AMA Annual Meeting

Delegates declare obesity a disease

The AMA’s classification is expected to influence changes in treatment, coverage, research and health policy.

CHRISTINE S. MOYER
AMNEWS STAFF

Chicago Within a day of the American Medical Association declaring it a disease, obesity also captured attention on Capitol Hill.

Lawmakers introduced bipartisan bills in the Senate and House to lower health care costs and prevent chronic diseases by addressing the nation’s obesity epidemic.

Although the timing was coincidental, observers say the declaration by the AMA House of Delegates meeting in June probably will have a significant impact in adding momentum to policy, research and treatment approaches to obesity — including a new dimension in exam room conversations between doctors and patients.

Although the AMA is not the first medical organization to classify obesity as a disease — the National Institutes of Health did so in 1998 — its role as the nation’s leading physician organization means its policies often carry more clout with industry, insurers and lawmakers than do statements by other groups, according to some health leaders.

“The American Medical Association, I would argue, is the most important medical association in the country,” said Marlene B. Schwartz, PhD, acting director for the Rudd Center for Food Policy and Obesity at Yale University in New Haven, Conn. “For the AMA to take a position on this will have an influence on health care in the United States.”

The declaration already is sparking discussions among medical organizations about the biologic, environmental and genetic factors contributing to unhealthy weight. Such conversations are important, because obesity long has been attributed to poor behavior; which fueled stigma against the disease, health experts say.

“How many of us believe that this is going to propel a critical mass effect so that we will see a lot of action,” said Jeffrey I. Mechanick, MD, president of the American Assn. of Clinical Endocrinologists. He wrote the resolution on designating obesity as a disease with colleagues from his

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How med schools will spend innovation grants

The mission for those selected for the AMA awards is to adapt their training to 21st-century needs and help lead a nationwide educational transformation.

KEVIN B. O’REILLY
AMNEWS STAFF

Chicago Teaching medical students by using virtual electronic health records. Embedding students in clinical care from their first weeks in medical school. Training tomorrow’s physicians to be leaders of interdisciplinary teams and deliver safer, higher-quality care. Giving students pursuing primary care the opportunity to speed their path to practice and averting dire physician shortages.

These are among the ambitious goals set forth by the 11 medical schools that won approval from the American Medical Association’s expert advisory panel. The $1 million grants awarded to each recipient over five years will give the schools the time and resources to implement changes that the AMA, physicians and educators hope will spark the biggest transformation of U.S. medical education since Abraham Flexner’s 1910 report set the standard for modern physician training.

In February, 82% of the nation’s 141 accredited medical schools — 119 in all — outlined grant proposals to the AMA. A 16-member panel nar-

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Rising Medicaid audit pressure

Program expansion will mean stepped-up payment investigations, which could ensnare physicians.

Government & Medicine, page 5

Make patient data work for you

Managing the data deluge an EHR provides can seem an onerous task, but corralling it can improve your practice.

Business, page 30

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AMA News
Delegates declare obesity a disease

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organization and others. The new AMA policy comes as the nation’s obesity epidemic has skyrocketed to epic proportions, with more than a third of adults and 17% of children aged 2 to 19 considered obese, according to the Centers for Disease Control and Prevention.

Researchers are projecting a dramatic rise in adult obesity and related health care costs by 2020 if the trend continues.

The seriousness and the broad scope of the problem prompted Dr. Mechanick and others to introduce the resolution at the AMA meeting. Another contributing factor was a report by the AMA Council on Science and Public Health that recommended against classifying obesity as a disease.

Because of that report, “a lot of organizations feared the AMA would defer or simply not declare it a disease, which was important,” said Dr. Mechanick, an endocrinologist and clinical professor of medicine at the Icahn School of Medicine at Mount Sinai in New York. There is “a contingent that believes obesity is a lifestyle or behavioral choice. ... The AACE fervently opposes that. Obesity has the characteristic signs, symptoms and morbidities that qualify it as a disease.”

Hope that payment will improve

The Treat and Reduce Obesity Act, introduced by lawmakers June 19, would require Medicare to cover additional obesity treatments such as prescription drugs for chronic weight management and to make it easier to receive weight-loss counseling.

How med schools will spend innovation grants

Continued from preceding page

owed the field to 28 in March, and those schools entered their final proposals in May.

The grantees were announced June 14 at the opening reception of the AMA Annual Meeting, a festive occasion held under the Chicago Cultural Center’s Tiffany dome.

“They will help identify changes in medical education that will enable students to thrive in an evolving health care environment and that can be applied across medical schools,” said then-AMA President Joseph A. Lazarus, MD, a Denver psychiatrist. “To facilitate that, the AMA will form a learning consortium so that participating schools can share best practices and structural innovations. Ultimately, our goal is to showcase successful innovations and promote their adoption in medical schools nationwide.”

Leaders from the 11 medical schools will have in-person, two-day meetings at least twice a year to share best practices in formulating new methods of teaching and evaluating students. They also will collaborate on an ongoing basis via listservs, conference calls, and get access to outside consultants in technology and informatics who will help them set up the systems to put their proposals into action.

“With this consortium does is really provide a forum to knit together all the innovative approaches from the different schools,” said Sherine E. Gabbrielli, MD, dean of one of the grant recipients, Mayo Medical School in Rochester, Minn.

Boosting technology’s educational role

Indiana University School of Medicine in Indianapolis and New York University School of Medicine each will explore how to better employ technology in teaching medical students. The schools will create virtual EHRs to aid in teaching clinical decision-making in an era when mouse clicks and drop-down menus are replacing paper charts and prescription pads.

The IU system will be a clone of an actual EHR used in clinical care, while NYU’s system will include deidentified patient data from NYU Langone Medical Center to train students how to manage both a virtual panel of patients and overall population health.

Meanwhile, some of the schools are aiming to integrate medical students into the mainstream of clinical care much earlier. At Pennsylvania State University College of Medicine in Hershey, students will help patients navigate the complicated health system. That will serve a dual purpose, helping improve the patient experience while teaching students what the real care delivery system is like.

At Vanderbilt University School of Medicine in Nashville, Tenn., students will integrate medical students into a single clinic site for the entirety of their undergraduate medical education. The program is under way, and the AMA’s grant will help greatly, said Jesse M. Ehrenfeld, MD, MPH, co-investigator of the school’s grant proposal.

“We were able to get about 90 medical students to see 5,000 patients in their first year of medical school, which is an unprecedented number,” he said.

The Brody School of Medicine at East Carolina University in Greenville, N.C., is planning a new core curriculum in patient safety, while the University of California, San Francisco School of Medicine’s proposal aims to evaluate students based on their progress on quality improvement topics and team-based care.

A faster finish

Several recipients will use the AMA funding to shift from time-based evaluation to competency-based assessments, offering faster-moving students the opportunity to graduate in less than the traditional four years. The University of California, Davis School of Medicine in Sacramento is going even further with a program designed for students who know they want to be primary care doctors.

Working through the Kaiser Permanente health system, UC Davis students will get the opportunity to complete medical school and residency training in general internal medicine in six years rather than the traditional seven.

The AMA initiative to accelerate change in medical education is one of three major elements that make up the Association’s strategic direction outlined in June 2012. Earlier in 2013, the AMA announced a multiyear, multimillion-dollar project to improve health outcomes in two target conditions: type 2 diabetes and cardiovascular disease. The Association is partnering with the YMCA of the USA for the diabetes portion of the effort and the Johns Hopkins Armstrong Institute for Patient Safety and Quality in Baltimore for work related to cardiovascular disease.

The third element of the strategic plan focuses on ways to improve physician satisfaction within various models of payment and care delivery. Details about findings from field research done in partnership with RAND Health are expected to be announced in fall 2013 and will inform the Association’s advocacy efforts as well as the tools it provides to doctors across the country.

Although Medicare covers a series of primary care visits for obesity counseling among patients with a body mass index of 30 kg/m2 or greater, such appointments are not covered by most other insurance. As a result, physicians squeeze complicated discussions on improving diet, boosting physical activity and changing eating behavior into short appointments that are scheduled for a separate health problem.

In such instances, physicians often code for morbid obesity, a BMI above 40.

Cover Stories

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Medical Education

ISSUE: Movement is under way in Washington to link graduate medical education funding to quality outcomes. The AMA could play a role in advocating for expanded provisions and help enhance GME funding, provided it has a policy on the issue.

PROPOSED ACTION: Explore evidence-based approaches to quality and accountability in residency education to support expanded, enhanced GME funding. [Adopted]

ISSUE: With a critical shortage of primary care physicians, additional sources of funding for resident training, including private donations, are needed.

PROPOSED ACTION: Continue to examine alternative funding models and report back at the 2014 Annual Meeting. [Adopted]

ISSUE: Physicians need a knowledge edge of all aspects of operating a practice. Medical schools can provide instruction on such important topics as insurance, patient advocacy and health care policy to the next generation of physicians through a rotation of electives.

PROPOSED ACTION: Encourage development of model guidelines and curricular goals for elective courses and suggest several potential subjects to be included in systems-based practice curricula. [Adopted]

ISSUE: The current interest rate on federal student loans may make it difficult for some people to attend and complete medical school. A decreased rate is important to maintain an adequate physician workforce.

PROPOSED ACTION: Advocate for the reduction of the current fixed rate of the Stafford student loan program. [Adopted]
Delegates declare obesity a disease

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40 kg/m², he said it’s unclear how well it’s covered.

The AMA’s declaration is expected to improve physician payment for efforts to prevent and treat obesity, some medical experts say.

“When you identify something as a disease, it encourages insurance companies to cover proven treatments,” said Jeffrey Cain, MD, president of the American Academy of Family Physicians.

But Susan Pisano, spokeswoman for America’s Health Insurance Plans, said classification doesn’t affect coverage. “Whether you call something a disease, or a risk factor, or a condition, what’s going to change coverage is going to be evidence that a particular treatment is safe and effective,” she said.

Such evidence for obesity prevention and treatment strategies are expected to become more abundant due to increased research funding following the AMA’s declaration.

“If obesity is taken more seriously, it would make sense for the government to provide more research funding … to really identify the types of changes that need to occur” and treatments that need to be implemented to effectively address the obesity epidemic, Schwartz said.

Reservations about impact

Some physicians remain skeptical, however, that the classification will result in improved health consequences. Robert A. Gilchick, MD, MPH, a member of the AMA Council on Science and Public Health, said he’s concerned about the implication of labeling the nation’s nearly 75 million obese adults as having a disease, even if an individual isn’t sick.

Another concern of some health professionals is that there will be an increased emphasis on treating the disease with medication and surgery rather than improving diet and boosting physical activity.

Two new obesity drugs came to the market in 2012 — Belviq (lorcaserin), manufactured by Arena Pharmaceuticals, and Qsymia (phentermine/topiramate) by Vivus.

AMA President Ardis Dee Hoven, MD, said the classification would not lead physicians to prescribe medicine improperly for obesity. “We have the capacity to determine what’s best for our particular patients,” she said.

The classification fits in perfectly with the first phase of the AMA’s initiative to improve health outcomes by preventing cardiovascular disease and type 2 diabetes, said Dr. Hoven, an internal medicine and infectious diseases specialist in Lexington, Ky.

“Obesity is a big risk factor” in those conditions, Dr. Hoven said. “In the past, we talked about diet and exercise, but we’re missing something. We have to figure out what we can do to keep people from becoming obese.”

A key step to preventing obesity is screening, just as physicians screen patients for diabetes and hypertension, Dr. Mechanick said.

Beyond calculating patients’ BMI, he encourages doctors to ask all patients about their risk factors for developing obesity. Such factors include having obese family members, sitting for prolonged periods, having unhealthy eating habits and using medications that can promote weight gain, he added.

He suggests screening for obesity at least annually in low-risk patients and more frequently in those with multiple risk factors. This recommendation is part of the AACE’s type 2 diabetes treatment algorithm, published in the March/April issue of Endocrine Practice.

“When you screen for obesity, not only do you pick up obese patients with a high risk of obesity-related complications, but you now have a disease that you can prevent,” said Dr. Mechanick.

During the next few years, the Rudd Center probably will monitor how the classification is affecting doctors’ feelings toward obese patients, Schwartz said.

Despite the nation’s obesity rate, studies show some doctors have biases toward obese patients. For example, a 2009 Journal of General Internal Medicine study of 40 Baltimore-area physicians and 228 of their patients found that doctors have lower respect for patients with high BMIs.

Schwartz expects that the AMA’s declaration will lead to improved physician attitudes toward patients who are an unhealthy weight.

“When you say obesity is a disease … it has the potential to remove the stigma, because you start seeing it as a place where people need help,” she said.

Schwartz encouraged physicians to help these people, rather than just telling them to “push away from the table.”

DR. MECHANICK
The AMA also introduced a new Administrative Burden Index aimed at identifying areas of the claims process that physicians and insurers can improve together.

Pamela Lewis Dolan
AMNEWS STAFF

A change to the AMA’s annual National Insurer Report Card reflects a growing burden physicians face when it comes to getting paid — collecting the patient portion.

Since its launch in 2008, the AMA’s annual report card has revealed the physicians’ burdens when it comes to getting paid by insurers. In the 2013 report, analysts calculated the percentage of the medical bill for which patients are responsible for paying through co-payments, deductibles and coinsurance and found that it accounts for nearly one-quarter of medical bills overall. Humana had the lowest patient responsibility at 15%, and Health Care Service Corp. had the highest at 29.2%.

The report, released during the AMA Annual Meeting in June, was based on claims data from services submitted in February and March from Aetna, Anthem Blue Cross Blue Shield, Cigna, HCSC, Humana, Regence, UnitedHealthcare and Medicare.

“For physicians used to getting payments exclusively from insurers, increased patient cost responsibility poses new challenges,” said Mark Rieger, vice president of payment and reimbursement strategy for National Healthcare Exchange Services, a compliance and denial management solutions provider in Sacramento, Calif., that supplied most of the data used in the analysis.

Because this was the first year the report looked at the patient portion, it did not provide historical context for the rise in patient responsibility. But a November 2012 Kaiser Family Foundation report showed that the percentage of workers covered by a plan that includes a deductible rose from 52% in 2006 to 72% in 2012. Those who were in such a plan

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<th>Insurer</th>
<th>% of claims requiring rework</th>
<th>Overall rework cost per claim</th>
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SOURCE: “2013 ADMINISTRATIVE BURDEN INDEX,” AMERICAN MEDICAL ASSOCIATION, JUNE

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Board certification process for doctors to be examined

Some physicians say there should be alternatives to mandatory exams to stay board certified.

Karen Caffarini
AMNEWS CORRESPONDENT

The House of Delegates directed the AMA to take several steps to look at the maintenance-of-certification process and ensure that it is not burdensome to physicians.

The AMA will commission an independent study to evaluate the impact that MOC and maintenance-of-licensure requirements have on physicians’ practices, the doctor work force and patients. A progress report on the study will be presented at the 2014 Annual Meeting.

The AMA also will work with the American Board of Medical Specialties and its specialty boards to determine if the mandatory exams still are needed and to explore alternatives to the exams. At the Annual Meeting, the house directed the AMA to encourage the ABMS to ensure that its member boards are transparent about the costs of preparing and administering certification exams.

Robert Hughes, MD, a delegate and immediate past president of the Medical Society of the State of New York, called the house’s action a step
Low morale a problem at every career stage

Doctors applaud the Association’s strategic focus on physician satisfaction. A CEJA forum examines burnout among practicing physicians and medical students.

Kevin B. O’Reilly
AMNews Staff

The Council on Ethical and Judicial Affairs is exploring the ethical dimensions related to the AMA’s strategic initiative aimed at improving physicians’ professional satisfaction.

As a first step in that process, the council’s open forum at the AMA Annual Meeting featured three presentations about factors driving the alarming rates of burnout and dissatisfaction among medical students, residents and physicians.

For medical students, the vast amount of material they are expected to master combined with starting life at the bottom of the medical totem pole can prove deeply unsettling, said Leon Vorobeichik, MD, the council’s student member.

Dr. Vorobeichik, who recently graduated from Saint Louis University School of Medicine, where student surveys told a sad tale. When surveyed during orientation, only 6% of students in the school’s class of 2011 reported depression, while a third were anxious.

By the end of the first year of medical school, the depression rate rose to 27%, while nearly 60% of students had moderate to high anxiety symptoms.

However, a comprehensive initiative at the school has helped address the problem. The program combined wellness-promotion activities such as mindfulness training with year-long elective courses and integrated opportunities to do volunteer activities outside the classroom.

Courses also were scrutinized to see if they could be shortened or the workloads lightened without sacrificing educational value. For example, a 10-week anatomy course was cut to eight weeks.

The changes are having an impact, with the Class of 2015 reporting a depression rate of 11% and anxiety rate of 31% after one year of medical school.

“There is hope,” Dr. Vorobeichik said.

Meanwhile, efforts to reduce burnout among medical residents appear to be having limited effect, according to Katherine L. Harvey, MD, MPH, CEJA’s resident/fellow member and a medical oncology and hematology fellow at Yale Cancer Center in New Haven, Conn.

The 80-hour-a-week duty restrictions mandated by the Accreditation Council for Graduate Medical Education have led to an increase in risky hand-offs and frustration among medical residents who feel they are being cheated of valuable opportunities to learn.

“Residents generally did not use the extra time for sleeping, and it’s hard to say [the duty-hour rules] improved quality of care. They faced more pressure to do more work in less time,” Dr. Harvey said.

She added that residents also face an ethical dilemma when reporting their duty hours. Accurately reporting excess time on duty could result in penalties levied against the program residents are counting on to further their own careers.

In testimony during the open forum, delegates agreed that the focus on professional satisfaction should occur throughout the continuum of a physician’s career.

“We go into medicine for all the right reasons, and if we’re lucky, we don’t have them beaten out of us by the training,” said Craig A. Backs, MD, a Springfield, Ill., internist and alternate delegate for the Illinois Medical Association.

Photo by Peter Wynn Thompson

Leon Vorobeichik, MD: Medical school’s efforts lowered student depression and anxiety rates.

Federal payment sought for Medicaid patients’ organ transplants

State budget shortfalls should not limit access to lifesaving transplants, doctors contend.

Kevin B. O’Reilly
AMNews Staff

AMA delegates say federal funding of organ transplants is needed for patients on Medicaid.

The move came after a 2010 action in Arizona that cut funding for certain “optional services” including some organ transplants. The policy affected nearly 100 Arizona patients on the organ wait list and was overturned in 2011 after intense pressure from transplant surgeons and the public.

Delegates to the AMA Annual Meeting wanted to take action on the issue because transplantation is not among the core medical services that must be covered by states under Medicaid.

With the struggling economy driving many state budgets deep into the red, physicians feared that other states would move to restrict or cut coverage of transplantation for financial rather than medical reasons.

Allowing that sort of coverage decision would be tantamount to “organ allocation by wallet biopsy,” said Jacksonville, Fla., transplant surgeon Thomas G. Peters, MD, an alternate delegate who spoke on behalf of the Florida Medical Assn.

Student drivers and donation The house also voted to encourage states and local organ procurement organizations to provide educational materials about organ and tissue donation to driver education and safety classes. Nine in 10 Americans say they are interested in registering as organ donors, but less than a third know how to do so, according to Donate Life America, the nonprofit alliance of organ procurement organizations.

Including education about organ and tissue donation could help narrow the gap, said Jan Kief, MD, a Highlands Ranch, Colo., internist.

“I work with a lot of high school students, and many don’t think they’re allowed to make that decision themselves, and there’s a lot of confusion about that. This will be very important for those students,” said Dr. Kief, an alternate delegate for the Colorado Medical Society who testified in favor of the action in reference committee testimony. Individuals 18 and older can register as organ donors through their state systems.

Meanwhile, a proposal asking the Association to study the feasibility of a unified registry of living kidney donors was referred to the AMA Board of Trustees for further study.

Photo by Peter Wynn Thompson

Dr. Peters decried “organ allocation by wallet biopsy.”

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The recommendations come as some physicians note it is critical for them to have compounded drugs available quickly.

Compounding pharmacies should comply with tighter restrictions, according to a report approved by the AMA House of Delegates.

The House of Delegates adopted a report with recommendations that compounding pharmacies comply with current U.S. Pharmacopeia and National Formulary compounding regulations concerning uniformity, quality and safety. The report also encourages state boards of pharmacy, which regulate the traditional compounding pharmacy, to require compounding pharmacies to adhere to sterile compounding practices. The report further recommends that large compounding pharmacies that introduce drugs into interstate commerce be regulated by the U.S. Food and Drug Administration.

The reference committee said the report was prepared in response to widespread concerns about pharmacy compounding safety and the extent to which the products were deeply embedded in the U.S. health care system. The issue arose in 2012 when a meningitis outbreak that killed 52 people and sickened 700 others was linked to a compounded injectable drug made in Massachusetts.

Dr. Solish: Compounded drugs essential for many ophthalmology practices

According to the FDA, compounding, “if done properly, can serve an important public health need if a patient cannot be treated with an FDA-approved medication.” Several ophthalmologists underscored this point during testimony when they spoke of the need for compounded medications to treat conditions such as macular degeneration, which could lead to loss of sight if treatment is delayed. Physicians buy these drugs to keep on hand in the office for such cases.

Sam Solish, MD, chair of the AMA Ophthalmology Section Council, said the section supported the concept of the report but said compounded drugs are essential to many ophthalmology practices, since some antibiotics needed for the eyes are available only in compounded form. Doctors must have medications on hand to treat patients at the time of diagnosis, said Dr. Solish, who practices in Portland, Maine. He said use of the phrase “compounding manufacturer” was confusing and

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Meeting Notes

Public Health

ISSUE: Sunscreen is considered an over-the-counter medication and is banned from use in some schools unless the student has a physician’s note for the product.

PROPOSED ACTION: Support the exemption of sunscreen from the list of over-the-counter medications that are banned from schools, and encourage schools to allow students to bring and use such products without requiring physician authorization. [Adopted]

ISSUE: Consumption of high stimulant/coffeine drinks has increased significantly in recent years, particularly among youths. Harmful effects of the beverages, including arrhythmia and ventricular tachycardia, are increasingly leading young people to seek care in the emergency department.

PROPOSED ACTION: Support a ban on the marketing of high stimulant/coffeine drinks to children and adolescents younger than 18. [Adopted]

ISSUE: Prolonged sitting is associated with an elevated risk of health problems, including mortality, recent studies say.

PROPOSED ACTION: Recognize the potential risk of sitting for long periods of time and encourage efforts by employers, employees and others to make alternatives available, such as standing work stations and isometric balls. [Adopted]

ISSUE: The Genetic Information Nondiscrimination Act of 2008 left undressed some areas in which individuals may experience genetic discrimination.

PROPOSED ACTION: Direct the AMA to oppose discrimination based on genetic information and pursue legislation intended to provide robust protections against genetic discrimination. [Adopted]

ISSUE: After analyzing studies from 1998 to 2010, the American Academy of Pediatrics revised its policy on neonatal male circumcision to reflect scientific evidence showing that the benefits outweigh the risks. Some state Medicaid plans do not cover the procedure, but studies have found circumcision rates to be 24 percent higher in states where it is covered.

PROPOSED ACTION: Revise AMA policy to reflect the AAP’s statement on neonatal male circumcision and encourage state Medicaid plans to cover the procedure. [Adopted]
Physicians respond to worries that technology may be interfering with patient communication and is a barrier to sharing information with other facilities.

**SUB TER MAAT**

The AMA House of Delegates approved a policy designed to help physicians navigate patient interactions while using computers and electronic health records during exams.

The policy encourages physicians to incorporate questions while using electronic devices and to ask patients in satisfaction surveys about the impact of using computers regarding the use of these devices during exams.

“Our board report looked at the effect of electronic health records on interactions between patients and physicians and found that the perspective and skills physicians bring to using computers determines whether the response to the physician in the exam room will be positive or negative,” said then-AMA Board Chair Steven J. Stack, MD, in a statement.

Delegates to the Annual Meeting also voted to push for greater EHR interoperability so that independent physicians could have an easier time meeting with systems of hospitals and others in their communities. The AMA was directed to seek legislation or regulations requiring that all EHRs vendors standardize their software.

Delegates asked the AMA to partner with the Centers for Medicare & Medicaid Services to develop incentives for hospitals and health systems that would promote more efficient sharing of EHRs with independent physicians.

**Interoperability an issue**

Those who supported the measure noted that some hospital EHR systems were incompatible with systems of physicians who worked outside the hospital. They also noted that no state or other government entity required vendors to standardize interconnectivity among EHR systems.

“The MSS supports collaborating with and incentivizing EHR vendors to improve interoperability and Internet-based accessibility, as well as encouraging the federal government to set data format and security standards for all vendors,” he said.

The interoperability of EHR systems has been an issue for many hospitals and physicians, according to the Certification Commission for Health Information Technology (CC HIT), one of the organizations assigned by CMS to certify systems for use in the Medicare and Medicaid meaningful use incentive programs.

**Board certification process to be examined**

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Toward improving the certification process.

“It’s looking at the process and attempting to come up with a fair solution,” said Dr. Hughes, an otolaryngologist from Queensbury.

Some delegates said the MOC process is expensive, time-consuming and at times not pertinent to the physician’s practice. They said physicians need to fulfill continuing medical education requirements, and there is no evidence that being board certified means that someone is a better physician.

“If I see 15 patients every day, I’m taking 15 tests, and I need to get an A on every one of them,” said Leah McCormack, a dermatologist from Forest Hills, called the requirements onerous and an insult to physicians.

Dr. Hughes said patients usually don’t know if their doctor is board certified.

Some delegates said recertification exams should not be mandated for hospital credentialing, a position that aligns with existing AMA policy opposing mandatory board certification.

Dr. Berkowitz pointed to the perspective and skills physicians bring to using computers during exams.

“According to our record, we process claims at $3.32 per claim. Cigna had the lowest at $1.25 per claim. A typical physician practice will lose $14,400 each year on claims reworked to address insurer denials, said Frank Cohen, senior analyst for Frank Cohen Group, a data analytics firm in Clearwater, Fla., that helped create the report card and the burdens index.

In an emailed statement to American Medical News, HCSC spokesman Greg Thompson said his company, which runs nonprofit BlueCross BlueShield plans in Illinois, New Mexico, Oklahoma and Texas, conducts quality reviews and audits regularly to evaluate and monitor performance. It also is investing in technology and asking physicians to focus on claims electronically.

“According to our record, we process claims accurately more than 99% of the time,” Thompson said. He said that although the company is proud of the work it has done evaluating and improving claims process efficiencies, “we welcome the AMA and others to reduce the administrative burdens and improve efficiencies in our health care system.”

Thompson said the company was reviewing the report card and the index, and did not have reaction to specific findings.

**Board certification process to be examined**

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Dr. Maldonado: AMA should not lose its influence about board recertification to other entities.

Council on Medical Education and a delegate for the American Academy of Pediatrics, said she doesn’t believe the AMA has the authority to make mandates to other bodies. Dr. Berkowitz spoke against a proposal to require the ABMS and other agencies and boards to wait until after the progress report on the exams’ impact is presented at the 2014 Annual Meeting before having physicians sit for MOL licensure exams.

Others disagreed, saying they don’t want the AMA to lose control to other entities. “The power in this [policy] is that the AMA has tremendous weight in terms of advocacy and public opinion,” said urologist Joseph Maldonado, MD, a New York delegate and vice president of the MSSNY.

**Board certification process to be examined**

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Board certification process to be examined.

**Board certification process to be examined**

Continued from page 21

Board certification process to be examined.
Pharmacists warned on intruding into prescribing decisions

Delegates say pharmacists have been second-guessing physician decisions on drug orders; pharmacists say they’re just trying to comply with DEA requirements.

Jennifer Lubell
AMNEWS STAFF

The AMA House of Delegates adopted policy stating that a pharmacist who makes inappropriate queries on a physician’s rationale behind a prescription, diagnosis or treatment plan is interfering with the practice of medicine. If the problem isn’t resolved, the AMA will advocate for regulatory and legislative solutions to prohibit pharmacies from denying medically necessary treatments, the policy states. Physicians need to send a clear message to pharmacists “that they can’t intrude on our practice of medicine,” said Robert Wailer, MD, an alternate delegate for the American Academy of Pain Medicine from Carlsbad, Calif.

Delegates to the Annual Meeting described instances in which pharmacies overstepped their roles in checking the propriety of drug orders.

When ordering narcotics for patients, Melvyn Sterling, MD, an alternate delegate from the Colorado Medical Assn., who spoke on his own behalf, said he receives faxes and calls from certain pharmacies asking what other medications he’s tried for pain relief, as well as questions about psychiatric comorbidities.

“There are doctors, and there are pharmacists. My responsibility is to write a prescription; it’s the pharmacist’s responsibility to fill it,” said Dr. Sterling, a palliative care specialist from Orange County.

It is not the intent of pharmacists to intrude on medical practice, said Kevin Nicholson, the National Assn. of Chain Drug Stores’ vice president for public policy and regulatory affairs. He said pharmacies have had to respond to new levels of scrutiny by the Drug Enforcement Administration, which has been investigating chain pharmacies for perceived over-dispensing of controlled substances.

DEA mandates on pharmacies “include assessing whether prescriptions for controlled substances were written for a legitimate medical purpose in the usual course of professional practice. A pharmacist cannot dispense a controlled substance unless he/she concludes that the prescription meets these criteria,” Nicholson said. Chain pharmacies query physicians to document compliance with these requirements, he said.

The AMA’s new policy directs the AMA to work with state legislation, and consider annual initiatives on improving health literacy.

The report calls on the AMA to pursue legislation or regulations that require direct-to-consumer advertising for DME to include a disclaimer saying that eligibility for and coverage of DME is subject to specific criteria and that only a physician can determine if a patient meets the standards. Such ads also should list the actual criteria from an appropriate source.

PROPOSED ACTION:

Dr. Annis chaired task force on pain management procedures.

Jennifer Lubell
AMNEWS STAFF

Advertising for DME to include a disclaimer saying that eligibility for and coverage of DME is subject to specific criteria and that only a physician can determine if a patient meets the standards. Such ads also should list the actual criteria from an appropriate source.

Doctors have final word

Inaccurate ads lead to some patients believing they can obtain DME when they do not qualify for the supplies, said Mobile, Ala., urologist Jeff Terry, MD, a delegate for the Medical Assn. of the State of Alabama, at the Annual Meeting.

“The doctors have got to say it’s medically necessary,” Dr. Terry pointed out. “We can’t say that without evaluating the patient and making sure it is appropriate. Then, if we don’t approve it, the patient gets mad at us, because the television ads say the doctor can just sign off on it.”

The board report said advertisers should refrain from statements that only a physician order or signature is required to obtain the desired items. The equipment first must meet federal standards before a doctor can approve use of the device.

The report says that MDE companies also should stop coercive acts that inappropriately influence physicians to sign such prescriptions for their patients.

Approval of the board report should help stop untruthful DME promotions, said Macon, Ga., family physician Michael Greene, MD, an alternate delegate for the Medical Assn. of Georgia. However, he would have liked to see the house go a step further by pushing for prosecution of DME advertisers who make fraudulent statements.

“I think it fell short of saying this is fraud and needs to be prosecuted as such,” he said.

AMERICAN MEDICAL NEWS
AMMEDNEWS.COM/HOUSE
JULY 11, 2013

Call for tougher rules to stop misleading medical device ads

Alicia Gallegos
AMNEWS STAFF

DME distributors frequently misconstrue the process in which patients must follow to receive their supplies, doctors contend.

Advertisers who promote durable medical equipment should follow tougher regulations to ensure that they do not mislead patients about how to obtain the products, according to a Board of Trustees report approved by the House of Delegates.

The report calls on the AMA to pursue legislation or regulations that require direct-to-consumer advertising for DME to include a disclaimer saying that eligibility for and coverage of DME is subject to specific criteria and that only a physician can determine if a patient meets the standards. Such ads also should list the actual criteria from an appropriate source.

Federal rules mandate that to be covered by Medicare, DME must be medically necessary and prescribed by a physician, among other criteria. Covered products include oxygen, wheelchairs, hospital beds, walkers and prosthetics. Delegates said advertisers frequently promote their products without explaining the qualification process.

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AMERICAN MEDICAL NEWS
AMMEDNEWS.COM/HOUSE
JULY 11, 2013
Doctors seek payment models to replace Medicare SGR

The American Medical Association (AMA) adopted a policy to replace Medicare’s sustainable growth rate formula with a range of payment models, allowing physicians to choose which options would work best for them. That approach would reflect diversity in physician-led practice models, such as patient-centered medical homes and regional health collaboratives, while maintaining fee-for-service and private practice as viable options. The AMA President Ardis Dee Hoven, MD, said that in transitioning from the SGR to a new system, it was vital to support doctors “in all types of practices, and avoid being too prescriptive in suggesting alternatives.”

Doctors also should have the flexibility to determine the basic payment method for their services, as well as the right “to establish their compensation arrangements, including private contracting, at a level which they believe fairly reflects the value of their professional judgment and services,” states the policy, which was adopted at the Annual Meeting. The policy reflects the general approach the AMA has taken in 2013 to replace the 2013 policy debate over the SGR formula, which has been threatening payment cuts to doctors for more than a decade. The Medicare’s trustees, the formula is set to cut payments by 24.7% in 2014, reducing rates to 61% of what private insurers pay for the same services.

For a decade, Congress has enacted stopgap measures to prevent the cuts, but a permanent solution has been out of reach. House Republicans have drafted a proposal to repeal the SGR and modernize the program, but no timetable has been set for debate. At a congressional hearing in May, the AMA and other groups urged lawmakers to stabilize payments for five years, giving doctors time to help develop and test new payment models.

Leaders speak to AMA efforts on behalf of patients and physicians

In her inaugural address, AMA President Ardis Dee Hoven, MD, recalled how she was the only infectious diseases specialist in private practice in her community when AIDS was just appearing on the medical landscape.

Over time, treating people with AIDS in Lexington, Ky., made a lasting impression on her. “My AIDS patients and their family members taught me about strength, about courage and about never, ever passing judgment about something you do not understand,” said Dr. Hoven, who also practices internal medicine.

In the June 18 speech, she urged physicians to work together on issues such as medical liability reform, innovations in medical education and health care technology improvements. Among her other goals as the AMA’s 168th president: Eliminate the sustainable growth rate formula in Medicare, and focus on the Association’s strategic plan.

“By standing together, unified in vision and commitment, physicians can shape the health care system this country needs,” she said.

Also during the Annual Meeting, the House of Delegates elected Robert M. Wah, MD, president-elect over Joseph P. Annis, MD, also a member of the AMA Board of Trustees. Dr. Wah will serve in that position for one year and become AMA president in June 2014. Jeremy A. Laza- rus, MD, a Denver psychiatrist, assumed the office of immediate past president.

Dr. Wah was chair of the AMA Board of Trustees from June 2011 to June 2012. He served in the House for 17 years and held several leadership positions. “Working together, I know we can make significant strides in reducing chronic disease, educating future physicians and improving how care is provided to our patients,” said Dr. Wah, a reproductive endocrinologist and ob-gyn in McLean, Va.

Delegates re-elected Andrew W. Gurnan, MD, an orthopedic surgeon from Hollidaysburg, Pa., as house speaker. Re-elected vice speaker was Susan R. Bailey, MD, an allergist-immunologist and pediatrician in Fort Worth, Texas. Named secretary was Carl A. Sirio, MD, an internist and critical care physician in Pittsburgh.

David D. Barbe, MD, MHA, a family physician from Mountain Grove, Mo., was elected to a second term on the board of trustees. Dr. Barbe is now board chair. Barbara L. Mccenery, MD, a medical oncologist/hematologist from Albuquerque, N.M., was chosen as chair-elect.

Steven J. Stack, MD, an emergency physician from Lexington, Ky., assumed the office of immediate past chair. Newly elected to the board are: Maya A. Babu, MD, MBA, a resident in neurosurgery from Rochester, Minn.; Jennifer Lubell, MD, an allergist-immunologist in Detroit; and Ryan J. Ribeira, a medical student at the University of California, Davis School of Medicine in Sacramento.

Strategic plan’s progress

At the meeting’s opening session, AMA Executive Vice President and CEO James L. Madara, MD, gave delegates an update on the AMA’s three-part strategic plan, which focuses on improving health outcomes, enhancing physician satisfaction and practice sustainability, and accelerating changes in medical education. The AMA is working to identify and support models of care delivery and payment that promote doctor satisfaction and practice sustainability. The Association is teaming up with RAND Health to conduct research on 30 practices in six states, with the goal of creating resources and tools that doctors can use to improve satisfaction and sustainability, Dr. Madara said.

On June 14, the AMA unveiled the 11 schools that will receive funding over five years as part of the accelerating change in medical education initiative. The $11 million will go toward educational innovations such as increased use of health IT and models for competency-based student progression.

In April, the AMA announced that cardiovascular disease and type 2 diabetes would be the first two conditions targeted to improve health outcomes. At the opening session of the house, Dr. Madara described how the Association has partnered with the Johns Hopkins Armstrong Institute for Patient Safety and Quality for work relating to cardiovascular diseases and with the YMCA of the USA for work on type 2 diabetes. The latter effort includes increasing doctor referrals to the Y’s diabetes prevention program.

“Our initial efforts to combat cardiovascular disease centers on patients with hypertension who have not been able to meet their blood pressure goals,” Dr. Madara told delegates. “Believe it or not, that’s 30 million of our citizens.”

Meeting Notes

Legislative Actions

ISSUE: The Centers for Disease Control and Prevention says one in three U.S. adults is obese, as well as 17% of children and teens. Evidence indicates that sugar-sweetened beverages, which account for almost half of added sugar in Americans’ diets, contribute to obesity.

PROPOSED ACTION: Work to remove or replace beverages from the Supplemental Nutrition Assistance Program. Educate patients about the health effects of these beverages, and encourage states to include information about food and beverage choices and nutrition in SNAP materials. [Adopted]

ISSUE: Gun control and mental illness have become high profile issues. Severe mental illness can begin before age 24, yet there is a shortage of trained clinicians to help young patients.

PROPOSED ACTION: Encourage doctors to talk about firearm safety; use of gun locks and firearm safety classes. Support research on firearm-related deaths and injuries and increased funding for injury databases. Work with specialty and state medical societies to develop standardized approaches to do mental health assessments on patients with potentially violent behaviors. [Adopted]

ISSUE: Medicare and insurers are using patient satisfaction as a factor to determine physician payment. Patient satisfaction is not a reliable indicator of quality of care.

PROPOSED ACTION: Work with the Centers for Medicare and Medicaid Services and nongovernment payers to ensure that subjective criteria, such as patient satisfaction surveys, are used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician payment. [Adopted]