

Annual Meeting of the CMA House of Delegates

By Michele E. Raney, M.D.

Member, CMA Board of Trustees, Specialty Delegation



The 138th Annual Session of the California Medical Association (CMA) House of Delegates took place on October 17-19, 2009, in Anaheim, California.

Representing the California Society of Anesthesiologists in CMA's Specialty Delegation were Drs. Brian Cross and Lawrence Robinson. Drs. Virgil Airola, Michele Raney, Benjamin Shwachman, and Lee Snook served as members of the CMA Board of Trustees. CSA members in other delegations included Drs. Thelma Korpman, James Merson, Hugh Vincent, and James Willis. Dr. R. Lawrence Sullivan, Jr., participated in the deliberations of the Organized Medical Staff Section (OMSS) and Dr. Rebecca Patchin, Chair of the AMA Board of Trustees, addressed the CMA Board before traveling to New Orleans for the American Society of Anesthesiologists Annual Meeting being held concurrently.

With the 2009 meeting, CMA began its transition to a paper-less (or paper-optional) system. A mechanism for electronic reference committee discussions prior to the actual meeting (with limited voluntary participation) was established, and online testimony could be provided in addition to that presented at the actual reference committee hearings. Evaluating this in terms of timeliness, efficiency, effectiveness, and results, the House of Delegates (HOD) subsequently rejected bylaws changes that would have changed the governance process and codified a condensed annual meeting with extended all-electronic reference committees, caucuses and reports, feeling the limited interpersonal communications and sidebar discussions hindered appropriate decision making.

Meanwhile, several changes to the parliamentary Standing Rules of Order resulted in more efficient and effective deliberations while adhering to the purpose of thoughtful, open debate. One of the other changes enacted by the HOD was a resolution authored by CSA Past President Mark Singleton, M.D., asking that CMA identify a time for the annual meeting that conflicts least with important meetings of other organized medical societies (such as ASA, the American College of Surgeons, and other specialty organizations).

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The Board of Trustees and the House of Delegates reaffirmed the CMA's overarching principles on health care reform. These key policies support health system reform that aids the truly uninsured, helps those eligible for coverage to obtain it, allows total deductibility of all healthcare expenses, enacts national tort reform similar to California's, preserves and promotes Health Savings Accounts, eliminates payment linked to the Sustainable Growth Rate formula, and supports the right of physicians to contract privately with patients.

CMA did not waver on scope-of-practice issues. CMA will urge the federal government to eliminate the opt-out provision of the Medicare Conditions of Participation requirement that certified registered nurse anesthetists practice under physician supervision. Furthermore, only a physician shall be responsible for direction of the medical team.

Leadership

Dr. J. Brennan Cassidy (Newport Beach) was installed as CMA President. Dr. James Hinsdale, a general and trauma surgeon from San Jose, was elected President-Elect. Other CMA officers reelected were Drs. James Hay (San Diego), Speaker; Luther Cobb (Arcata), Vice-Speaker; Paul Phinney (Sacramento), Chair, Board of Trustees, and Steven Larsen (Riverside), Vice-Chair. CSA members Drs. Virgil Airola and Michele Raney were reelected to the Board of Trustees from the Fresno and Specialty Delegations, respectively.

Retiring from CMA after three years, Mr. Joseph Dunn completed his final House of Delegates as CEO. He will be succeeded by Mr. Alfred Gilchrist, formerly CEO of the Colorado Medical Society and, prior to that, Legislative Director for the Texas Medical Association.

Proceedings of the House of Delegates

Seven reference committees, composed of members of the House of Delegates, considered all the submitted resolutions and reports, supporting documentation, online and verbal testimony, relevant CMA policy, state and federal statutes and regulations, and ongoing governmental relations activities, and presented a series of recommendations for the HOD to modify and/or ratify. Highlights of those actions follow.

Medical Practice Issues

CMA will continue to inform physicians and the public about the questionable practices of Recovery Audit Contractors (RAC) while seeking legislation that requires reimbursement of physician costs, appeal policies that include peer review and medical-necessity determination by a physician practicing in the

CMA Report (cont'd)

relevant specialty and geographical area, and contractor-payment methodology changed from contingency-based to fee-for-service.

CMA supported expeditious action by the Drug Enforcement Administration to establish reasonable requirements for e-prescribing of controlled substances.

CMA will work with other organizations, including medical and specialty societies and the CMA Alliance, to identify resources available to assist physicians seeking treatment for physical and mental health and substance-abuse issues, while preserving the physician's right to confidentiality for this treatment.

Health System Reform

CMA will continue its active role in determining the future of the health care delivery system through engagement of decision makers, both in Washington and Sacramento. Additionally, CMA supported enactment of federal legislation that will extend federal funding to the states for emergency services provided to undocumented immigrants and establish mechanisms for increasing Medical physician payment with further federal matching funds.

CMA Membership, Finance & Governance

Changes in the CMA bylaws will formally update the relationships with CMA's component societies (county medical associations) and allow for a Charter Commission to be established and serve as a dispassionate mediator and advisor on specific issues associated with component society charters.

Insurance and Physician Payment

CMA will pursue legislation to deal with health plan payments of emergency on-call specialists' claims for EMTALA-obligated medical screening and emergency care, and look at emergency care risk pool formation (or similar arrangements) designed to maintain the health of chronically ill enrollees, offer increased access to unscheduled care appointments, and lessen the burden on the emergency departments.

CMA endorsed establishing appropriate billing and payment mechanisms for online and telephone services as well as remuneration for time spent communicating with insurers.

CMA will work with AMA to seek federal guidance on handling misleading or false statements about a physician's performance posted online or in other public venues, particularly when patients use protected health information. CMA will develop the educational resources to assist physicians subject to

CMA Report (cont'd)

online posting of false or misleading statements regarding their performance, and these resources may include guidelines or strategies as well as examples of documents dealing with false statements.

Numerous resolutions addressed utilization review and the determination of medical necessity, which will be further developed in the upcoming year. Core principles remain that the examining and treating physician shall be the primary medical authority determining medical necessity—not an outside entity who has not examined the patient or developed a doctor-relationship with all the duties, obligations, and privileges that such a relationship entails—and that only a California-licensed, actively practicing, competent physician, with board certification or training and experience as the treating physician, may review, modify, or deny requests for authorization based on medical necessity. Furthermore, the practice of an insurer failing to use utilization review to argue medical necessity, and retroactive denial of payment for Workers' Compensation by subsequently arguing medical necessity after treatment has been rendered, should be prohibited.

Quality, Ethics and Legal Issues

Development of medical practice guidelines was discussed. CMA continues to support that all practice guidelines be peer-reviewed by independent reviewers prior to publication to ensure that they are evidence-based to the greatest degree possible and that any possible conflict of interest of the committee members, organization, or reviewers be disclosed with each publication thereof. Likewise, CMA supports the ability of non-governmental organizations to evaluate appropriate medical diagnosis or therapy, current or new diagnostic or therapeutic tests, procedures, medications, or other procedures that improve the quality of patient care, and believes that practice guidelines, parameters, best practice models, or similar sets of principles or clinical recommendations should state expressly that they do not establish standard of care or create specific requirements for physicians that restrict the exercise of their clinical judgment.

CMA will continue to participate in discussions with the Medical Board and other interested stakeholders on malpractice protections for physicians providing voluntary, unpaid service, and continues to support immunity from liability for triage decisions made and medical and nonmedical care rendered during a major disaster or state of emergency.

Health Professions and Facilities

CMA will evaluate the extent to which standards of the other two CMS-approved hospital accrediting organizations—the Healthcare Facilities

CMA Report (cont'd)

Accreditation Program (of the American Osteopathic Association) and DNV Healthcare, Inc. (alternatives to the Joint Commission)—are consistent with California state law, particularly with respect to the requirements for an independent self-governing medical staff. Some hospitals are utilizing these accreditation organizations instead of The Joint Commission, primarily because of simpler, less expensive processes.

Model Medical Staff Bylaws revisions that address medical executive committee accountability, peer review, credentialing of low volume practitioners, and disruptive behavior policies were accepted. With respect to the latter, model language includes that “acceptable medical staff behavior includes ... advocacy on medical matters and making recommendations or criticism intended to improve care.”

In looking at new models for financing medical education, CMA elected to support establishment of a program that allows institutions such as government agencies to fully fund medical student education and training in exchange for an agreement to practice medicine at a designated institution upon completion of medical training.

CMA reviewed a report on the performance of a history and physical by a podiatrist and voted to take all appropriate steps to clarify in state law that the performance of medical history and physical examinations be limited to licensed physicians and surgeons, or nurse practitioners and physician assistants, when acting under direct supervision of a physician or surgeon; that health care providers be authorized to perform admission screenings only within their scope of practice; and that a physician and surgeon be available with respect to any medical problem that may arise which is not within the scope of practice of the practitioner.

Science and Public Health

More than one reference committee discussed influenza. CMA continued to support universal annual seasonal influenza vaccination of all health care workers with direct patient contact, recommended vaccination of H1N1 and other pandemic strains according to Centers for Disease Control and Prevention recommendations, and supported CDC and California Department of Public Health recommendations for personal protective equipment use by unvaccinated health care workers. CMA recommended health facility planning for influenza outbreaks should include the establishment of physician-directed medical staff committees qualified to assess and recommend changes in staffing plans in the event of an influenza outbreak, and opposed the use of

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sanctions against health care facilities that are unable to meet mandated staff/patient ratios due to influenza staffing shortages.

CMA endorsed programs that will aid in educating students of the dangers of alcohol, supported increased taxes on sodas and other sugar-sweetened beverages to fund obesity prevention and treatment programs, and encouraged compliance with CDC guidelines for increased physical education activities.

CMA declared criminalization of marijuana a failed public health policy and will encourage participation in debate and education about the health aspects associated with changing current policy on cannabis use.

Concluding Remarks

Within the governance structure of the CMA, its members are represented through geographic societies, specialty societies, and practice forums defined by size or characteristics such as hospital-based, ethnic, or administrative medicine. CSA members on the Board of Trustees have been elected to the Board through each of these channels. A new forum for hospital-based physicians has been activated, and CSA members are asked to consider changing their forum designation from one based on group size to that of being hospital-based. This new forum also has delegates and a seat on the Board of Trustees and is another way that CSA can extend its influence within organized medicine.

The CMA states its mission is to “promote the science and art of medicine, protection of public health, and the betterment of the medical profession.” Lest the medical profession isolate itself as some ineffective, interesting-yet-peculiar historical footnote, it is vitally important that all actively practicing anesthesiologists in California join the CSA, and all CSA members, regardless of type of practice, become members in the CMA. CSA and CMA can exert influence only to the extent that membership represents a credible and critical constituency, and members must speak, not by fighting **with** each other, but **for** each other, even if only to prevent those who oppose us from believing they have unanimous support. Never has it been more true that advocacy is powered by membership, just as membership is empowered by advocacy.