AMA People and Elections
CMA Trustee Albert Ray, MD, of San Diego was elected Chair of the California Delegation and Chair of the CMA Board of Trustees Steven Larson, MD, of Riverside was elected Vice-Chair.

The California Delegation and Pacific RIM Caucus recognized outgoing Delegation Chair Gerald Murphy, MD, for his dedication and leadership.

UCLA emergency medicine fellow Erin Wilkes, MD, was elected Sectional Alternate from the AMA Resident and Fellow Section.

Stanford medical student, and current CMA student trustee, Malini Daniel was elected Trustee from the AMA Medical Student Section to the AMA-HOD.

UC Davis medical student Shahram Ahari was elected Region 1 Delegate, and UC Davis medical student Adam Dougherty, UC San Diego medical student Beth Griffiths, and UCLA medical student Erik Madden were elected Region I Alternate Delegates.

Retiring medical executive William Guertin was awarded the AMA Medical Executive Lifetime Achievement Award. The award is presented to a medical executive of a county medical society, state medical association, or national medical specialty society, who has contributed substantially to the goals and ideals of the medical profession.

Throughout his 40-year career, Mr. Guertin has been a dedicated and loyal advocate for the medical profession as the Executive Director of the Alameda-Contra Costa Medical Association. He is recognized for his counsel and leadership among his peers and among many medical leaders who have called on him to provide input on fundamental challenges facing organized medicine. Examples of this at the AMA level include him serving on the Federation Advisory Committee to the AMA Executive Vice-President and on the AMA Federation Coordination Team. He also serves on the Board of Directors of the national Physicians Foundation representing the California Medical Association, a nonprofit foundation supporting projects to improve medical practice through grant support, and served as President of the American Association of Medical Society Executives and on various CMA Committees that have addressed the future of organized medicine and how it can be most effectively structured.

Mr. Guertin has been unwavering in promoting the interests of the medical profession and a relentless advocate and defender of their prerogatives. His insight and guidance has been invaluable to the physician leaders he serves as they develop policies for the benefit of physicians and the patients we serve. For his 40 years of dedication and service, the AMA Medical Executive Lifetime Achievement Award is a fitting tribute to his many contributions to organized medicine and the medical profession.

CALIFORNIA RESOLUTIONS

1. Truth and Transparency in Pregnancy Counseling Centers: Adopted a substitute resolution in lieu of a California resolution which asks the AMA to: (1) support that any entity offering crisis pregnancy services disclose information onsite, in its advertising, and before any services are provided concerning the medical services, contraception, termination of pregnancy or referral for services, adoption options or referral for such services that it provides; and (2) advocate that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws. (Res. 7)
2. **Addressing Substance Use and Misuse in the United States**: Adopted a substitute resolution in lieu of a California resolution which asks the AMA to: (1) promote physician training and competence on the proper use of controlled substances; (2) encourage physicians to use screening tools (such as NIDAMED) for drug use in their patients; (3) provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; (4) encourage physicians to query a state’s controlled substances databases for information on their patients on controlled substances; and (5) that the AMA Council on Science and Public Health report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities. (Res. 933)

3. **Preventive Health and Health Services Grant Funding**: Adopted a California resolution which asks the AMA to: (1) support the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion in California and nationwide, and to maintain training of the public health physician workforce; and (2) communicate support of the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, to the US Congress. (Res. 935)

4. **Statistical Significance of FDA Safety Data**: Defeated a California resolution which asked the AMA to request that the US Food and Drug Administration require pharmaceutical package inserts to include the following statement: “Statistical significance of safety data is unknown.” (Res. 936)

5. **Prior Authorization and Medical Exception Process**: Reaffirmed existing policy in lieu of a California resolution which asked the AMA to support legislation: (1) to develop a uniform prior authorization form for prescription drug benefits, and that upon enactment of such law, our AMA work with regulators and other interested parties in developing a uniform prior authorization form for prescription drug benefits that is consistent with existing AMA policy; and (2) requiring third party payers to reimburse physicians for reasonable office practice expenses related to physician processing of prior authorizations, medical exceptions and any other administrative requirements needed for their patients to access medications. (Res. 822)

The following AMA policies were reaffirmed in lieu of the California resolution:

**H-320.944 Standardized Preauthorization Forms**
Our AMA: (1) supports the simplification and standardization of the preauthorization process for physicians and patients; (2) supports the adoption of a standardized paper preauthorization form by health plans for those physicians who choose to submit paper preauthorization forms; (3) will publicize and support the legislatively mandated adoption of HIPAA electronic standard transactions by health plans and encourage adoption of HIPAA electronic standard transactions by physicians; and (4) supports efforts to develop clear and complete requirements for each HIPAA electronic standard transaction. (CMS Rep. 4, I-10)

**H-385.951 Remuneration for Physician Services**
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols. 2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work. 3. Our AMA urges insurers to adhere to the AMA’s Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly. (Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11)
D-125.992 Opposition to Prescription Prior Approval
Our AMA will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians. (Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08)

H-285.965 Managed Care Cost Containment Involving Prescription Drugs
(1) Physicians who participate in managed care plans should maintain awareness of plan decisions about drug selection by staying informed about pharmacy and therapeutics (P&T) committee actions and by ongoing personal review of formulary composition. P&T committee members should include independent physician representatives. Mechanisms should be established for ongoing peer review of formulary policy. Physicians who perceive inappropriate influence on formulary development from pharmaceutical industry consolidation should notify the proper regulatory authorities. (2) Physicians should be particularly vigilant to ensure that formulary decisions adequately reflect the needs of individual patients and that individual needs are not unfairly sacrificed by decisions based on the needs of the average patient. Physicians are required to advocate for additions to the formulary when they think patients would benefit materially and for exceptions to the formulary on a case-by-case basis when justified by the health care needs of particular patients. Mechanisms to appeal formulary exclusions should be established. Other cost-containment mechanisms, including prescription caps and prior authorization, should not unduly burden physicians or patients in accessing optimal drug therapy. (3) Limits should be placed on the extent to which managed care plans use incentives or pressures to lower prescription drug costs. Financial incentives are permissible when they promote cost-effectiveness, not when they require withholding medically necessary care. Physicians must not be made to feel that they jeopardize their compensation or participation in a managed care plan if they prescribe drugs that are necessary for their patients but that may also be costly. There should be limits on the magnitude of financial incentives, incentives should be calculated according to the practices of a sizable group of physicians rather than on an individual basis, and incentives based on quality of care rather than cost of care should be used. Physician penalties for non-compliance with a managed care formulary in the form of deductions from withholds or direct charges are inappropriate and unduly coercive. Prescriptions should not be changed without physicians having a change to discuss the change with the patient. (4) Managed care plans should develop and implement educational programs on cost-effective prescribing practices. Such initiatives are preferable to financial incentives or pressures by HMOs or hospitals, which can be ethically problematic. (5) Patients must fully understand the methods used by their managed care plans to limit prescription drug costs. During enrollment, the plan must disclose the existence of formularies, the provisions for cases in which the physician prescribes a drug that is not included in the formulary and the incentives or other mechanisms used to encourage physicians to consider costs when prescribing drugs. In addition, plans should disclose any relationships with pharmaceutical benefit management companies or pharmaceutical companies that could influence the composition of the formulary. If physicians exhaust all avenues to secure a formulary exception for a significantly advantageous drug, they are still obligated to disclose the option of the more beneficial, more costly drug to the patient, so that the patient can decide whether to pay out-of-pocket. (6) Research should be conducted to assess the impact of formulary constraints and other approaches to containing prescription drug costs on patient welfare. (7) Our AMA urges pharmacists to contact the prescribing physician if a prescription written by the physician violates the managed care drug formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary. (8) When pharmacists, insurance companies, or pharmaceutical benefit management companies communicate directly with physicians or patients regarding prescriptions, the reason for the intervention should be clearly identified as being either educational or economic in nature. (9) Our AMA will develop model legislation which prohibits managed care entities, and other insurers, from retaliating against a physician by disciplining, or withholding otherwise allowable payment because they have prescribed drugs to patients which are not on the insurer’s formulary, or have appealed a plan’s denial of coverage for the prescribed drug. (10) Our AMA urges health plans including managed care organizations to provide physicians and patients with their medication formularies through multiple media, including Internet posting. (11) In the case where Internet posting of the formulary is not available and the formulary is changed, coverage should be maintained until a new formulary is distributed. (12) For physicians who do not have electronic access, hard copies must be available. (CEJA Rep. 2,
A-95; Res. 734, A-97; Appended by Res. 524 and Sub. Res. 714, A-98; Reaffirmed: Res. 511, A-99; Modified: Res. 501, Reaffirmed: Res. 123 and 524, A-00; Modified: Res. 509, I-00; Reaffirmed: CMS Rep. 6, A-03; Reaffirmation I-04; Reaffirmed: Sub. Res. 529, A-05; Reaffirmation A-08; Reaffirmation A-10)

6. **Electronic Health Record “Lemon Law”:** Referred a California resolution which asks the AMA to maintain a record of feedback and specific complaints by physicians about EHR products and vendors, which all AMA members can access on the AMA web site. (Res. 823)

7. **Censorship of Physician Discussion of Firearm Risk:** Adopted a California resolution which asks the AMA to: (1) oppose any restrictions on physicians being able to inquire and talk about firearm safety issues and risks with their patients; and (2) oppose any law restricting physicians' discussions with patients and their families about guns as an intrusion into medical privacy. (Res. 219)

8. **Generic vs. Brand Medications:** Adopted a California resolution which asks the AMA to advocate to the FDA against removal of generic medications from the market in favor of more expensive brand name products based solely on a lack of studies of the efficacy of the generic drug. (Res. 220)

9. **Federal Liability Protection for EMTALA Mandated Care:** Adopted as amended a California resolution which asks the AMA to: (1) support the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(6), shows evidence that physicians would benefit by such extension; and (2) that, if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(6), shows evidence that physicians would benefit by extension of the FTCA, the AMA conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and that the AMA assign a high priority to this effort. (Res. 221)

**D-130.971 The Future of Emergency and Trauma Care**

Our AMA will:
(1) expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care;
(2) with the advice of specific specialty societies, advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties;
(3) continue to advocate for the following:
   a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status,
   b. Financial support for providing EMTALA-mandated care to uninsured patients,
   c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service,
   d. Federal and state liability protections for physicians providing EMTALA-mandated care;
(4) report on progress in addressing these issues to the AMA House of Delegates at the 2007 Interim Meeting; and
(5) disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation. (BOT Rep. 14, I-06; Reaffirmation A-07; Reaffirmation A-08)
(6) support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care.

10. **Opposing Legal Prohibition of Circumcision:** Adopted, with title change, a California resolution which asks the AMA to oppose any attempt to legally prohibit male infant circumcision. (Res. 222)
OTHER KEY ACTIONS:

1. **Equal Access to Organ Transplantation for Medicaid Beneficiaries:** Referred a resolution which asks the AMA to urge the Centers for Medicare and Medicaid Services to designate organ transplantation as a mandatory benefit under Medicaid such that coverage across the United States will be uniform and predictable. (Res. 1)

2. **Stop the Implementation of ICD-10:** Adopted a substitute resolution which asks the AMA to: (1) vigorously work to stop the implementation of ICD-10 and to reduce its unnecessary and significant burdens on the practice of medicine; (2) do everything possible to let the physicians of America know that our AMA is fighting to repeal the onerous ICD-10 requirements on their behalf; and (3) work with other national and state medical and informatics associations to assess an appropriate replacement for ICD-9. (Res. 216)

3. **Third Party Payer Coverage Process Reform and Advocacy:** Adopted a resolution which asks the AMA to work with: (1) interested state medical and national specialty societies to develop model legislation and/or regulations to require that commercial insurance companies, state Medicaid agencies, or other third party payers utilize transparent and accountable processes for developing and implementing coverage decisions and policies; and (2) state medical and national specialty societies to actively seek the implementation of such model legislation and/or regulations at the national and state levels. (Res. 820)

4. **Medicaid Waivers and Maintenance of Effort Requirements:** Adopted as amended Council on Medical Service Report 5 which provides an overview of the financial challenges facing the Medicaid program, summarizes current AMA policy regarding Medicaid reform, and solicits feedback from the House and the Federation regarding future AMA policy development.

   The report recommends that the AMA: (1) reaffirm Policy D-165.966, which advocates that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes; (2) oppose any efforts to repeal the Medicaid maintenance of effort requirements in the ACA and American Recovery and Reinvestment Act (ARRA), which mandate that states maintain eligibility levels for all existing adult Medicaid beneficiaries until 2014 and for all children in Medicaid and the Children’s Health Insurance Program (CHIP) until 2019; (3) forward the testimony and comments from Reference Committee and House discussions regarding the financing of Medicaid to the Council on Medical Service for consideration in developing its recommendations for a follow-up report at the 2012 Annual Meeting; (4) encourage members of the House, state medical associations, and national medical specialty societies to forward any additional comments on the financing of Medicaid to the Council on Medical Service by January 6, 2012; and (5) make the comments submitted to the Council on Medical Service for its 2012 Annual Meeting report on Medicaid financing available to AMA members via the AMA website or other appropriate mechanism. (CMS Report 5)

5. **Patient Navigator Programs:** Adopted as amended Council on Medical Service Report 7 which describes the various roles patient navigators assume in the current health care environment, discusses provisions in the Patient Protection and Affordable Care Act (ACA, PL 111-148) that address patient navigators, and recommends guidelines to ensure that patient navigator services enhance rather than undermine the delivery of high-quality patient care.

   The concept of patient navigation evolved from a model designed to reduce health care disparities, and has expanded to include a variety of patient populations, clinical conditions and program goals. Many patient navigator or patient advocacy services today fall into one of four broad, often overlapping, categories: those focused on reducing health care disparities and increasing access to care; those focused on improving patient outcomes for a specific illness or chronic disease; those focused on streamlining care and managing cost growth; and those focused on helping patients effectively negotiate the complex web of administrative and clinical decisions associated with the current health care system.
The report recommends that the AMA:

1. That our American Medical Association recognize the increasing use of patient navigator and patient advocacy services to help improve access to care and help patients manage complex aspects of the health care system. In order to ensure that patient navigator services enhance the delivery of high-quality patient care, our AMA supports the following guidelines for patient navigator programs:
   a) The primary role of a patient navigator should be to foster patient empowerment, and to provide patients with information that enhances their ability to make appropriate health care choices and to receive medical care with an enhanced sense of confidence about risks, benefits, and responsibilities.
   b) Patient navigator programs should establish procedures to ensure direct communication between the navigator and the patient’s medical team.
   c) Patient navigators should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions, or making treatment recommendations. Patient navigators should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of their medical care team.
   d) Patient navigators should fully disclose relevant training, experience, and credentials, in order to help patients understand the scope of services the navigator is qualified to provide.
   e) Patient navigators should fully disclose potential conflicts of interest to those whom they serve, including employment arrangements.

2. Rescind Policy D-373.997, Patient Navigator Programs, which states:
   Our AMA will prepare a report for the AMA House of Delegates 2011 Interim Meeting on the emerging role of patient navigators which includes, but is not limited to, training and other recommendations that ensure entities seeking to establish patient navigator programs: a) recognize that patients must retain the choice of choosing their own health care provider and be given information so as to be able to seek the best health care provider, regardless of whether that provider is within or outside of the healthcare system which employs the patient navigator; b) require such entities to adopt AMA developed minimum patient navigator training requirements; and c) identify guidelines for initial contact and timely communication of patient navigator’s patient interaction with the patient’s medical care team. (Res. 118, A-11)

3. That our AMA work with the American College of Surgeons and other entities and organizations to ensure that patient navigators are free of bias, do not have any role in directing referrals, do not usurp the physician’s role in and responsibility for patient education or treatment planning, and act under the direction of the physician or physicians primarily responsible for each patient’s care. (CMS Report 7)

6. Support for Physician-Led, Team-Based Care: Adopted as amended Board of Trustees Report 9 which addresses four main elements: (1) brief discussion of the role of physician assistants in modern medical practice; (2) key scope of practice developments in 2011; (3) an overview of prescriptive authority by non-physicians to provide greater clarity regarding the issue of non-physicians currently authorized to “prescribe drugs”; and (4) discussion of the concept of physicians and non-physicians providing the “same service” to patients. The report also includes a discussion of the 2010 Institute of Medicine “Future of Nursing” report, a review of activity in Colorado and other states with respect to certified registered nurse anesthetists and work done by the Scope of Practice Partnership to help defeat numerous psychology prescribing bills.

The report recommends that the AMA:

2. That our AMA identify and review available data to analyze the effects on patients’ access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.

3. That our AMA identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.

4. That our AMA advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation’s primary care workforce needs.

5. That our AMA continue to recognize non-physician providers as valuable components of the physician-led health care team.

6. That our AMA continue to advocate that physicians are best qualified by their education and training to lead the health care team.

7. That our AMA communicate opposition to the October 18, 2011 Robert Wood Johnson Foundation report entitled, “Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care” to both the Robert Wood Johnson Foundation and the organizations participating in the development of the report, and ask all members of the AMA Scope of Practice Partnership to sign a formal letter of opposition and send it to the same parties. (Note: Recommendation 7 was Referred for Decision.)

8. That our AMA call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, “Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care” was premature; was not released officially; was not signed; and was not adopted by the participants. (BOT Report 9)

H-405.969 Definition of a Physician
1. The AMA affirms that a physician is an individual who has received a “Doctor of Medicine” or a “Doctor of Osteopathic Medicine” degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine. 2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a “doctor”, and who is not a “physician” according to the AMA definition above, must specifically and simultaneously declare themselves a “non-physician” and define the nature of their doctorate degree. 3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign. (CME Rep. 4-A-94; Reaffirmed by Sub. Res. 712, I-94; Reaffirmed and Modified: CME Rep. 2, A-04; Res. 846, I-08; Reaffirmed in lieu or Res. 235, A-09; Reaffirmed: Res. 821, I-09; Appended: BOT Rep. 9, I-09)

H-160.919 Principles of the Patient-Centered Medical Home
1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows: Principles Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. Whole Person Orientation - The personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care. Care is coordinated and/or integrated.
across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. Quality and safety are hallmarks of the medical home: Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient’s family. Evidence-based medicine and clinical decision-support tools guide decision making. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication. Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model. Patients and families participate in quality improvement activities at the practice level. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit. It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. It should support adoption and use of health information technology for quality improvement. It should support provision of enhanced communication access such as secure email and telephone consultation. It should recognize the value of physician work associated with remote monitoring of clinical data using technology. It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits). It should recognize case mix differences in the patient population being treated within the practice. It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting. It should allow for additional payments for achieving measurable and continuous quality improvements. 2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care. 3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home. 4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes. 5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home. (Res. 804, I-08; CMS Rep. 8, A-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmed: Res. 723, A-11; Appended: Res. 723, A-11)

D-35.988 The Joint Commission Primary Care Home Initiative

Our AMA Commissioners to The Joint Commission will strongly advocate that the requirements for any primary care home or medical home initiative of The Joint Commission strictly meet the requirements of the Joint Principles of the Patient-Centered Medical Home and more specifically that (1) each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care and (2) that a personal physician lead a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. The Joint Principles of the Patient-Centered Medical Home were developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association and approved by the AMA. (Res. 831, I-10)
**H-35.989 Physician Assistants**

(1) The AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire. (2) A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine. (3) The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ. (4) While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to his physician assistant. (5) The AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient. (6) In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.


**H-160.949 Practicing Medicine by Non-Physicians**

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional
pattern of practice in which the physician directs and supervises the care given; (2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers; (3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; and (5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine. (Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appendeed: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11)

**H-160.950 Guidelines for Integrated Practice of Physician and Nurse Practitioner**

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings. (2) The physician is responsible for managing the health care of patients in all practice settings. (3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law. (4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients. (5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients’ condition, as determined by the supervising/collaborating physician. (6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts. (7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients’ condition. (8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner. (9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner. (10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other’s contributions to patient care. (11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns. (CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09)

**H-35.974 Prescribing by Allied Health Practitioners**

Our AMA will work with national specialty societies to monitor the status of any initiatives to introduce legislation that would permit prescribing by psychologists and other allied health practitioners, and develop in concert with state medical associations specific strategies aimed at successfully opposing the passage of any such future legislation. (Sub. Res. 203, A-02)

**H-35.973 Scopes of Practice of Physician Extenders**

Our AMA supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care. (Res. 213, A-02)

**H-35.988 Independent Practice of Medicine by "Nurse Practitioners"**

The AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery in all of its branches. (Sub. Res. 53, I-82; Reaffirmed: A-84; Reaffirmed: CLRDP Rep. A, I-92; Reaffirmed: BOT Rep. 28, A-03)
H-35.992 Reimbursement for Allied Health Personnel
Our AMA believes that (1) reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel; and (2) such personnel should be under the supervision of practicing physicians. (BOT Rep. A, NCCMC Rec. 41, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: BOT Rep. H, A-93; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10)

H-35.993 Opposition to Direct Medicare Payments for Physician Extenders
Our AMA reaffirms its opposition to any legislation or program which would provide for Medicare payments directly to physician extenders, or payment for physician extender services not provided under the supervision and direction of a physician. (CMS Rep. N, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: BOT Rep. 6, A-10)

H-160.929 Anesthesiology is the Practice of Medicine
It is the policy of the AMA that anesthesiology is the practice of medicine. Our AMA seeks legislation to establish the principle in federal and state law and regulation that anesthesia care requires the personal performance or supervision by an appropriately licensed and credentialed doctor of medicine, osteopathy, or dentistry. (Sub. Res. 216, I-98; Reaffirmed: BOT Rep. 23, A-09)

H-160.947 Physician Assistants and Nurse Practitioners
Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician. The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety.): (1) The physician is responsible for managing the health care of patients in all settings. (2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner’s authorized practice, as defined by state law. (3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients. (4) The physician is responsible for the supervision of the physician assistant in all settings. (5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician’s delegatory style. (6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means. (7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician. (8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant. (9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice. (10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care. (BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03)

H-160.950 Guidelines for Integrated Practice of Physician and Nurse Practitioner
Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings. (2) The physician is responsible for managing the health care of patients in all practice settings. (3) Health care services delivered in an integrated practice must be within the scope of each practitioner’s professional license, as defined by state law. (4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients. (5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients’ condition, as determined by the supervising/collaborating physician. (6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and
written contracts. (7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients’ condition. (8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner. (9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner. (10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other’s contributions to patient care. (11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other’s practice patterns. (CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09)

H-35.970 Doctor of Nursing Practice
1. Our American Medical Association opposes participation of the National Board of Medical Examiners in any examination for Doctors of Nursing Practice (DrNP) and refrain from producing test questions to certify DrNP candidates. 2. AMA policy is that Doctors of Nursing Practice must practice as part of a medical team under the supervision of a licensed physician who has final authority and responsibility for the patient. (Res. 214, A-08)

H-360.987 Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice
Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care. (2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team. (3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians. (4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team. (5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities. (6) Physicians must be responsible and have authority for initiating and implementing quality control programs for non-physicians delivering medical care in integrated practices. (BOT Rep. 23, A-96; Reaffirmed A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10)

Physician Supervision of Invasive Procedures and the Provision of Fluoroscopy: Adopted as amended Board of Trustees Report 10 which addresses non-physicians who may be performing invasive procedures, including the use of fluoroscopy, interventional pain management procedures and other treatments. The report includes: (1) an analysis of AMA policy regarding concepts and terms such as “invasive procedure”; (2) a discussion on how “supervision” is defined by groups such as the Accreditation Council on Graduate Medical Education and agencies such as the Centers for Medicare and Medicaid Services; (3) an analysis of the roles of physician assistants and advanced practice nurses; and (4) a review of state legislative efforts regarding invasive pain management procedures.

The report recommends that the AMA: (1) advocate that interventional chronic pain management including those techniques employing radiation (e.g., fluoroscopy or CT) is within the practice of medicine and should be performed only by physicians, and (2) develop appropriate model state legislation with interested state and medical specialty societies that reflects this policy; and (2) convene a task force of appropriate AMA councils and interested state and medical specialty societies to develop principles to guide advocacy efforts aimed at addressing the appropriate level of supervision, education, training and provision of other invasive procedures by non-physicians including those employing radiologic imaging and report back to our House of Delegates. (BOT Report 10)