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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.

"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 interprofessional 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.

PHOTO BY TED GRUDZINSKI / AMA

"Ultimately, our goal is to showcase successful innovations and promote their adoption in medical schools nationwide," said then-AMA President Jeremy A. Lazarus, MD.

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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Special section on AMA meeting

Newly inaugurated President Ardis Dee Hoven, MD, details the critical issues facing doctors. House of Delegates coverage starts on page 21.

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.
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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 youths age 2 to 19 considered obese, according to the Centers for Disease Control and Prevention.

Researchers are projecting a dramatic increase in adult obesity and related health care costs by 2030 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 we felt 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.

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 insurers. As a result, physicians squeeze complicated discussions on improving diet, boosting physical activity and changing eating behaviors into short appointments that are scheduled for a separate health problem.

In such instances, physicians often code for conditions such as dysmetabolic syndrome or type 2 diabetes, Dr. Mechanick said. Although there's a code for morbid obesity, a BMI above

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How med schools will spend innovation grants

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rowed 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 the evolving health care environment and that can be applied across medical schools," said then-AMA President Jeremy 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 through email lists and 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.

"What this consortium does is really provide a forum to knit together all the innovative approaches from the different schools," said Sherine E. Gabriel, 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 rapidly 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 work at a single clinical 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 6,000 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.

Through a partnership with 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 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. ◆

11 MEDICAL SCHOOLS TO ACCELERATE CHANGE

The 11 medical schools awarded $1 million each by the American Medical Association will pursue educational initiatives in areas such as team-based care, use of health information technology and patient safety during the next five years. The winners, announced June 14 at the AMA Annual Meeting, are:

- Brody School of Medicine at East Carolina University in Greenville, N.C.
- Indiana University School of Medicine in Indianapolis.
- Mayo Medical School in Rochester, Minn.
- New York University School of Medicine in New York.
- Oregon Health & Science University School of Medicine in Portland.
- Pennsylvania State University College of Medicine in Hershey.
- University of California, Davis School of Medicine in Sacramento.
- University of California, San Francisco School of Medicine.
- University of Michigan Medical School in Ann Arbor.
- Vanderbilt University School of Medicine in Nashville, Tenn.
- Warren Alpert Medical School of Brown University in Providence, R.I.

SOURCE: AMERICAN MEDICAL ASSOCIATION

Meeting Notes

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 those discussions 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 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 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 work force.

❒ **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.

DR. MECHANICK

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 238 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." ◆

More oversight seen as needed for compounding pharmacies [PAGE 23]

AMA House of Delegates

■ COVERAGE FROM THE 162ND ANNUAL MEETING, JUNE 15–19 IN CHICAGO ■

Insurer report card points to patient collection hassles

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.

"Physicians are basically not very good at collecting the patient responsibility. And this is a problem, overall, because as the burden shifts more to patients, more of your revenue is at risk," he said.

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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Cost of reworked claims

The AMA set out to quantify the administrative burden placed on physicians when they must rework claims. On average, physician practices waste $14,600 each year on reworked claims through phone calls, investigative work and claims appeals.

Insurer	% of claims requiring rework	Overall rework cost per claim
HCSC	14.9%	$3.32
Anthem	14.3%	$2.64
Humana	7.6%	$2.29
Regence	20.5%	$2.28
UnitedHealthcare	5.4%	$2.13
Aetna	7.1%	$1.68
Cigna	5.5%	$1.25

SOURCE: "2013 ADMINISTRATIVE BURDEN INDEX," AMERICAN MEDICAL ASSOCIATION, JUNE

PHOTO BY PETER WYNN THOMPSON

A forum for the nation's physicians

More than 500 delegates convened to consider dozens of proposed resolutions and reports on issues such as delivery of care and health system reform. Policies adopted by the House of Delegates include recognizing obesity as a disease, calling for tighter restrictions of compounding pharmacies, encouraging states to provide educational materials about organ donation to driver education classes, and examining the impact of maintenance of certification on physicians.

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

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Meeting Notes

Medical Ethics

ISSUE: Physicians can identify and help victims of human trafficking, yet many doctors have not been trained how to do so.

❒ **PROPOSED ACTION:** Encourage AMA member groups, sections and the Federation of Medicine to raise awareness about human trafficking and inform doctors about resources available to help them serve affected patients. *[Adopted]*

ISSUE: Forty-four states require transgender patients to have undergone sex reassignment surgeries to change the gender designation listed on their birth certificates. But the standard of care for transgender patients has shifted, with a majority of people completing gender transition without surgery.

❒ **PROPOSED ACTION:** Support changing jurisdictional policies so that a physician's verification "that the individual has undergone transition according to applicable medical standards of care" is sufficient to alter the birth certificate sex designation. *[Adopted]*

ISSUE: Sometimes there is a conflict between a physician's refusal to provide a treatment on conscience grounds and patient autonomy and access to care.

❒ **PROPOSED ACTION:** Outline the circumstances in which conscience-based treatment refusals are inappropriate, such as when a patient faces a life-threatening emergency and no other qualified physician is available. *[Referred]*

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 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 year one 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.

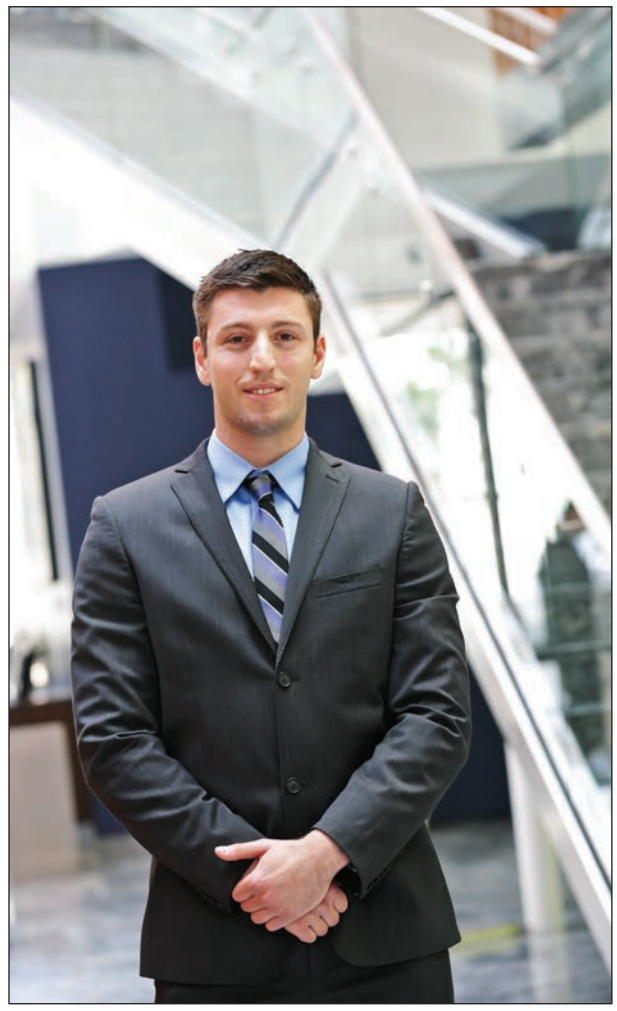

PHOTO BY PETER WYNN THOMPSON
Leon Vorobeichik, MD: Medical school's efforts lowered student depression and anxiety rates.

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 many 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 programs 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

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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.

DR. KIEF

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.

PHOTO BY PETER WYNN THOMPSON
Dr. Peters decried "organ allocation by wallet biopsy."

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

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State Medical Society.

Yet the troubles do not end with entry into medical practice. Research shows that about one in three practicing physicians is burned out and that doctors who are professionally dissatisfied are likelier to have less-satisfied patients.

High burnout rates are not just a problem for physicians, but for the country as a whole, said Michael Tutty, PhD, the AMA vice president of physician practice sustainability.

"Our society is best served when our brightest minds consider, choose and enjoy a fulfilling career in the medical profession and provide high-quality patient care," he said.

AMA research expected in fall

The AMA has partnered with the Santa Monica, Calif.-based nonprofit think tank RAND Health to do field research at 30 physician practices in six states to better understand the elements linked to dissatisfaction and how to address them. The early themes emerging from the project are that unstable revenue streams, lack of control over the practice environment and less time with patients are the primary culprits of physician dissatisfaction, Tutty said.

The initial findings probably will be released in October, and the AMA will work to develop tools to help physicians address the factors impeding satisfaction while advocating for changes in areas beyond doctors' direct control.

At a separate educational session, Jay Crosson, MD, said the AMA action plan probably will include toolkits and webinars for physicians, and dissemination of the project findings through media mailings and speaking engagements. Dr. Crosson is the Association's group vice president, professional satisfaction — care delivery and payment.

"We are going to take all these factors and try to understand the key drivers. From that we will create an action plan," he said. ◆

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of Trustees for a decision. The Organ Procurement and Transplantation Network already is working with the American Society of Transplant Surgeons and other bodies to examine this issue, and delegates did not want to duplicate those efforts.

Nearly 120,000 Americans are on the United Network for Organ Sharing's transplant waiting list. More than 96,000 await a kidney.

When patients are fortunate enough to receive a kidney transplant, those who are uninsured are at greater risk of renal failure due to the cost of the immunosuppressive drug regimens and nephrology care they need. Medicare, for example, covers kidney transplants for patients of any age, but only those 65 and older enrolled in the program will have their follow-up care covered.

Delegates adopted new policy supporting "private and public mechanisms that would extend insurance coverage for evidence-based treatment of renal transplant care for the life of the transplanted organ." ◆

More oversight seen as needed for compounding pharmacies

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

Pamela Lewis Dolan
AMNEWS STAFF

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

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 industry, 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 report, approved at the AMA Annual Meeting, was heavily debated during reference committee testimony, as some doctors argued that tighter restrictions could limit access to compounded pharmacy products, placing patients at risk of not receiving necessary treatments in time.

Traditional drug compounding is done by pharmacists for individual prescriptions. The AMA wants compounding facilities that mass produce compounded products to be recognized as "compounding manufacturers" that are subject to FDA regulations.

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 58 people and sickened 700 others was linked to a compounded injectable drug made in Massachusetts.

PHOTO BY PETER WYNN THOMPSON

Dr. Solish: Compounded drugs essential for many ophthalmology practices.

Ophthalmologists share concerns

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.

Ed Bryant, MD, an ophthalmologist from West Memphis, Ark., and an alternate delegate for the Arkansas Medical Society, said his practice is more than 1½ hours away from any compounding pharmacies. "I have to have these drug in supply in my office. There's no way many of my patients could make it to a compounding pharmacy. If we don't have this, there will be many patients in my practice that will have vision loss. There's no doubt."

Language was added to the original report to support the view that allowances must be made to meet anticipated needs, including urgent and emergency cases. David Ball, spokesman for the International Academy of Compounding Pharmacists, said the academy was glad that there was discussion of the needs for compounded products in emergencies.

The same day delegates approved the report, former Health and Human Services' Secretary Tommy Thompson announced a new group to push Congress for compounding reform. He backs legislation co-sponsored by Sens. Pat Roberts (R, Kansas), Lamar Alexander (R, Tenn.), Tom Harkin (D, Iowa) and Al Franken (D, Minn.). If passed, the bill would give the FDA authority to regulate so-called compounding manufacturers.

In May, David G. Miller, RPh, executive vice president and chief executive officer of the compounding pharmacists group, testified before the U.S. Senate Committee on Health, Education, Labor and Pensions, about the bill. He said use of the phrase "compounding manufacturer" was confusing and would "blur the jurisdictional authority of regulators."

Ball said members of Thompson's coalition were drug manufacturers whose products could be copied legally by compounders and sold at a lower price. "We understand why a group that represents pharmaceutical manufacturers might want to see limitations placed on compounding. It is important to note that pharmacy compounding has risen in popularity in part due to the shortages of medications produced by drug manufacturers." ◆

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

❒ **PROPOSED ACTION:** Support a ban on the marketing of high stimulant/caffeine 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 unaddressed 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 1996 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 percentage points 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]*

Report card points to collection hassles

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saw deductibles rise from an estimated average of $584 to $1,097 during the same period.

The problem for physicians, says the AMA, is that they don't always know what the patient portion is at the time of care, making it difficult to collect during the visit. That's when patients are most likely to pay, and it also saves the physicians the cost of chasing down bills.

"Physicians want to provide patients with their individual out-of-pocket costs but must work through a maze of complex insurer rules to find useful information," said AMA Board of Trustees Member Barbara L. McAneny, MD. "The AMA is calling on insurers to provide physicians with better tools that can automatically determine a patient's payment responsibility prior to treatment."

The patient portion piece was just one of the many areas of claims adjudication that could benefit from streamlining technology, the report card found. The electronic submission of claims, for example, could reduce the amount of time for claims to be received by insurers.

Health plans said it also falls to doctors to ensure that their systems are ready for faster claims adjudication.

"Health plans and providers share the responsibility of improving the accuracy and efficiency of claims payment. Health plans are doing their part to streamline health care administration to reduce paperwork, improve efficiency and bring down costs," said Robert Zirkelbach, spokesman for America's Health Insurance Plans, the trade group representing health plans.

"At the same time, more work needs to be done to increase electronic submission of claims and to reduce the number of claims submitted to health plans that are duplicative, inaccurate or delayed."

For example, Zirkelbach pointed to a February AHIP survey that found 16% of electronic claims and 54% of paper claims were received from a physician or hospital more than 30 days after the service date.

Administrative burdens quantified

Along with the annual report card, the AMA also launched its Administrative Burden Index. It examined the claims that required reworking and calculated a monetary amount of each reworked claim, per each evaluated health plan. A five-star rating system also was designed to highlight areas that need focus.

The index said HCSC had the highest cost associated with reworking claims at $3.32 per claim. Cigna had the lowest at $1.25 per claim.

A typical physician practice will lose $14,600 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 doctors to file more 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. ◆

Guidance offered on effective EHR use

Physicians respond to worries that technology may be interfering with patient communication and is a barrier to sharing information with other facilities.

Sue Ter Maat
AMNEWS STAFF

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 how they felt regarding the use of these devices during exams.

DR. STACK

"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 their introduction in the exam room will be positive or negative," said then-AMA Board Chair Steven J. Stack, MD, in a statement. "We look forward to gathering more information to help physicians best incorporate this new technology into their interactions with patients."

Delegates to the Annual Meeting also voted to push for greater EHR interoperability so that independent physicians will have an easier time connecting 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 Medical Student Section broadly supports improving interoperability between electronic health records, as well as actions by federal agencies that set technical interoperability and data integrity standards across the industry," said Paul Pukurdpol, a regional medical student alternate delegate for the Colorado Medical Society on behalf of the Medical Student Section, in testimony submitted before the meeting.

"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, 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

Continued from page 21

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 certificated 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, MD, a New York delegate and past president of the MSSNY. Dr. 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.

PHOTO BY TED GRUDZINSKI / AMA

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

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

Exams take time and money

Several delegates said that although doctors must prove their competency, it doesn't have to be done through stressful and burdensome exams.

Brigitta Robinson, MD, a Denver general surgeon who spoke on behalf of the Colorado Medical Society, expressed concern about the cost and travel time involved in taking the exams, which often are administered in another state.

Carol Berkowitz, MD, a member of the AMA 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. ◆

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 Wailes, 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 California Medical Assn. who spoke on his own behalf, said he receives faxes and calls from certain chain 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 NACDS, the DEA and others to develop policies on reducing inappropriate dispensing and drug diversion. "Pharmacists and physicians are in the same situation; we are both frustrated and feel there is a better way to help patients while confronting prescription drug abuse," Nicholson said.

PHOTO BY PETER WYNN THOMPSON
Dr. Annis chaired task force on pain management procedures.

The National Community Pharmacists Assn. opposes the AMA resolution. It "takes a simplistic approach to the prescription drug abuse epidemic that is very complex and wide-ranging in nature," said NCPA CEO B. Douglas Hoey, RPh.

Pain procedure supervision

In another scope-of-practice issue, delegates approved a Board of Trustees report with guidelines on invasive pain management procedures for treating chronic pain, including procedures that use fluoroscopy.

Testimony focused on the degree of supervision required for nonphysicians. Such procedures require physician-level training, but there are instances in which appropriately trained, credentialed nonphysicians could perform certain technical tasks under the supervision of experienced physicians either on site or in the same room, the report stated.

Nonphysicians "are extremely valuable, and we believe strongly that we want to work in cooperation and partnership with them," said AMA Trustee Joseph P. Annis, MD, chair of the task force that wrote the report.

Dr. Annis said in an interview that there are treatment situations, considered on a case-by-case basis, in which physicians don't need to be on site to supervise nonphysician practitioners in a general capacity.

In cases involving radiologic imaging, however, the report specified that invasive pain management procedures should be performed only by doctors with appropriate credentials and training. ◆

Meeting Notes
Medical Service

ISSUE: Employers are increasingly turning to work site health clinics as a way to control their spending while offering insurance coverage to their employees.

❒ **PROPOSED ACTION:** Recommend 14 principles regarding work site clinics. The principles include: establishing referral systems with physician practices if patient conditions are beyond a clinic's scope of care; adopting protocols to ensure continuity of care with local practicing physicians; and developing expertise in specific occupational hazards and medical conditions that are likely to be more common in particular industries. *[Adopted]*

ISSUE: Some physicians have been prosecuted for unintended errors in medical judgment or unintended errors in medical record keeping or both.

❒ **PROPOSED ACTION:** Oppose the criminalization of good-faith errors in medical judgment and medical recordkeeping. *[Adopted]*

ISSUE: Nearly nine in 10 adults demonstrate low proficiency health literacy, according to the National Assessment of Adult Literacy. Adults with low literacy tend to lack health insurance and have poor health status.

❒ **PROPOSED ACTION:** Direct the AMA to recommend that all health care institutions adopt a health literacy policy with the primary goal of enhancing communication and education approaches to the patient visit. Encourage the development of low-cost community and health system resources, support state legislation, and consider annual initiatives on improving health literacy. *[Adopted]*

Call for tougher rules to stop misleading medical device ads

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

Alicia Gallegos
AMNEWS STAFF

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.

DR. GREENE

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 DME 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. ◆

Doctors seek payment models to replace Medicare SGR

New Association policy says physicians should have the freedom to determine what models would apply best to their practices.

JENNIFER LUBELL
AMNEWS STAFF

The AMA adopted 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. 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 the 2013 debate over the SGR formula, which has been threatening payment cuts to doctors for more than a decade. According to 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 timeline 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 pay models. ◆

Leaders speak to AMA efforts on behalf of patients and physicians

The AMA president talks about critical issues facing doctors while the executive vice president gives a progress report on the strategic plan.

DAMON ADAMS
AMNEWS STAFF

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 doctor payment 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. Lazarus, 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. Gurman, 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 O. Barbe, MD, MHA, a family physician from Mountain Grove, Mo., was elected to a second term on the board and is now board chair. Barbara L. McAneny, MD, a medical oncologist/hemotologist 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.; Gerald E. Harmon, MD, a family physician from Pawleys Island, S.C.; and Ryan J. Ribeira, a medical student at the University of California, Davis School of Medicine in Sacramento.

PHOTO BY PETER WYNN THOMPSON

Robert M. Wah, MD, will serve a year as president-elect before assuming the AMA presidency in June 2014.

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 such 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 firearms 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 behavior. *[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 & 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]*