectiveness of measures implemented that mitigate boarding and crowding in the ED. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$7,636.</p> | Support | Current policy reaffirmed |
| Resolution 702: Recognizing Transitions of Care for Performance Improvement | <p>RESOLVED, That our American Medical Association make it a priority to work to improve and standardize the flow of critical information across the spectrum of care through collaboration with long-term care stakeholders, including the American Medical Directors Association (AMDA) (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA work with other stakeholder organizations including the AMDA in an effort to develop standardized transfer forms and to promote educational initiatives that optimize transfer of information across the spectrum of care (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA work with the Physician Consortium for Performance Improvement to develop specific measures appropriate for recognizing the work effort that assure transitions of care across the continuum of care to be safe, patient centered and outcome driven (Directive to Take Action); and be if further</p> <p>RESOLVED, That our AMA work with other stakeholder organizations including the AMDA to develop educational initiatives and long-range projects to optimize the transfer of information across the spectrum of acute and long-term care. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated cost of \$3,000.</p> | Monitor | Adopted as amended; see http://www.ama-assn.org/ama1/pub/upl oad/mm/471/annotated g.doc for exact wording |

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| <p>Resolution 703: Inclusion of Observation Bed Status and Emergency Room Observation Time as a Part of the Mandatory Three-Day Inpatient Hospital Stay Requirement to Receive the Medicare Skilled Nursing Facility Benefit</p> | <p>RESOLVED, That our American Medical Association, as stated in policy since 1993, continue to oppose the Medicare three-day mandatory hospitalization requirement for skilled nursing facility admission (Reaffirm HOD Policy); and be it further</p> <p>RESOLVED, That should the three-day mandatory stay requirement remain in place, our AMA urge the Centers for Medicare and Medicaid Services to allow observation bed status and emergency room observation time to count toward meeting the mandatory three-day inpatient stay requirement for the Medicare skilled nursing facility benefit. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,859.</p> | <p>Support</p> | <p>Referred</p> |
| <p>Resolution 704: Health Care Quality Improvement Act Amendment</p> | <p>RESOLVED, That our American Medical Association review the Health Care Quality Improvement Act (HCQIA) of 1986 to determine whether the Act can be improved upon in order to accomplish the following goals: (1) reduce the opportunity for a hospital governing body or its medical staff to subvert the peer review process into a retaliatory weapon against a physician who advocates for quality patient care, or for a primary economic purpose; and (2) increase the likelihood a peer review hearing process will be structured to assure fairness and justice. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$4,365.</p> | <p>Monitor</p> | <p>Current policy reaffirmed</p> |
| <p>Resolution 705: Evaluating the Physician Quality Reporting Initiative</p> | <p>RESOLVED, That, through its committee structure, our American Medical Association examine and evaluate the implementation and data relating to the Physicians Quality Reporting Initiative and report back to the House of Delegates at the 2008 Interim Meeting on compliance of the program with AMA Principles and Guidelines on Pay-for-Performance as well as any benefits, unintended consequences and negative effects for patients and physicians. (Directive to Take Action)</p> <p>Fiscal Note: Estimated cost of \$4,580 for study and report.</p> | <p>Monitor</p> | <p>Adopted</p> |

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| Resolution 706: Appropriate Hospital Charges | <p>RESOLVED, That our American Medical Association study the consequences of hospital cost-shifting upon individuals who are not covered by large purchasers of health care and report the suggested remedy (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA work with the American Hospital Association to develop a transparent pricing system similar to that developed by the Wisconsin Hospital Association, develop patient education information explaining individual hospital billing processes and discounts available, and educate patients on their bill-paying rights and responsibilities. (Directive to Take Action)</p> <p>Fiscal Note: Estimated cost of \$4,970 includes staff time, study and report.</p> | Monitor | Adopted as amended; see http://www.ama-assn.org/ama1/pub/upl oad/mm/471/annotated g.doc for exact wording |
| Resolution 707: Opposition to Pre-authorization for Prescriptions | <p>RESOLVED, That our American Medical Association urge pharmacy benefit managers and Medicare Part D contractors to use evidence-based criteria for more uniformity in their coverage policies and to streamline any prior approval or exception processes. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$2,615.</p> | Support | Current policy reaffirmed |
| Resolution 708: Unreasonable Payer Requirements for Physician Orders for Imaging and Other Diagnostic Studies | <p>RESOLVED, That our American Medical Association investigate current practices and, if needed, introduce legislation or take other actions that will result in elimination or extreme simplification of current administrative insurance requirements for patient diagnostic tests, procedures, or services. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$4,365.</p> | Support | Current policy reaffirmed |
| Resolution 709: Replacing "Surrogate Requirement for Nursing Home Residents" | <p>RESOLVED, That our American Medical Association request changes in federal law to require upon entering a nursing home, residents without a durable power of attorney for health care to provide names and contact information of the person or persons who could be deemed healthcare surrogate decision makers. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,188.</p> | Support | MOVED to REF COM B |

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| Resolution 710: Safeguard National Provider Identifier and Physician Privacy | RESOLVED, That our American Medical Association develop and mandate adequate safeguards for the protection of physician privacy, such as those used by the banking industry, showing only the last four digits of the National Provider Identifier number on publicly accessible web sites, in published lists, and on electronically communicated documents and faxes. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$1,859. | Active Support | Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotatedg.doc for exact wording |
| Resolution 711: Seek Guidelines for Handling Prejudiced Patients | RESOLVED, That our American Medical Association work with the appropriate authorities and health care facilities to encourage hospitals and health care facilities to adopt uniform guidelines for physicians to follow in non-life threatening emergencies when encountering abusive patients. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$1,859. | Support | Referred |
| Resolution 712: History and Physical Examination 24 Hours Before Surgery | RESOLVED, That our American Medical Association enter into discussions with The Joint Commission to review and clarify the 2008 Hospital Accreditation Standards: Elements of Performance for PC.2.120 #6 by replacing "patient's condition" with more specific language. (Directive to Take Action) Fiscal Note: Staff cost estimated at less than \$500 to implement. | Monitor | Referred for decision |
| Resolution 713: Real-Time Claims Processing | RESOLVED, That our American Medical Association promote real-time data access and communication by physician offices with Medicare, Medicaid, private health insurers and third party administrators that would include verification of patient eligibility, co-payment due by patient, status of deductible payable by patient and claims processing. (New HOD Policy) Fiscal Note: Implement accordingly at estimated staff cost of \$1,914. | Support | Substitute Resolution 713 adopted; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotatedg.doc for exact wording |

Reference Committee G (medical practice)

YPS HOD Handbook Review Committee: Robert Melendez, MD, Chair; Sanjay Parikh, MD; and Gary Katz, MD, MBA

Note: The text of all resolutions and reports can be viewed at <http://www.ama-assn.org/ama/pub/category/18592.html>.

| HOD resolution/report | Action requested | Recommended AMA-YPS position | Final AMA-HOD actions |
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| Resolution 714: Skilled Nursing Facility Admissions | RESOLVED, That a study be authorized by our American Medical Association to investigate and update the consequences of Medicare's Skilled Nursing Facility (SNF) regulations, develop a plan to support regulatory changes and/or legislation deleting the three day hospital requirement for admission to an SNF as called for in AMA policy (H-280.977), and provide a report to the HOD at the 2009 Annual Meeting. (Directive to Take Action) Fiscal Note: Estimated cost of \$3,056 for study and report. | Monitor | Referred |
| Resolution 715: Optional Use of Social Security Numbers During the Council for Affordable Healthcare Credentialing Process | RESOLVED, That our American Medical Association advocate for the Council for Affordable Quality Healthcare to make Social Security Numbers an optional field in their on-line provider credentialing application. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$756. | Monitor | Adopted |
| Resolution 716: AMA Model Agreement with Advanced Practice Nurse Clinicians, Nurse Practitioners and / or Clinical Nurse Specialists | RESOLVED, That our American Medical Association develop criteria or elements that should be contained in agreements with Advanced Practice Nurse Clinicians, APRN(s), Nurse Practitioners, NP(s), Clinical Nurse Specialists CNS(s) (Directive to Take Action); and be it further RESOLVED, That such model agreement(s) with APRN(s), NP(s), CNS(s), at a minimum, address quality of care, continuity of care, the scope of practice of the APRN(s)/NP(s)/CNS(s) within a specific collaborative agreement, the verification and ongoing maintenance of the skills, education and training of the APRN(s)/NP(s)/CNS(s) and the responsibilities of the collaborative physicians and report back to the House of Delegates at the 2008 Interim Meeting. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$10,836. | Monitor | Referred |
| Resolution 717: Contract and Fee Schedule Disclosure | RESOLVED, That our American Medical Association seek legislation, regulation or other appropriate means, to compel health plans to provide physicians with full written contracts with all changes highlighted, a full fee schedule applicable to the physician's specialty, and a written summary of such changes, each time they renew the contract. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$1,188. | Support | Current policy reaffirmed |

Reference Committee G (medical practice)

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| HOD resolution/report | Action requested | Recommended AMA-YPS position | Final AMA-HOD actions |
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| Resolution 718: Home Infusion of Antibiotics | RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to develop a coordinated system among the various Medicare plans to ensure an expedited, seamless process for provision of home infusion of antibiotics to reduce the need of the patient to remain in the hospital unnecessarily. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$4,580. | Support | Adopted as amended with change in title; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotatedg.doc for exact wording |
| Resolution 719: Universal Bill | RESOLVED, That the our American Medical Association seek legislation or other appropriate means to assure that all durable medical equipment vendors have a universal bill that is consumer-friendly and clearly states what was paid by the health plan, secondary insurer and what is owed by the patient and that these bills are received in a timely fashion. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$4,365. | Monitor | Current policy reaffirmed |
| Resolution 720: Consumer Rights for Durable Medical Equipment | RESOLVED, That our American Medical Association conduct a study regarding greater transparency and increased choices to patients in meeting their durable medical equipment needs. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$3,056. | Monitor | Current policy reaffirmed |
| Resolution 721: Denial of Use of Evaluation and Management Codes | RESOLVED, That our American Medical Association take appropriate actions to oppose payers that have discriminatory policies with respect to reimbursement for evaluation and management (E&M) services. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$750. | Support | Current policy reaffirmed |

Reference Committee G (medical practice)

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| HOD resolution/report | Action requested | Recommended AMA-YPS position | Final AMA-HOD actions |
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| <p>Resolution 722: Studying and Supporting Health Information Exchange</p> | <p>RESOLVED, That our American Medical Association study existing health information exchange pilots, create a report for the 2008 Interim Meeting that specifically outlines the ways in which a health information exchange might be used to maximally benefit physicians and their patients and includes ways in which the AMA might apply its resources to assist in the further study and eventual realization of those benefits (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA explore ways to help our members have access to and/or share aggregated practice performance data including claims-based and clinical information. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated cost of \$40,000.</p> | <p>Monitor</p> | <p>Adopted</p> |
| <p>Resolution 723: Increasing Transparency of Hospital Contracts for Ancillary Services</p> | <p>RESOLVED, That our American Medical Association believe that hospitals should publicly disclose the following parameters of their contracts for the delivery of ancillary services:</p> <ul style="list-style-type: none"> • the entity with which the hospital has contracted; • the ownership of the entity with which the hospital has contracted; and • what services are being provided per the contract (New HOD Policy); and be it further <p>RESOLVED, That our AMA adopt the policy that ancillary services providers in hospitals must be selected with medical staff participation. (New HOD Policy)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p> | <p>Monitor</p> | <p>Referred</p> |
| <p>Resolution 724: Privileging Physicians With Low Hospital Activity</p> | <p>RESOLVED, That our American Medical Association adopt the following guidelines to assist medical staffs with credentialing:</p> <ol style="list-style-type: none"> 1. Individual medical staffs best understand the environment in which they work. Therefore, a hospital's medical staff should be the entity that develops and implements the appropriate, hospital-level methodologies for credentialing, re-credentialing and recommending privileges for physicians and allied health professionals who have low or no hospital activity. As all hospitals and health systems are different, there cannot be a one-size-fits-all approach to this issue. Rather, individual medical staffs should use local, regional and national best practices--along with their unique hospital experience--to determine how to best construct their methods to credential, re-credential and | <p>Monitor</p> | <p>Referred</p> |

Reference Committee G (medical practice)

YPS HOD Handbook Review Committee: Robert Melendez, MD, Chair; Sanjay Parikh, MD; and Gary Katz, MD, MBA

Note: The text of all resolutions and reports can be viewed at <http://www.ama-assn.org/ama/pub/category/18592.html>.

| HOD resolution/report | Action requested | Recommended AMA-YPS position | Final AMA-HOD actions |
|--|--|------------------------------|--|
| | <p>recommend privileges for these physicians and allied health professionals.</p> <p>2. Hospitals and medical staffs should consider creating a separate staff category for physicians and allied health professionals who have low or no hospital activity. Such a category should confer more limited privileges without rights of other medical staff categories, such as “refer and follow” privileges, to ensure continuity of care and patient safety.</p> <p>3. Physicians giving recommendations should be very familiar with the competency and work of the physician/allied health professional seeking hospital and medical staff privileges. Therefore, references should come from such individuals as the applicant’s department chair and chief of staff.</p> <p>4. Hospitals and medical staffs should use data and references, if available, from another hospital at which the applicant physician may be active as an additional vehicle to verify his/her competency within that hospital’s environment.</p> <p>5. Ongoing proctoring and evaluation are tools that should be used when recommending privileges for physicians who are classified as low-volume for certain procedures only. Hospitalists and other specialists also should serve in a consultative role in this regard.</p> <p>6. Medical staffs should credential only when there is adequate clinical data to permit an objective assessment of an applicant’s, or medical staff member’s, clinical skill and ability.</p> <p>7. When an organized medical staff determines that there is not adequate data on an applicant physician, or if a physician seeking privileges has limited experience, consideration should be given to require mandatory consultation for admissions and other appropriate indications. (New HOD Policy)</p> <p>Fiscal Note: Estimated cost of \$3,500 to develop and mail communication to appropriate groups.</p> | | |
| <p>BOT Report 1: Communication Between Hospitals and Primary Care Referring Physicians</p> | <p>The Board of Trustees recommends that the following be adopted in lieu of Resolution 532 (A-07) and that the remainder of this report be filed:</p> <p>1. That our American Medical Association (AMA) advocate for continued Physician Consortium for Performance Improvement® (PCPI) participation in the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM) work to develop principles and standards for care transitions that occur between the inpatient and outpatient settings. (Directive to Take Action)</p> <p>2. That our AMA reaffirm Policy H-160.942 and advocate for timely and consistent inpatient and outpatient communications to occur among the hospital and hospital-based</p> | <p>Support</p> | <p>Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotated_g.doc for exact wording</p> |

Reference Committee G (medical practice)

YPS HOD Handbook Review Committee: Robert Melendez, MD, Chair; Sanjay Parikh, MD; and Gary Katz, MD, MBA

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| HOD resolution/report | Action requested | Recommended AMA-YPS position | Final AMA-HOD actions |
|--|--|------------------------------|---|
| | <p>providers and physicians and the patient's primary care referring physician; including the physician of record, admitting physician, and physician-to-physician, to decrease gaps that may occur in the coordination of care process and improve quality and patient safety. (Directive to Take Action)</p> <p>3. That our AMA continue its participation with the Health Information Technology Standards Panel (HITSP) and provide input on the standards harmonization and development process. (Directive to Take Action)</p> <p>4. That our AMA continue its participation with The Joint Commission for input in the development of accreditation standards that improve patient safety and quality. (Directive to Take Action)</p> <p>Fiscal Note: \$1,500</p> | | |
| <p>Resolution 725: Anthem Coding Audit</p> | <p>RESOLVED, That our American Medical Association adopt policy that:</p> <ul style="list-style-type: none"> • third-party payers be required to reimburse involved physicians for their reasonable audit-related expenses, including their lost time, if the physicians' coding is found to be reasonably consistent with currently accepted standards; • third-party payers be required to reimburse involved physicians if the audit demonstrates under-coding; • third-party payers' staff be required to provide adequate clerical assistance to accomplish the audit process; • third-party payers be limited to record review within the previous twelve (12) months; and • third-party payers be required to provide sixty days for involved physicians to respond to the audit process without penalty. (New HOD Policy) <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p> | <p>Support</p> | <p>Recommended for Reaffirmation Consent Calendar</p> |